Pain Management Consultants, P.A.

SPINAL DIAGNOSTICS & THERAPEUTICS

101 W. Koenig Ln, Suite 100 Austin, TX 78751 Phone (512) 454-9426/877-804-7021 Fax (512) 454-7294
15808 F.M. 620 North, Suite 215 Austin, Texas 78717
301 W. HWY 71, Suite 109 Bastrop Texas 78602

J. Lowell Haro, MD Diplomate, American Board of Anesthesiology, Certificate of Added Qualifications in Pain Management	**Jeffrey Higginbotham, MD** Diplomate, American Board of Anesthesiology, Certificate of Added Qualifications in Pain Management	**Clayton Adams, MD** Diplomate, American Board of Anesthesiology, Certificate of Added Qualifications in Pain Management

Welcome

Welcome to our practice! We look forward to meeting with you and developing a treatment plan that fits your medical needs. To ensure the best quality of care, it is important that you fill out and sign the consultation packet in its entirety. Her are important items to remember:

- Please call PMC 24 hours in advance if you need to cancel an appointment. A $25 fee can be assessed for failure to give us 24-hour notice.
- PMC has a strict narcotic agreement. A narcotic agreement is enclosed. Our providers will not dispense medication in the evening or on weekends.
- Please list your current medications on the medication log provided in our packet.
- Please fax pages 1 through 6 of the packet to us prior to your appointment, if possible. This allows your chart to be prepared prior to your arrival. Please also bring your packet to your appointment.
  - Fax: (512) 454-7294

We look forward to seeing you and please do not hesitate to call us at (512) 454-9426 if you have any questions.

Please fill in all areas below.

Name:

Preferred Name:

SSN:

DOB:

Address:

Email:

Ethnicity: ☐Hispanic or Latino
☐Not Hispanic or Latino
☐Refuse to report

Primary language: ☐English
☐Spanish
☐Other: ___________

☐Asian
☐Black or African American
☐More than one race
☐Native American or Alaska Native
☐Native Hawaiian
☐Other Pacific Islander
☐White
☐Refuse to report

Date of first visit:

Gender:

Marital Status:

Emergency Contact Name and phone #:

