Vital Pain Care

A division of American Pain and Wellness

Date: _____

Patient Name: _____ **Referring Physician:** _____

Age: _____ Date of Birth: _____ **Family Doctor:** _____

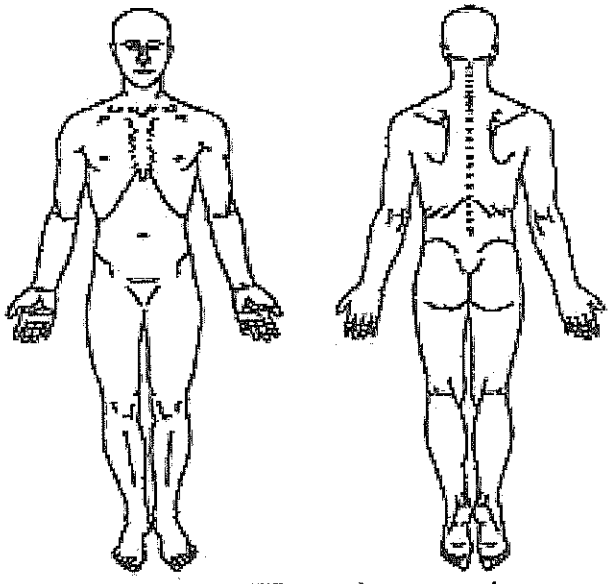
Greatest Area of Pain _____

Was this due to an injury?
Yes☐ No☐
Please describe:

Other Areas of Pain _____

When did it start (mo/yr)? _____

Please shade in your areas of pain on the picture below:



Rate your pain on a scale of 1 (best) to 10 (worst) at its most **SEVERE:**

best **0 1 2 3 4 5 6 7 8 9 10** worst

Rate your pain on a scale of 0 (best) to 10 (worst) **TODAY:**

best **0 1 2 3 4 5 6 7 8 9 10** worst

Rate your pain on a scale of 0 (best) to 10 (worst) at its **BEST:**

best **0 1 2 3 4 5 6 7 8 9 10** worst

Are there any legal actions related to your pain? Yes ☐ No ☐

√	**How do you describe your pain?**
	aching
	burning
	dull
	electrical
	knifelike
	sharp
	shooting
	stabbing
	stinging
	throbbing
	tingling
	toothache
	OTHER:

√	**What makes your pain worse?**
	arching your back
	bending over
	bowel movements
	cooking
	coughing
	getting out of a chair
	lying down
	sex
	sitting
	sneezing
	standing
	twisting
	vacuuming
	walking
	climbing stairs
	walking down a hill

√	**What makes your pain better?**
	sitting
	standing
	lying down
	walking
	stretching
	hot bath or shower
	application of heat
	ice
	relaxation
	massage
	TENS unit
	acupuncture
	chiropractors
	previous injections:
	Pain medications:

√	Do you currently experience the following?	Where?
	Numbness	
	Tingling	
	Weakness	
	NEW bowel or bladder changes?	

When is your pain worst? ☐ Morning ☐ Midday ☐ Evening ☐ Night

Have you tried any of the following for your current pain?

		Did it help? √ YES	√ NO
Bracing	☐	☐	☐
Chiropractor	☐	☐	☐
Injections	☐	☐	☐
Medications	☐	☐	☐
Oral Steroids	☐	☐	☐
Physical Therapy	☐	☐	☐
Surgery	☐	☐	☐
TENS Unit	☐	☐	☐

√	**Do you have or have you had ANY of the following conditions?**
	Hypertension/High Blood Pressure
	Heart Attack
	Chest Pain/Angina
	Congestive Heart Failure
	Atrial Fibrillation
	Stroke / TIA
	Asthma
	COPD (emphysema)
	Lung Disease
	Kidney Disease/Failure
	Kidney Stones / UTI
	Cirrhosis
	Liver Disease
	Hepatitis A? B? C?
	Diabetes Insulin? YES or NO
	Thyroid Problems
	Peptic Ulcers
	Cancer: Type-
	Seizures
	Multiple Sclerosis
	Arthritis: osteo/rheumatoid/psoriasis
	Bleeding Disorders
	Sickle Cell Disease
	HIV or Immune Disease
	Alcoholism
	Drug Addiction
	Psychiatric Disorder, Anxiety, Depression, other (please list)
	Other medical conditions not listed:

√	**Have you had ANY type of surgeries before?**	**Year**
	SPINE surgery	
	Neck/Cervical spine	
	Neck/Cervical Fusion	
	Back/Lumbar spine	
	Back/Lumbar Fusion	
	Cardiac surgery	
	Bypass	
	Angioplasty	
	Pacemaker/AICD	
	Cardiac Stents	
	Hysterectomy	
	Appendectomy	
	Tonsillectomy	
	Breast Biopsy	
	Lung surgery	
	Brain surgery	
	Cholecystectomy	
	Carpal tunnel: Left / Right	
	Hip surgery: Left / Right	
	Ankle surgery: Left / Right	
	Foot surgery: Left / Right	
	Knee Replacement: Left / Right	
	Shoulder surgery: Left / Right	
	Cancer surgery: YES / NO Type of cancer?	
	Other surgeries not listed?	