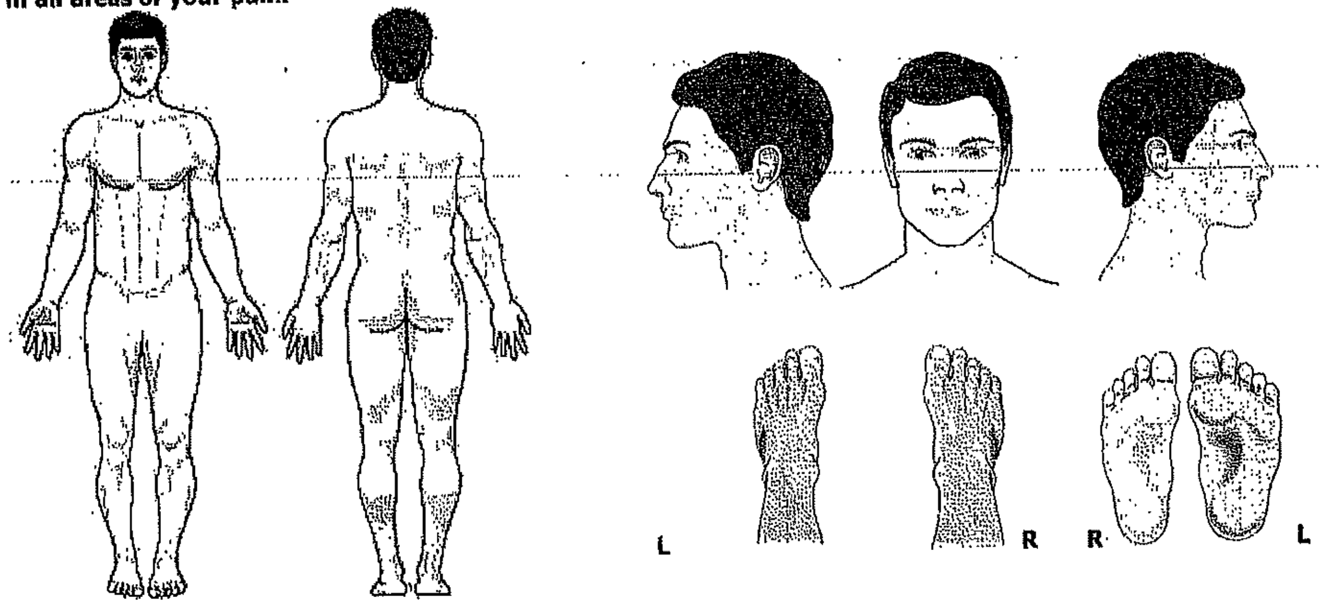
Referring Physician:
Phone#

Primary Care Physician:
Phone#

*Please select the Race you MOST IDENTIFY WITH. These categories are chosen by the US Census Bureau and are the only acceptable answers to report. will default your answer to "Refuse to report". We apologize for any confusion.

Please state your Weight: ________________ **Height:** ________________

Shade in all areas of your pain.



In the space below, please list the areas of pain (#1 bothers you the most).

List Primary Area(s) of pain:

ONSET: How did your pain begin?
- ☐ After a specific incident ____________
- ☐ After no specific incident
- ☐ Began gradually over time

Other: ________________________

What date did your pain begin? __________

PATTERN:
- ☐ Constant
- ☐ Episodic (If episodic, how long does each episode of pain last?)
  - ☐ Lasts for _____ seconds at a time
  - ☐ Lasts for _____ minutes at a time
  - ☐ Lasts for _____ hours at a time
  - ☐ Lasts for _____ weeks at a time
  - ☐ Lasts for _____ months at a time

- ☐ Occurs more in the early morning
- ☐ Occurs more in the evening
- ☐ Occurs more at night

List Other Area(s) of pain (if applicable):

ONSET: How did your pain begin?
- ☐ After a specific incident ____________
- ☐ After no specific incident
- ☐ Began gradually over time

Other: ________________________

What date did your pain being? ____________

PATTERN:
- ☐ Constant
- ☐ Episodic (If episodic, how long does each episode of pain last?)
  - ☐ Lasts for _____ seconds at a time
  - ☐ Lasts for _____ minutes at a time
  - ☐ Lasts for _____ hours at a time
  - ☐ Lasts for _____ weeks at a time
  - ☐ Lasts for _____ months at a time

- ☐ Occurs more in the early morning
- ☐ Occurs more in the evening
- ☐ Occurs more at night

(Primary pain continued)

CHARACTERIZED AS: Describe your pain. Please circle.

A dull ache Burning Coldness Sharp
Stabbing Tight Cramping
Piercing Hotness Heavy
Shooting Tingling Throbbing

RADIATION: Does your pain radiate anywhere?
☐ No
☐ Yes. Where? ______________________

AGGRAVATED BY: What makes your pain worse?
☐ Nothing
☐ Cold
☐ Heat
☐ Exertion
☐ Walking
☐ Rest
☐ Prolonged standing
☐ Prolonged sitting
☐ Lying down
☐ No medication(s)
☐ Stress
☐ Weather changes
☐ Bending
Other: ______________________

RELIEVED BY: What makes your pain better?
☐ Nothing
☐ Rest
☐ Lying down
☐ Stretching
☐ Change in position
☐ Sitting
☐ Walking
☐ Medication(s)
☐ Heat
☐ Cold
☐ Massage
Other: ______________________

ASSOCIATED FEATURES: Do you have

Yes	No	
☐	☐	Numbness? If yes, where? ____________
☐	☐	Weakness? If yes, where? ____________
☐	☐	Loss of bowel or bladder function? If yes, please

explain:

On a scale of 0 to 10, how would you rate your pain (0=no pain, 10=worst pain imaginable)? Circle one.

Today:	At its worst:	At its best:
0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9
10	10	10

(Other pain continued)

CHARACTERIZED AS: Describe your pain. Please circle.

A dull ache Burning Coldness Sharp
Stabbing Tight Cramping
Piercing Hotness Heavy
Shooting Tingling Throbbing

RADIATING: Does your pain radiate anywhere?
☐ No
☐ Yes. Where? ______________________

AGGRAVATED BY: What makes your pain worse?
☐ Nothing
☐ Cold
☐ Heat
☐ Exertion
☐ Walking
☐ Rest
☐ Prolonged standing
☐ Prolonged sitting
☐ Lying down
☐ No medication(s)
☐ Stress
☐ Weather changes
☐ Bending
Other: ______________________

RELIEVED BY: What makes your pain better?
☐ Nothing
☐ Rest
☐ Lying down
☐ Stretching
☐ Change in position
☐ Sitting
☐ Walking
☐ Medication(s)
☐ Heat
☐ Cold
☐ Massage
Other: ______________________

ASSOCIATED FEATURES: Do you have

Yes	No	
☐	☐	Numbness? If yes, where? ____________
☐	☐	Weakness? If yes, where? ____________
☐	☐	Loss of bowel or bladder function? If yes, please

explain:

On a scale of 0 to 10, how would you rate your pain (0=no pain, 10=worst pain imaginable)? Circle one.

Today:	At its worst:	At its best:
0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9
10	10	10

WORKERS COMPENSATION: If this is a workers comp claim, what is your date of injury?

What is your compensable injury? ________________

PAST INTERVENTIONS:
PREVIOUS EVALUATION: Provider's Name/Year. Please list area of pain next to each provider listed.

- ☐ Neurologist: ________________
- ☐ Neurosurgeon: ________________
- ☐ Orthopedic surgeon: ________________
- ☐ Pain Management: ________________
- ☐ Primary care physician:

Other: ________________

DIAGNOSITC TESTS: PRIOR TESTS PERFORMED
Provider/Year/Name of Test(s)/Outcome. Please list area of pain next to each test listed.

- ☐ X-rays:
- ☐ CT scan:
- ☐ CT myelogram:
- ☐ MRI:
- ☐ Discogram:
- ☐ EMG/Nerve Conduction Study:
- ☐ None

PREVIOUS MEDICATIONS Medications used previously for your pain complaints. Please state the reason the medications were discontinued.

Chiropractic: ☐ Yes ☐ No
If yes, was it helpful? ☐ Yes ☐ No

Have you had physical therapy? ☐ Yes ☐ No

If yes, what area(s)? ________________
was it helpful? ☐ Yes ☐ No

TENS unit: ☐ Yes ☐ No ☐ I don't know
If yes, was it helpful? ☐ yes ☐ No

Have you seen a psychiatrist or psychologist?
☐ Yes, currently ☐ No

☐ Yes, in the past

If yes, whom? ________________

REVIEW OF SYSTEMS Check the appropriate box.

Skin

Itching	☐ Present	☐ Not Present
Easy bruising	☐ Present	☐ Not Present
Jaundice	☐ Present	☐ Not Present

Vision/Hearing (HEENT)

Wear glasses	☐ Present	☐ Not Present
Blindness, R/L eye	☐ Present	☐ Not Present
Glaucoma	☐ Present	☐ Not Present
Blurry vision	☐ Present	☐ Not Present
Hearing loss	☐ Present	☐ Not Present
Ringing in ears	☐ Present	☐ Not Present

Pulmonary/Respiratory

Shortness of breath	☐ Present	☐ Not Present
Chronic cough	☐ Present	☐ Not Present
Wheezing	☐ Present	☐ Not Present

Cardiovascular

Chest pain	☐ Present	☐ Not Present
Heart attack	☐ Present	☐ Not Present
High blood pressure	☐ Present	☐ Not Present
Heart murmur	☐ Present	☐ Not Present
Arrhythmia	☐ Present	☐ Not Present
Valve Disease	☐ Present	☐ Not Present