√	Do you have any of the following symptoms?
	Abnormal bruising
	Allergic reaction
	Anxiety
	Bleeding
	Chest pain
	Cold intolerance
	Confusion
	Constipation
	Cough
	Cramps
	Depression
	Diarrhea
	Diplopia – double vision
	Edema
	Fatigue
	Fever
	Headaches
	Hearing loss
	Heat intolerance
	Incontinence
	Indigestion/heartburn
	Insomnia–sleep difficulty
	Itching
	Joint pain
	Memory loss
	Nausea
	Pain at night
	Palpitations
	Rash
	Recurrent infections
	Restless legs
	Sexual dysfunction
	Shortness of breath
	Sore throat
	Sweats
	Syncope – dizziness
	Tinnitus – ringing in ears
	Tremors
	Unusual weight gain
	Unusual weight loss
	Urinary frequency
	Urinary hesitancy
	Vertigo
	Vision loss
	Weakness
	wheezing

List ALL Medications you are currently taking: Including over the counter medications, supplements, vitamins.

Medication:	Dose	How many per day	Please List any medications which you have tried which did not help your pain:
			Have you had side effects from pain medications?
			Medicine **Side Effect**

ALLERGIES TO MEDICATIONS: _____

Family History:

Living	Deceased	Family Member	Please list their major health problems
☐	☐	Mother	
☐	☐	Father	
☐	☐	Brothers	
☐	☐	Sisters	
☐	☐	Son	
☐	☐	Daughter	

Personal History:

Occupation: _____ Currently Working? Yes ☐ No ☐

Are you receiving disability? Yes ☐ No ☐ Disability diagnosis: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Do you live: ☐ independently ☐ require home health assistance ☐ in an assisted facility?

Do you smoke cigarettes? Yes ☐ No ☐ Amount: _____

Do you drink alcohol? Yes ☐ No ☐ Amount: _____

Do you use illegal drugs? Yes ☐ No ☐ What do you use? _____

Did you, within the past year, want or need to *cut* down on controlled substance use? Yes ☐ No ☐

Have you been *annoyed* and *angered* by someone else complaining of your drug or alcohol use? Yes ☐ No ☐

Have you felt *guilty* about the consequences of prescription drug or alcohol use? Yes ☐ No ☐

Do you use a drug or alcohol in the morning as an *"eye opener"* for "withdrawls" or a hangover? Yes ☐ No ☐

SOAPP® Version 1.0

Name: Date:

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment.

Please answer the questions below using the following scale:

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

1. How often do you have mood swings?	0	1	2	3	4
2. How often do you smoke a cigarette within an hour after you wake up?	0	1	2	3	4
3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	0	1	2	3	4
4. How often have any of your close friends had a problem with alcohol or drugs?	0	1	2	3	4
5. How often have others suggested that you have a drug or alcohol problem?	0	1	2	3	4
6. How often have you attended an AA or NA meeting?	0	1	2	3	4
7. How often have you taken medication other than the way that it was prescribed?	0	1	2	3	4
8. How often have you been treated for an alcohol or drug problem?	0	1	2	3	4
9. How often have your medications been lost or stolen?	0	1	2	3	4
10. How often have others expressed concern over your use of medication?	0	1	2	3	4
11. How often have you felt a craving for medication?	0	1	2	3	4
12. How often have you been asked to give a urine screen for substance abuse?	0	1	2	3	4
13. How often have you used illegal drugs (for example marijuana, cocaine, etc.) in the past five years?	0	1	2	3	4
14. How often, in your lifetime, have you had legal problems or been arrested?	0	1	2	3	4

The SOAPP® was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

A division of American Pain and Wellness

(Please Print Clearly) **REGISTRATION FORM**

Today's Date: _____ /_____ /_____

Patient's Name: ❑Mr. ❑Miss ❑Ms. ❑Mrs. _____
Last Middle First

Is this your legal name? ❑Yes ❑No If not, what is your legal name? _____

_____ _____
Home Address/City/State/Zip P.O. Box/City/State/Zip (if applicable)

Birth Date: _____ /_____ /_____ Age: _____ Race: _____ Sex: ❑M ❑F Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed

Social Security #: _____ Home Phone #:(_____) _____-_____ Cell Phone #:(_____) _____-_____

Employer: _____ Employer Phone #: (_____) _____-_____ Currently working? ❑Yes ❑No

_____ Occupation: _____
Employer Address City State Zip Code

Referring Physician: _____ Referring Physician Phone #: (_____) _____-_____

Primary Care Physician: _____ Primary Care Physician Phone #: #:(_____) _____-_____