Gastrointestinal

Nausea/Vomiting	☐ Present	☐ Not Present
Diarrhea	☐ Present	☐ Not Present
Constipation	☐ Present	☐ Not Present

Genitorurinary

Pain with urination	☐ Present	☐ Not Present
Blood in urine	☐ Present	☐ Not Present
Urinary frequency	☐ Present	☐ Not Present
Kidney stones	☐ Present	☐ Not Present
Infection	☐ Present	☐ Not Present
Prostate problems	☐ Present	☐ Not Present
Menstrual problems	☐ Present	☐ Not Present

Musculoskeletal

Difficulty walking	☐ Present	☐ Not Present
Arthritis	☐ Present	☐ Not Present
Varicose veins	☐ Present	☐ Not Present
Fractures	☐ Present	☐ Not Present

Neurological

Headaches	☐ Present	☐ Not Present
Seizures	☐ Present	☐ Not Present
Paralysis	☐ Present	☐ Not Present
Numbness	☐ Present	☐ Not Present
Weakness	☐ Present	☐ Not Present
Dizziness	☐ Present	☐ Not Present

Psychological

Trouble with "nerves"	☐ Present	☐ Not Present
Considered suicide	☐ Present	☐ Not Present
Depression	☐ Present	☐ Not Present

Endocrine

Thyroid problem	☐ Present	☐ Not Present
Hypoglycemia	☐ Present	☐ Not Present

PAST MEDICAL HISTORY

Please list all **MEDICATION ALLERGIES** and your reaction.

Please check the medical illnesses that you currently have and document the relationship if a family member has any of these listed:

ILLNESS	YOU	FAMILY
HIV/AIDS		
Asthma		
Cancer (type)		
Diabetes		
Emphysema		
Epilepsy		
Glaucoma		
Heart/Vascular disease		
Hepatitis (type)		
Hypertension		
Hyperthyroid		
Hypothyroid		
Kidney Disease		
Lupus		
Osteoarthritis		
RheumatoidArthritis		
Shingles		
Stroke		
Tuberculosis		
Other:		

Please list any surgeries/hospitalizations. (Year/Hospital name/Outcome):

SOCIAL HISTORY:

Current school status:

Are you going to school currently?

- ☐ No
- ☐ Yes, full-time
- ☐ Yes, part-time

Current work status:

- ☐ Full-time. Job title: ______
- ☐ Part-time. Job title: ______
- ☐ Self-employed. Job title: ______
- ☐ Full-time parent
- ☐ Retired
- ☐ Disabled
- ☐ Unemployed, looking for work
- ☐ Unemployed, not looking for work

Tobacco Use

- ☐ Never a smoker
- ☐ Former smoker. Date quit/how much: ______
- ☐ Current smoker. How much: ______
- ☐ Use chewing tobacco

Alcohol consumption ☐ Yes ☐ No

If yes, frequency, type and amount

______

Illicit drug use? ☐ Yes ☐ No

If yes, which type of drug and how often? ______

Have you been in a drug or alcohol treatment program?

☐ Yes ☐ No

If yes, please specify type and dates:

Exercise ☐ Yes ☐ No Type/frequency: ______

How many hours do you sleep per night? ______

I understand that Health Care Personnel will rely upon the above questionnaire for my medical history to arrive at an accurate diagnosis and treatment of my medical condition.

I understand that all answers will be held in the strictest confidence according to the current standards of medical records.

My signature below certifies that the answers given are complete and true.

______

Patient Signature Date

Pain Management Consultants, P.A.

MEDICATION LIST

Please list all medcations you are currently taking.

Medication Name and Dose	Directions or quantity taken per day	Prescribing Physician

Date:_______________

JULIAN L. HARO, MD
JEFFREY N. HIGGINBOTHAM, MD
CLAYTON ADAMS, MD

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT AS REQUIRED BY THE TEXAS MEDICAL BOARD REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9, CHAPTER 170; 3[Rd] Edition:

Developed by the Texas Pain Society, April2008 (www.texaspain.org) Revised Feb.2013

______________________: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to use the drug(s) recommended to you by me, as your physician. For the purpose of this agreement the use of the word physician is defined to include not only my physician but also my authorized associates, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat my condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I,____________________, voluntarily request my physician at Pain Management Consultants, P.A. to treat my condition which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent for my physician to administer or write prescription(s) for dangerous and/or controlled drugs (medications) as an element in the treatment of my chronic pain.

For female patients only:
To the best of my knowledge I am NOT pregnant.

If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment. I accept that it is MY responsibility to inform my physician immediately if I become pregnant.

If I am pregnant or am uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY.

All of the possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo/ fetus / baby.

It has been explained to me that these medication(s) include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s). I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NO LIMITED TO THE FOLLOWING: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension(low blood pressure), arrhythmias(irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death.

THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT HAVE BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT (THIS IS SOMETIMES REFERRED TO AS OFF-LABEL PRESCRIBING). MY DOCTOR WILL EXPLAIN HIS TREATMENT PLAN(S) FOR ME AND DOCUMENT IT IN MY MEDICAL CHART.

I HAVE BEEN INFORMED AND understand that I will undergo medical tests and examinations before and during my treatment. Those tests include routine unannounced checks for drugs and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances may result in my being discharged from your care.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medication(s) for the treatment of my chronic pain.
The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and active life. I realize that I may have a chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s),

Date:________________

but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored specifically for me. I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time and that I will notify my physician of any discontinued use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

I understand that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of medications to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

PAIN MANAGEMENT AGREEMENT:

I UNDERSTAND AND AGREE TO THE FOLLOWING:
That this pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called narcotics, painkillers, and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). Therefore, medication(s) will only be provided so long as I follow the rules specified in this Agreement. My physician may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior:

- My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the medication(s) may be discontinued.
- I will disclose to my physician all medication(s) that I take at any time, prescribed by any physician.
- I will use the medication(s) exactly as directed by myphysician.
- I agree not to share, sell or otherwise permit others, including my family and friends, to have access to these medications.
- I will not allow or assist in the misuse/diversion of my medication; nor will I give or sell them to anyone else.
- All medication(s) must be obtained at one pharmacy, where possible. Should the need arise to change pharmacies, my physician must be informed. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my physician to release my medical records to my pharmacist as needed.
- I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money. If either are lost or stolen, they may NOT BE REPLACED.
- Refills will not be ordered before the scheduled refill date. I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.
- If a prescription is changed before a current prescription is scheduled to end, I agree to bring in the remaining medication to be destroyed before a new prescription is issued. I understand that the medication is my property but another prescription will not be issued without destruction of a previous prescription for the same condition. The destruction of the medication at home, without the witness of my physician or his associates will not be sufficient proof for an exchange of medication.
- I will receive pain medication(s) from ONE physician unless being treated at an inpatient facility, ER or Dentist. During hospital admissions, pain medications will be the responsibility of the inpatient provider. Upon discharge from the inpatient facility, I will not accept any pain medication prescriptions. During ER care, pain medications can be administered by the ER physician, but I will not take any pain medication prescriptions to be filled outside of the ER facility. It is my responsibility to inform all ER and/or inpatient providers that I am under the care of a pain management physician and under the obligation of this pain management agreement as required by the Texas Medical Board. Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my pain management physician may lead to a discontinuation of medication(s) and treatment.
- If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then my physician may try alternative medication(s) or may taper me off all medication(s). I will not hold my physician liable for problems caused by the discontinuance of medication(s).