Is this patient covered by insurance? ❑Yes ❑No Name of Primary Insurance: _____

Address: _____ City: _____ State: _____ Zip Code:_____

Phone #:(_____) _____-_____ Policy #: _____ Group #: _____ Co-Payment:$_____

Subscriber's Name: _____ Birth Date: _____ /_____ /_____
Last First

Subscriber's Social Security #: _____ Patient's Relationship to Subscriber ❑Self ❑Spouse ❑Child ❑Other

---

Is there a Secondary Insurance: ❑Yes ❑No Name of Secondary Insurance: _____

Address: _____ City: _____ State: _____ Zip Code:_____

Phone #:(_____) _____-_____ Policy #: _____ Group #: _____ Co-Payment:$_____

Subscriber's Name: _____ Birth Date: _____ /_____ /_____
Last First

Subscriber's Social Security #: _____ Patient's Relationship to Subscriber ❑Self ❑Spouse ❑Child ❑Other

---

Is this a workers' compensation injury? ❑Yes ❑No Date of injury: _____ /_____ /_____ Claim #: _____

Adjustor's Name: _____ Adjustor's Phone #: (_____) _____-_____

Treating Physician: _____ Treating Physician Phone #: (_____) _____-_____

Party Responsible for Bill:_____ Birth Date: Birth Date: _____ /_____ /_____

Address: _____ City: _____ State: _____ Zip Code:_____

Phone #: (_____) _____-_____ Fax #: (_____) _____-_____ Employer:_____

In case of an emergency, who can we contact:

Name: _____ Phone #: (_____) _____-_____ Relationship:_____

Name: _____ Phone #: (_____) _____-_____ Relationship:_____

❑ The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Vital Pain Care, a division of American Pain and Wellness or my insurance company to release any information required to process my claims.

X_____
Patient Signature/Legally Responsible person Date

A division of American Pain and Wellness

Patient Financial Policy

Thank you for choosing Vital Pain Care, a division of American Pain and Wellness. This goal is best achieved if everyone is aware of our policies. Your clear understanding of our financial policy is important to our professional relationship. Everyone is treated equally ad fairly.

PAYMENTS:
Payment is expected at the time services are rendered. Outstanding balances are due within 30 days of statement date, unless prior arrangements have been made with our billing department or Office Manager. Any services not paid by your insurance carrier for whatever reason within 90 days will become your responsibility. All balances owed by you that are over 120 days will be sent to a collection agency. You will not be able to schedule any office appointments or procedures and will face possible termination from the practice.

PAYMENT METHODS:
We accept a variety of payment methods, including: cash, check, money order, credit cards such as Visa, Mastercard, Discover, American Express via telephone. A $25.00 fee will be charged for any returned checks and we will report bad checks to the District Attorney's Office. We will not accept your check for any services thereafter.

INSURANCE INFORMATION:
Your insurance policy is a contract between you and your insurance company. Please check with your insurance carrier to determine any pre-existing limitation or other benefit restrictions that you may have prior to your appointment.

We will file your insurance assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

Most insurance companies do not cover 100% of the cost of services and there is a portion that the patient is responsible for. There are several patient responsibility components that may apply to an insurance payment.

Co-payments – A set dollar amount per office visit that is the patient's responsibility.
Co-insurance – A percentage of the charge that is the patient's responsibility.
Deductible – A set annual amount that the patient is responsibility for paying prior to his or insurance making a payment.

Because of the contract you have with your insurance company, we are obligated to collect payment from you for your portion of the balance. All co-payments, co-insurance and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

To bill your insurance accurately and in a timely manner, we will need assistance from you. We ask that you provide our office with accurate demographic information (address, phone number, etc) and proof of insurance card(s). All patients will be required to show proof of insurance and a government issued photo identification card.

INSURANCE CHANGES
If there are any changes in your insurance, you are required to call our office and give the detailed changes of your insurance at least 24-48 hours prior to your appointment. If you fail to provide us with the correct information in a timely manner, you may be responsible for the balance.

ALL MANAGED CARE INSURANCES (HMO, PPO, POS, etc)
Co-payment, co-insurance and deductible amounts are due at the time of check-in. If your insurance plan requires a referral authorization from your Primary Care Physician, you are responsible for obtaining the approval from your Primary Care Physician prior to any services with our physicians and associates and will need to present this information before your scheduled appointment. If you have an office visit or procedure without a referral authorization, your insurance may deem this as a non-covered treatment and you will be responsible for all charges.

MEDICARE
We accept assignment with Medicare. Medicare pays 80% of their allowed amount after satisfaction of the yearly deductible. You are responsible for 20% of Medicare's allowed amount. All co-payments or deductibles are due and payable at the time of service.

SECONDARY AND TERTIARY PLANS
We will bill your secondary insurance as a courtesy. We do not bill tertiary insurance. If you have supplemental insurance to cover the portion of the charges that Medicare or your primary insurance carrier does not pay, please provide us with a copy of this insurance card. Medicare and secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding.