Date:________________

- I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work. Further, while PMC cannot prohibit you from these activities, we caution against operating a motor vehicle or other form of transportation as well as any machinery while using these medications due to the potential for impairment
- I understand that drinking alcohol while taking narcotic medication is dangerous and the combination could cause an adverse outcome, including death.
- I agree to submit to pill counts when required. I understand that any substantive discrepancies could lead to non-narcotic care.
- I agree to submit to urine and/or blood screens to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), such as marijuana, speed, cocaine, etc., treatment for chronic pain may be terminated. Also, a consult with, or referral to, an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an addictionologist or a physician who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.
- I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize that my active participation in the management of my pain is extremely important. I agree to actively participate in all aspects of the pain management program recommended by my physician to achieve increased function and improved quality of life.
- I agree that I shall inform any doctor who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.
- I hereby give my physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).
- I must take the medication(s) as instructed by my physician. Any unauthorized increase in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.
- I must keep all follow-up appointments as recommended by my physician or my treatment may be discontinued.

I certify and agree to the following: (initials)

1. I am not currently using illegal drugs or abusing prescription medication(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment. _______
2. I am not involved in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.)_______
3. No guarantee or assurance has been made as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life. _______
4. I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain. I fully understand the explanations regarding the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain. _______

Patient Signature	Date
Print Name	
Name and Location of Pharmacy	Physician or Authorized Representative

Pain Management Consultants, P.A.

SPINAL DIAGNOSTICS & THERAPEUTICS

101 W. Koenig Ln, Ste 100, Austin, TX 78751 Phone 512-454-9426/877-804-7021 Fax 512-454-7294
15808 F.M. 620 North, Suite 215 Austin, Texas 78717
301 W. Hwy 71, Ste 109, Bastrop, Texas 78602

J. Lowell Haro, MD
Diplomate, American Board of Anesthesiology, Certificate of Added Qualifications in Pain Management

Jeffrey Higginbotham, MD
Diplomate, American Board of Anesthesiology, Certificate of Added Qualifications in Pain Management

Diane Dewan, PA-C
Helen Zook, PA-C
Laura Brynestad, ACNP-BC

Richard Todd, PA-C
Kristy Markell, PA-C

Authorization for Release and Disclosure of Protected Health Information

Patient Name: DOB:

Sometimes a patient's friend or family member calls on the patient's behalf. Your consent is required to discuss any of your health information. Is there anyone we are allowed to discuss your medical care with over the phone or in person without you present?

Information may be released to:

Name: ____________________ Relationship: ________________

From:

PAIN MANAGEMENT CONSULTANTS, P.A.
101 W. Koenig Ln, Suite 100
AUSTIN, TX 78751
Phone: (512) 454-9426
Fax: (512) 454-7294

1. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol/drug abuse.
2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization.
3. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this in order to assure treatment.

______________________________ ______________________________
Signature of Patient or Legal Representative Date

______________________________ ______________________________
Relationship to Patient Witness

Payment Policy-PATIENT'S COPY

If you have a procedure, you may receive charges from the facility where these services were performed (i.e. Central Park Surgery Center, Seton Medical Center, Seton Northwest Hospital, Northwest Surgical Center, Hill Country Surgery Center, Hyde Park Surgery Center, etc.).

If the physician orders lab work, x-rays or scans, physical therapy, psychotherapy, TENS unit or any other pain management modality or combination of modalities, you may receive charges from the facility where these services were performed or by the professional who performed these services.

PMC will charge the patient $25 if they fail to show up for an appointment or fail to give 24 hours notice of cancellation prior to their scheduled appointment. **This charge will be due prior to the next visit. Appointments will not be scheduled until this payment is received.** This will be considered a patient convenience charge and will be assessed to all patients including Workers Comp and Medicare patients as a personal item charge. This is not covered by insurance and will be considered the patient's responsibility. This charge applies to all appointments.

Insurance - Co-pays are due at the time of service or visit. As a courtesy, PMC will file with your primary and secondary insurance. To ensure accuracy, we need a current copy of your insurance card at the time of your visit. You are responsible for guaranteeing payment on your account.

Self-pay- Balances are due at the time of service unless special arrangements have been made with our billing office and a signed payment contract is on file.

Workers' Compensation- If the procedure or office visit was verified and approved through the WC carrier prior to your procedure office visit, as a courtesy, PMC will submit your workers compensation bill directly to your workers compensation carrier. To ensure accuracy, we need your current claim number, date of injury, insurance billing address, adjustor and phone number prior to the day of your procedure or office visit. Failure to obtain recertification may cause your procedure or visit to be postponed.

Medicare- As a courtesy, PMC will file directly with Medicare. To ensure accuracy, we need a current copy of your Medicare card. Please be aware that payments from Medicare are based on their fee schedule. You will be responsible for any remaining balance after Medicare and/or any supplemental insurance(s) has paid their usual and customary.

LOP/PIP Claims- Balances are due at the time of service. We do not accept Letters of Protection or third party claims in lieu of payment for services rendered.

Notice of Privacy Practices-PATIENT'S COPY

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Understanding Your Health Record/Information
Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided
- tool in educating health professionals
- source of data for medical research
- source of information for public health officials charged with improving the health of the nation
- source of data for facility planning and marketing
- tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- ensure its accuracy
- better understand who, what ,when, where and why others may access your health information
- make more informed decisions when authorizing disclosure to others

Your Health Information Rights
Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522. Requests for restrictions on disclosures to your health plan for health care items or services paid out of pocket must be accepted
- obtain a paper copy of the notice of information practices upon request
- inspect and obtain a copy of the notice of information practices upon request
- inspect and obtain a copy of your health record as provided for in 45 CFR 164.524 and HB 300 (paper or electronic)
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken
- receiving a notice of a breach of "unsecured" protected health information

Our Responsibilities
Pain Management Consultants, P.A. is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you

- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- notify you of a break of "unsecured" protected health information

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us.

We will not use or disclose or sell your health information without your written authorization, except as described in this notice.

To Report a Problem
If you have questions and would like additional information, you may contact the Privacy Officer, Joel Haro at 101 W. Koenig Ln, Ste 100, Austin, TX 78751 or (512) 406-0158.

If you believe your privacy rights have been violated, you can file a complaint with this office or with the secretary of Health and Human Services. There will be no retaliation for filing a complaint.

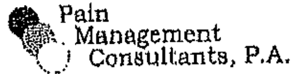
Examples of Disclosures for Treatment, Payment and Health Operations
Treatment: Information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We will also provide subsequent healthcare providers with copies of various reports that should assist them in treating you.

Payment: A bill may be sent to you or a third-party payer. This information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

Health Operations:

1. **Risk Management** - Members of the medical staff or the quality improvement staff may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.
2. **Business Associates** - There are some services provided in our organization through contacts with business associates. Examples include radiology, laboratory, copy services, transcription services, billing services, etc. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do and bill you for your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.
3. **Notification** - We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location and general condition.
4. **Communication With Family** - Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.
5. **Research** - We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
6. **Funeral Directors** - We may disclose health information to funeral directors consistent with applicable law to carry out their duties.
7. **Organ Procurement Organizations** - Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.
8. **Marketing** - We may contact you to provide appointment reminders or face-to-face information about treatment alternatives or other health-related benefits and services that may be of interest to you.
9. **Food and Drug Administration (FDA)** - We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, recalls, repairs or replacement.
10. **Workers' Compensation** - We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.
11. **Public Health** - As required by law, we may disclose your health information to public health or legal authorities charted with preventing or controlling disease, injury or disability.
12. **Law Enforcement** - We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.
13. **Schools** - We may disclose childhood immunization records to schools.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and potentially endangering one or more patients, workers or the public.



SPINAL DIAGNOSTICS & THERAPEUTICS

101 W. Koenig Ln, Ste 100, Austin, TX 78751 Phone 512-454-9426/877-804-7021 Fax 512-454-7294
15808 F.M. 620 North, Suite 215 Austin, Texas 78717
301 W. Hwy 71, Ste 109, Bastrop, Texas 78602

J. Lowell Haro, MD
Diplomate, American Board of Anesthesiology, Certificate of Added Qualifications in Pain Management

Jeffrey Higginbotham, MD
Diplomate, American Board of Anesthesiology, Certificate of Added Qualifications in Pain Management

Diane Dewan, PA-C
Helen Zook, PA-C
Laura Brynestad, ACNP-BC

Richard Todd, PA-C
Kristy Markell, PA-C

INSURANCE

Acknowledgment of Payment Policy

I certify that:

I have read and understand the Payment Policies of Pain Management Consultants, P.A.