PRE-AUTHORIZATION
Please remember that it is up to you to understand the requirements of your individual insurance plan and know whether prior authorization from your insurance company is required.

NON-COVERED SERVICES
Any care not paid for by your existing insurance carrier will require you pay in full at the time services are provided or upon notice of insurance claim denial.

WORKER'S COMPENSATION
If your injury is work-related, we will need the claim number, date of injury, employer, and worker's compensation carrier information prior to your visit. This information will assist us in obtaining approval for appointments you have with our physicians and associates. This information is also used to send claims and bills. If any of your visits are denied by worker's compensation, your visit may need to be rescheduled and you will need to contact your case manager.

SURGERY & INJECTIONS
All co-payments, co-insurance, deductibles, and payments for non-covered surgical procedures are due prior to surgery. We will make every attempt to determine your coinsurance amount prior to your surgery. This will be based on your insurance benefits and an estimate of the services to be provided. We will provide you with that estimate and we will expect to collect that amount prior to the time of surgery. If any changes are made to the scope of services provided and the co-insurance amount has changed, we will either refund or bill you upon final resolution of your account. Fees are ultimately the responsibility of the patient, whether your insurance company pays or not, and are due within 30 days of receiving the statement from Vital Pain Care, a division of American Pain and Wellness.

SELF-PAY PATIENTS
We accept self-paying patients on a case by case basis only. If you are accepted as a self-paying patient, you are required to pay in full at the time services are rendered.

APPOINTMENTS
A scheduled appointment is a time we have reserved just for you. We reserve the right to charge for appointments not cancelled 24 hours in advance. If a service charge is incurred, you must pay the fee prior to another appointment being scheduled. Patients who habitually fail to keep scheduled appointments and do not give a 24-hour cancellation notice will face termination from our practice. Same day cancellations and missed appointments for an office visit will be charged a fee of $50.00. Same day cancellations and missed appointments for procedures/injections will be charged a fee of $150.00.

CHILDREN OF DIVORCED PARENTS
Responsibilities for payment of patients, who are minor children, whose parents are divorced, rests with the parent who seeks the treatment.

MEDICAL RECORDS
All medical records cannot be released without a Disclosure of Protected Health Information form signed by the patient. There is a charge for medical records release.

FORMS AND FEES
A $30.00 fee will be charged for disability paperwork, life insurance paperwork, and other forms requested by a third party or patient and must be paid in full prior to completion.
**All paperwork received must be reviewed by our physicians and associates prior to it being completed and fee being charged.*

A $10.00 fee will be charged for Handicap Placard Forms and letters.

SPECIAL CIRCUMSTANCES
We are aware that circumstances in our daily lives may vary. If you need to establish a payment plan or require additional assistance, please contact our Office Manager or Central Business Office at (469) 326-5100 prior to your scheduled appointment. Unless you have made prior arrangements for payment of your balance, our financial policy will stand.

ACCOUNT BILLING QUESTIONS AND REFUNDS
Questions or concerns regarding your account or insurance claim should be directed to our business office staff. If your account has a credit balance, we will promptly release a refund check to you once your insurance carrier has processed all pending insurance claims remaining on your account. If you feel an error appears on the statement or if you have any questions or concerns, please contact our central billing office immediately at (469) 326-5100.

By signing below, you acknowledge and accept the Patient Financial Policy.

Print Patient name

Patient Signature/Legally Responsible Person Date

Signature of Office Staff Date

Vital Pain Care

A division of American Pain and Wellness

Advanced Practice Nurse, Nurse Practitioner and Physician Assistant Consent

Vital Pain Care would like you to know that we employ Advanced Practice Nurses, also known as Nurse Practitioners, and/or Physician Assistants to assist us in a team approach to deliver our high quality of medical care.

An Advanced Practice Nurse (APN), Nurse Practitioner (NP), and Physician Assistants (PA) are mid-level practitioners who have received advanced education and training in the provision of health care. Advanced Practice Nurses, Nurse Practitioners or Physician Assistants are not doctors. They can however, diagnose, treat, and monitor routine and complex pain disorders. If you are seen by an APN, NP, or PA, your doctor will review your care with them as part of the care plan.

Patient Acknowledgment:
I have read the above and understand that in this practice a team approach is used, with my unique needs presented and discussed with one or more physicians in the development of my care plan. I also understand that typically one physician will direct my overall care, but that from time to time I may be seen by any or all the practitioners in this practice, including an APN, NP or Pa.

I hereby consent to the services of an Advanced Practice Nurse, Nurse Practitioner, and/or Physician Assistant for my healthcare needs.

I understand that I can refuse to see the APN, NP, or PA and request to see the physician. I understand that this may require my appointment to be cancelled, rescheduled, require a longer wait time for an appointment, or I will no longer be able to make further appointments.

☐ By checking this box, I acknowledge that I have read and accept the above.