I understand that the charges incurred at or through Pain Management Consultants, P.A. are my responsibility and that my insurance coverage is a contract between that company and myself. No guarantee of insurance benefits has been made by Pain Management Consultants, P.A.

I authorize payment of medical benefits to Pain Management Consultants, P.A. for services provided.

I authorize release of medical or other information necessary to process my claims. I also request payment of government benefits to myself or to the party who accepts assgnment.

Full payment is required in lieu of an acceptable insurance policy.

PATIENT SIGNATURE ____________________ Date ____________________

Responsible Party Signature (if other than patient) ____________________ Relationship to Patient ____________________

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

PATIENT SIGNATURE ____________________ Date ____________________

Responsible Party Signature (if other than patient) ____________________ Relationship to Patient ____________________

PATIENT'S PRINTED NAME ____________________ Date of initial consult (if different from date signed) ____________________

Pain Management Consultants, P.A.
SPINAL DIAGNOSTICS & THERAPEUTICS

JULIAN L. HARO, MD
JEFFREY N. HIGGINBOTHAM, MD
CLAYTON ADAMS, MD

Central office: 101 West Koenig Lane, Suite 100 | Austin, Texas 78751 North
Round Rock office: 15808 FM 620 North, Suite 215 | Austin, Texas 78717
Bastrop office: 301 West HWY. 71, Suite 109 | Bastrop, Texas 78602
Phone (512) 454-9426, (877) 804-7021 | Fax (512) 454-7924

SOAPP-R

This is an assessment tool recommended by the American Pain Society. The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each questions as honestly as possible. There are no right or wrong answers.

0 = Never 1 = Seldom 2 = Sometimes 3 = Often 4 = Very Often

Patient Name:_______________________________**Date:** ______________________________________

Question	Rating
1. How often do you have mood swings?	0 1 2 3 4
2. How often have you felt a need for higher doses of medication to treat your pain?	0 1 2 3 4
3. How often have you felt impatient with your doctors?	0 1 2 3 4
4. How often have you felt that things are just too overwhelming that you can't handle them?	0 1 2 3 4
5. How often is there tension in the home?	0 1 2 3 4
6. How often have you counted pain pills to see how many are remaining?	0 1 2 3 4
7. How often have you been concerned that people will judge you for taking pain medication?	0 1 2 3 4
8. How often do you feel bored?	0 1 2 3 4
9. How often have you taken more pain medication than you were supposed to?	0 1 2 3 4
10. How often have you worried about being left alone?	0 1 2 3 4
11. How often have you felt a craving for medication?	0 1 2 3 4

12. How often have others expressed concern over your use of medication?	0 1 2 3 4
13. How often have any of your close friends had a problem with alcohol or drugs?	0 1 2 3 4
14. How often have others told you that you had a bad temper?	0 1 2 3 4
15. How often have you felt consumed by the needs to get pain medication?	0 1 2 3 4
16. How often have you run out of pain medication early?	0 1 2 3 4
17. How often have others kept you from getting what you deserve?	0 1 2 3 4
18. How often, in your lifetime, have you had legal problems or been arrested?	0 1 2 3 4
19. How often have you attended an AA or NA meeting?	0 1 2 3 4
20. How often have you been in an argument that was so out of control that someone got hurt?	0 1 2 3 4
21. How often have you been sexually abused?	0 1 2 3 4
22. How often have others suggested that you have a drug or alcohol problem?	0 1 2 3 4
23. How often have you had to borrow pain medications from your family or friends?	0 1 2 3 4
24. How often have you been treated for an alcohol or drug problem?	0 1 2 3 4

Please include any additional information you wish about the above answers.

Patient Name:____ **Date:** __________________