Patient Signature/Legally Responsible Person Date

Print Patient Name

9301 N. Central Expressway, Suite 685, Dallas, TX 75231
17051 N. Dallas Parkway, Suite 440, Addison, TX 75001

Vital Pain Care

A division of American Pain and Wellness

Patient Consent and Acknowledgment of Receipt of Notice of Privacy Practices

I understand that as a part of the provision of healthcare services, Vital Pain Care, a division of American Pain and Wellness creates and maintains health records and other information describing, among other things, my health history, symptoms, examination, test results, diagnosis, treatment and any plans for future care or treatment.

I acknowledge receipt of this Notice of Privacy Rights which I have reviewed and give my permission to Vital Pain Care, a division of American Pain and Wellness to use and disclose my health information in accordance with the regulations.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations.

Patient Signature: _____ Date: _____

Print Patient Name: _____ DOB: _____

Personal Representative if patient unable to sign: _____

If personal representative, please note relationship to patient: _____

Do you have a Power of Attorney? ☐ YES ☐ NO
If yes, please attach a copy for our records.

Prescriptions and Documents Pick-Up Authorization:
If you would like to give consent for another individual to pick up your prescription from our office, please provide their name below. **Authorized persons must present a valid photo I.D. upon pick up of prescriptions and/or documents.**

1. _____ 2. _____

3. _____ 4. _____

Discuss Medical Care Authorization:
I give consent for my physician and associates of Vital Pain Care, a division of American Pain and Wellness to discuss my medical care with the persons listed below:

1. _____ Relationship: _____

2. _____ Relationship: _____

3. _____ Relationship: _____

Vital Pain Care

A division of American Pain and Wellness

Texas law requires that physicians disclose to their patients any financial relationships between the physician and entities to which the physician refers the patient.

Please be aware that Dr. Jeffrey Wasserman and Dr. Aaron Lloyd have ownership in the following entities to which you may be referred:

NORTH CENTRAL SURGICAL CENTER, L.L.P., A HOSPITAL
9301 N. CENTRAL EXPRESSWAY, SUITE 670
DALLAS, TX 75231

NORTH TEXAS SURGERY CENTER
7992 WEST VIRGINIA
DALLAS, TX 75231

ROCKWALL SURGERY CENTER
825 W. YELLOW JACKET LN
ROCKWALL, TX 75087

PRIORITY SURGICAL CARE, L.L.C.
3050 S. CENTER ST, SUITE 160
ARLINGTON, TX 76014

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

A division of American Pain and Wellness

PATIENT RESPONSIBILITY AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTION

Today's Date: _____

Name of Patient: _____ DOB: _____

TO THE PATIENT: 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 sue 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 physician's 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 Vital Pain Care, a division of American Pain and Wellness 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.

It has been explained to me that these medication(s) include opioid 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).

The specific medication(s) that my physician plans to prescribe will be described 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 physician will explain his treatment plan(s) for me.

REGARDING SIDE-EFFECTS: I understand that the most common side-effects that could occur in the use of controlled substance used in my treatment include but **are not** 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. 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. I also understand that operating a motorized vehicle while taking these medications may lead to a conviction of driving while under the influence if it is determined that I am impaired.

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 change for a 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), 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.

FOR FEMALE PATIENTS ONLY: To the best of my knowledge **I AM NOT PREGNANT.** 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 above 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 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.

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 this 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:

1. My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the medication(s) may be discontinued.
2. I will disclose to my physician ***all medication(s)*** that I take at any time, prescribed by any physician. This disclosure will include any herbal remedies, since controlled substances can interact with over-the-counter medications and other prescribed medications, especially cough syrup that contains alcohol, codeine, or hydrocodone.
3. I will receive controlled substance pain medication(s) **only from ONE physician** unless it is for an emergency or the medication(s) that is being prescribed by another physician is approved by my physician. Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.
4. I will use **ONE pharmacy, where possible,** to obtain all controlled substances prescribed by my physician. Should the need arise to change pharmacies; Vital Pain Care, a division of American Pain and Wellness will be notified. In addition, I will provide my pharmacist a copy of this agreement. I authorize my physician to release my medical records to my pharmacist as needed:

   Pharmacy and Address: _____

   Phone Number:_____ Fax Number: _____
5. I will use the medication(s) **exactly** as directed by my physician.
6. I **will not** use marijuana for medicinal or recreational purposes while receiving controlled substance prescriptions, unless there is a change in Texas legislation to legalize it for medicinal use.
7. 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.
8. I understand that my medication(s) and prescriptions will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money. I am responsible for keeping my pain medication and prescription in a safe and secure place, such as a locked cabinet or safe. Stolen medications and prescriptions should be reported to the police and to my physician immediately. **If either lost, stolen, or misplaced, my physicians have the right NOT to replace my medications or prescriptions.**
9. Refill(s) **will not be ordered before the scheduled refill date.** However, early refill(s) are allowed when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, 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. Only my prescribing physician or his/her surrogate can decide to increase my medication(s) dosage. I understand that self-medicating **will result** in running out of my medication(s) early and that I **will not** be granted an early refill.
10. I understand that **I am responsible** for providing **48 to 72 hours** notice on any refill(s). I understand that if I make a refill request after 3:00pm it will not be processed until the next business day, and that refill request(s) **will not be submited** on Fridays, weekends, or holidays since the on-call physician cannot prescribe these safely for me.
11. I understand that there are side effects with controlled substances which may include, but not exclusively, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, or the possibility of impaired cognitive and/or motor ability. Overuse of controlled substances can cause decreased respiration.
12. If I have a history of alcohol or drug misuse/addiction, I **will notify** the physician of such history since the treatment with controlled substances for pain may increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one for treatment of pain with controlled substances but starting or continuing a program for recovery is a must.
13. If the responsible legal authorities have questions concerning my treatment, as might occur, for example if I obtained medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to Vital Pain Care, a division of American Pain and Wellness records of controlled substances administration. In the event that I am arrested or incarcerated related to legal or illegal drugs, refills on controlled substances will not be given to you.

14. I hereby give my physician **permission** to discuss all diagnostic and treatment detailed with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s) and **agree to allow** my physician to contact any healthcare professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about my care or actions, if the physician feels it is necessary.
15. I **agree to submit to urine, blood, and/or oral fluid 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, amphetamines, cocaine, etc., this may be grounds for termination of the doctor/patient relationship at the sole discretion of my physician. If I decide not to provide a urine sample, I understand that my physician may change my treatment plan, including safe discontinuation of any controlled substances when applicable or complete termination of the doctor/patient relationship. Urine, blood and/or oral fluid testing is not a forensic testing, but is done for my benefit as a diagnostic tool and in accordance with certain legal and regulatory materials on the use of controlled substances to treat pain. I accept the responsibility for the cost of the urine, blood and/or oral fluid testing in the event that my healthcare coverage will not cover the cost of this test. I am also aware that my physician may refer me to the on-staff professional counselor, or that a consult with, or referral to a qualified profession, such as an addictionalogist, or a profession who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy may also be provided if my physician feels it is necessary.
16. I understand that any evidence of drug hoarding, acquisition of any controlled substances from other physicians (which includes emergency rooms), uncontrolled dose escalation or reduction, loss of prescriptions, or failure to follow the agreement may result in termination of the doctor/patient relationship.

I CERTIFY AND AGREE TO THE FOLLOWING:

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 have **never been involved** in the sale, illegal possession, misuse/diversion of 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.**

I understand that if I violate any of the above conditions, my prescriptions for controlled substance may be terminated immediately. If the violation involves obtaining controlled substance medications from another individual, or the use of non-prescribed illicit drugs, I may also be reported to all my physicians, medical facilities and appropriate authorities.

I have read this agreement and the same has been explained to me by Vital Pain Care, a division of American Pain and Wellness. In addition, I fully understand the consequences of violating this agreement may include cessation of therapy with controlled substances and/or discharge from Vital Pain Care.

Patient signature/Legally Responsible Person Date

Print Patient Name

Physician Signature (or Appropriately Authorized Assistant) Date

Pharmacy and Address: _____

Phone Number: _____ Fax Number: _____

Vital Pain Care
9301 N. Central Expressway, Suite 685, Dallas, TX 75231
17051 N. Dallas Parkway, Suite 440, Addison, TX 75001

A division of American Pain and Wellness

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

To appropriately treat you and receive payment for the services we provide, we need to obtain information from you including your full name and address, insurance company, family medical history, current medical history, and current medical condition. We will use and disclose this information and other information we collect in the ways described below. To help you understand how we will use and disclose your information we have put the different uses and disclosures into categories and give examples of each. All of the ways we use or disclose your information will fit into one of the categories listed below, but we cannot list all of the uses and discloses in each category.

We may use and disclose your health information, without your consent or authorization, for treatment, payment, and health care operations, and for the following other reasons.

Treatment. We may use and disclose your information to provide you with medical treatment and services. Your information may be disclosed to individuals and facilities providing care to you. These individuals and facilities need your information to provide care, and to coordinate and provide services (such as prescriptions, lab tests, meals, and x-rays).

Payment. We may use and disclose your information to receive payment for the services and treatment provided to you. We use your information to create a bill and disclose your information when we send the bill to your insurance company, you, or a third party. The individual or entity paying the bill may request more information to determine whether the bill is covered by your insurance. We may tell your health plan about a treatment you are going to receive to get approval for payment or to determine whether your health plan will cover the treatment.

Health Care Operations. We may use and disclose your information for health care operation purposes. Health care operations includes review of the care you receive for quality assessment, educational, business planning, and compliance plan purposes.

Business Associates. From time to time, we enter into agreements with Business Associates who perform services on our behalf. These Business Associates are required to keep your information confidential according to the terms of the agreement and the requirements of the Health Insurance Portability and Accountability Act (HIPAA) privacy rules. In general, Business Associates are required to keep your information confidential to the same extent as we are.

Appointment Reminders. We may provide appointment reminders to you. You may request in writing that we send reminders to a confidential or alternative address.

Treatment Alternatives. We may provide you with information about treatment alternatives and other health related benefits and services.

We may also disclose your health information to outside entities, without your consent or authorization, in the following circumstances:

Required by Law. We disclose information as required by law. For example, we are required to report gunshot wounds to the police.

Public Health Purposes. We disclose information to health agencies as required by law for preventing or controlling disease. Examples are reporting of sexually transmitted, communicable, and infectious diseases.

To Prevent a Serious Threat to Health or Safety. We may disclose information about you to law enforcement or an identified victim to prevent a serious threat to your health or safety or the health or safety of another individual or the public.

Research. Your information may be used by or disclosed to researchers for research approved by a privacy board or an institutional review board.

Health Oversight Activities. Your health information may be disclosed to governmental agencies and boards for investigations, audits, licensing, and compliance purposes.

Judicial and Administrative Proceedings. We may be required to disclose your health information to a court or for an administrative proceeding.

Law Enforcement Activities. We may be required to disclose your information as required by law, pursuant to a court order, warrant, subpoena, or summons.

In Emergency Circumstances.

Deceased Individual. We may disclose information for the identification of the body or to determine the cause of death.

Military and Veterans. If you are a member of the armed forces, we may release information about you as required by military command authorities. We may also release information about foreign military personnel to the appropriate foreign military authority.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official. This release must be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety or security of the correctional institution.

Protective Services for the President and Others.

Organ and Tissue Donation. If you are an organ donor, we may release your medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ bank, as necessary to facilitate organ or tissue donation.

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs.

National Security and Intelligence Activities. We may release information about you to authorized Federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

We will give you the opportunity to object to the following uses and disclosure of your information:

Notification. We may tell your friends, relatives and other caretaker's information which is relevant to their involvement in your care.

Disaster Relief. We may disclose information about you to public or private agencies for disaster relief purposes.
Except as provided above, we will obtain your written authorization prior to disclosure of your information for any other purpose. Specifically, written authorization is required prior to the disclosure of your information:

Psychotherapy Notes. We will not use or disclose your psychotherapy notes without a written authorization except as specifically permitted by law.

Marketing. We will not use or disclose your information for marketing purposes, other than face-to-face communications with you or promotional gifts of nominal value, without your written authorization.

Sale of Information. We will not sell your PHI without your written authorization, including notification of the payment we will receive.

Where a disclosure is made under your written authorization, you have the right to revoke the authorization at any time. Revocation of an authorization must be in writing. The revocation is effective as of the date you provide it to USAP and does not affect any prior disclosures made under the authorization.

If a state or federal law provides additional restrictions or protections to your information, we will comply with the most stringent requirement.

Your Rights

You, or a person with legal authority to act on your behalf, have the right to:
Request a restriction on how information about you is used and disclosed. If you want to request a restriction of a use or disclosure of your information, contact our Privacy Officer at the number or e-mail listed at the end of this form. We are required to agree to a request for a restriction related to disclosure of information to your health plan for payment or healthcare operations where you pay for the service in full.

We are not otherwise required to agree to any restriction on the use or disclosure of your information.

Request communications with you be made at an alternative address or phone number.
We will honor any reasonable request. To request that communication be made at a different address or phone number contact our Privacy Officer at the number or e-mail listed at the end of this form to obtain the form to make your request.

Inspect and copy your PHI maintained in the Vital Pain Care, a division of American Pain and Wellness designated record set. To inspect and copy your record, a request must be made in writing on the form provided by American Pain and Wellness. There are limited situations in which American Pain and Wellness may deny this request. To obtain a form, contact our Privacy Officer at the number or e-mail listed at the end of this form.

Request that we amend your medical record if you believe the information we have about you is incorrect or incomplete. Your request must be made in writing to American Pain and Wellness. To request a form, contact our Privacy Officer at the number or e-mail listed at the end of this form.

You have the right to receive an accounting of disclosures, a list of individuals and entities that received your health information for reasons other than treatment, payment, or healthcare operations and other certain disclosures. You may receive one (1) free accounting during a twelve (12) month period. If you request more than one (1) accounting in a twelve (12) month period, you will be charged a fee. An accounting is not provided for disclosures prior to April 14, 2003.

You have the right to request a paper copy of this Notice.

Our Duties

We are required by law to maintain the privacy of PHI and to provide individuals with this Notice of our legal duties and privacy practice regarding health information.

We are required to notify you if there is a breach of your unsecured PHI.

We are required to follow the terms of the current Notice.

We may change the terms of this Notice and the revised Notice will apply to all health information in our possession. If we revise this Notice, a copy of the revised Notice will be posted and a copy may be requested from our Privacy Officer at the number or e-mail listed at the end of this form.

Organized Health Care Arrangement

If you are an inpatient or outpatient of a hospital or other health care facility where our health care professionals perform services, our practice is part of an organized health care arrangement (OCHA) with the hospital or other health care facility and the Notice of Privacy Practices of the hospital or other health care facility controls the use and disclosure of your information. The participants in the OCHA will share your information as necessary to carry out treatment, payment, and healthcare operations, and as permitted by law.

Use of Electronic Records

We may use an electronic health record. Your records may be disclosed in electronic form for treatment, payment, and healthcare operations, and as permitted by law.

Questions

If you have questions about this notice or want more information, please contact American Pain and Wellness at (469) 326-5100.

Complaints

If you believe your privacy rights have been violated or you disagree with a decision made by Vital Pain Care or American Pain and Wellness about your health information, you may contact The Privacy Officer for American Pain and Wellness at 469-326-5115 or email at mcollins@coremdpartners.com or you may contact the U.S. Department of Health and Human Services Office for Civil Rights.

Under no circumstances will we ever ask you to waive your rights under this notice or retaliate against you in any manner for filing a complaint.

Effective Date

The effective date of this notice is January 1, 2019.

WARNING REGARDING PHYSICAL DEPENDENCE OF CONTROLLED SUBSTANCES

Physical dependence and/or tolerance can occur with the use of controlled substances.

Physical dependence means that if the controlled substance is abruptly stopped or not taken as directed, a withdrawal symptom can occur. This is a normal physiological response. The withdrawal syndrome could include, but not exclusively, sweating, nervousness, abdominal cramps, diarrhea, goose bumps, and alterations in one's mood.

It should be noted that physical dependence does not equal addiction. One can be dependent on insulin to treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to the insulin or prednisone.

Addiction is a primary, chronic neurobiologic disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases one's quality of life.

Tolerance means a state of adaptation in which exposure to the drug induces changes that result in diminution of one or more of the drug's effects over time. The dose of the controlled substance may have to be titrated up or down to a dose that produces maximum function and a realistic decrease of the patient's pain.

It may be deemed necessary by your doctor that you see an addiction medicine specialist at any time while receiving controlled substance medications. Understand that if you do not attend such an appointment, your medication may be discontinued or may not be refilled beyond a tapering dose to completion. If the specialist feels that you are at risk for addiction or psychological dependence, medications will no longer be refilled.

Vital Pain Care

A division of American Pain and Wellness

GUIDELINES FOR OPIATE THERAPY

Side effects for Opiate/Narcotic Medications may include...

- Drowsiness, sedation, disorientation, resulting in falls and resultant significant injury
- Constipation and bowel obstruction, possibly requiring surgical intervention and potentially resulting in ischemic (dead) bowel, sepsis and death
- Allergic and/or anaphylactic reactions to the medications resulting in hypotension (low blood pressure), tachycardia (fast heart rate), arrhythmia (irregular heart rhythm), respiratory or cardiac arrest and death
- Respiratory depression resulting in respiratory arrest and/or death, as well as resultant cardiac arrest and/or death
- Tolerance to the medication may develop after long-term use, which means that ultimately this medication may become less effective
- Physical dependency, psychological dependency and addiction are possible with all narcotic medications. These situations may result in discontinuation of the pain medication by your doctor.
- Withdrawal phenomenon may occur with abrupt discontinuation of the pain medication. This may cause significant side effects such as heart palpitations, diaphoresis (sweating), anxiety, nausea, vomiting, elevated pulse and blood pressure. Do not abruptly discontinue this medication. Your health care provider will guide you on how to stop narcotics using a slow weaning process.

Precautions while taking Opiate Medications:

- Patients taking anticoagulants (blood thinners) are at particularly high risk of any kind of trauma (falls, etc.) as a resultant life-threatening hemorrhage, intracranial bleeding, or death may occur.
- The elderly may exhibit marketed or dramatic side effects from narcotic medications, even in low doses.
- Patients with other significant medical problems (including heart or lung disease) are at high risk for complications related to the use of narcotic medications.
- Patients taking sedative medications or central nervous system depressants should use narcotics sparingly and in reduced doses due to additive and/or synergistic interactions and greater than expected or enhanced side effects.
- Narcotic analgesics should not be used during pregnancy.

Take precautions with the following activities while taking Opiate Medications:

- Any kind of activity where judgment is required (i.e. driving, signing important documents, caring for the sick, the elderly, or the very young).
- Narcotic medications may affect the ability to drive or operate machinery.
- Avoid working on high-risk area (i.e. construction sites, elevated work sites, working with power tools, etc.).
- Drinking alcohol is prohibited while on narcotics due to potent and unpredictable enhancement of central nervous system depression if these two substances were taken together.
- If you experience the side effects such as sedation with opiate use, do not participate in the above activities.

If you have questions regarding these items, please ask your physician or nurse practitioner during your visit.