Advanced Spine and Pain Center

Today's Date: _____

Name: (Last, First, Middle)	☐ **M** ☐ **F**	**Home Phone**	**Cell Phone**
Date of Birth / **Age** / **SS#**		**Driver's License #**	
Address	**City**	**State**	**Zip Code**
Email Address:	**Race:** ☐ White ☐ African American ☐ Native American/Eskimo/Aleut ☐ Asian/Pacific Islander ☐ Other ☐ Unknown		
Preferred Language:	**Ethnicity:** ☐ Hispanic or Latino/Spanish ☐ Not Hispanic or Latino/Spanish ☐ Other ☐ Unknown		
Marital status	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Employment Status	☐ Full Time ☐ Part Time ☐ Self-Employed ☐ Unemployed ☐ Active Military ☐ Retired ☐ Student (Full/Part-time)		
Name of Patient Employer	**Occupation**	**Employer Telephone #**	
Patient Employer Address	**City**	**State**	**Zip Code**
Do you receive health care benefits from employers plan? ☐ **Yes** ☐ **No** **Does this plan pay you before Medicare?** ☐ **Yes** ☐ **No** **Is your condition a result of an accident or personal injury?** ☐ **Yes** ☐ **No** **Date of Accident/Injury:_____** **Is your condition covered under a Workmen's Comp claim?** ☐ **Yes** ☐ **No**			
If your condition is a result of a Worker's Comp/Accident/Personal Injury, Please Provide:			
Claim Adjuster Name	**Claim #**	**Telephone #**	
Nature of Injury			
Are you involved in a pain related legal case? ☐ **Yes** ☐ **No** **If Yes, Please Provide:**			
Name of Attorney	**Telephone #**		
Attorney Address	**City**	**State**	**Zip Code**
Emergency Contact Name	**Emergency Contact #**	**Relationship**	
Emergency Contact Address	**City**	**State**	**Zip Code**
Primary Insurance Information: ☐ **Group/Medical** ☐ **Worker's Comp** ☐ **Auto**			
Insurance Company Name	**Owner of Insurance Policy (Last, First, Middle)**	**DOB**	**Insurance ID#**
Secondary Insurance Information: ☐ **Group/Medical** ☐ **Worker's Comp** ☐ **Auto**			
Insurance Company Name	**Owner of Insurance Policy (Last, First, Middle)**	**DOB**	**Insurance ID#**

Advanced Spine and Pain Center

New Patient Questionnaire

Today's Date: _____

Last Name	**First Name**	**Middle Initial**
☐ **M** ☐ **F**	**Date of Birth: / /**	

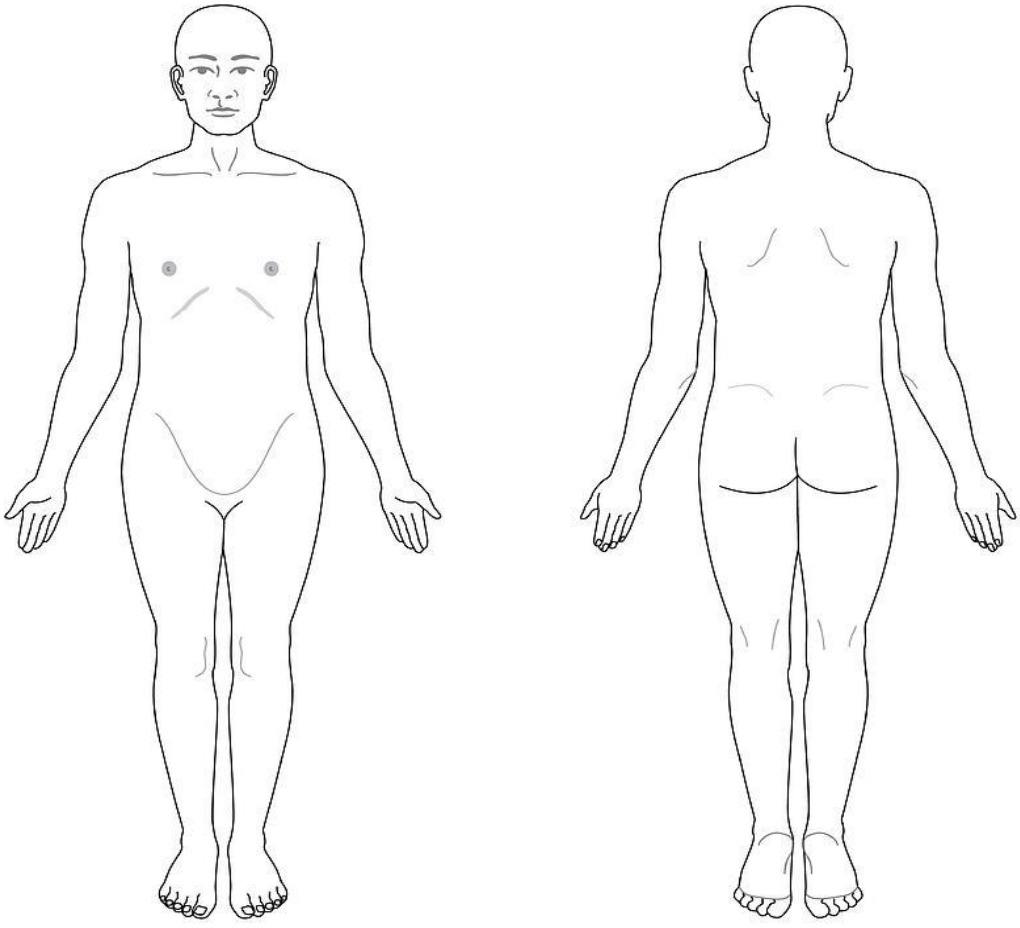
Reason For Physician Office Visit (Please Describe as accurate as possible)
Is this a Chronic Pain Condition? ☐ **Yes** ☐ **No**
Date symptom(s) and problem(s) began: / /
How did the pain start or what may have been the cause:
Does the pain radiate to any other part of your body? ☐ **Yes** ☐ **No Where?**
Can you please describe your pain? ☐ Sharp ☐ Electric ☐ Shooting ☐ Burning ☐ Tearing ☐ Ache ☐ Throbbing ☐ Other
Do you have any numbness or tingling? ☐ **Yes** ☐ **No Where?**
Is this Injury from an accident? ☐ **Yes** ☐ **No** **Is this a work related injury?** ☐ **Yes** ☐ **No**
Are you actively working? ☐ **Yes** ☐ **No If No, how long? _____Weeks _____Months _____Years**
Worker's Compensation? ☐ **Yes** ☐ **No** **Occupation:**
Have you had a physician consultation recently for this condition? ☐ **Yes** ☐ **No**
If Yes, Name of Physician: **Date of consultation: / /**
Have you been treated for this condition? ☐ **Yes** ☐ **No**
Describe treatment (such as epidural injections, spinal cord stimulators, physical therapy, etc.):
Date of Last Treatment: / /

Please indicate any activities that make the pain worse:
Please indicate anything that reduces the pain:
Please circle a number below to indicate your pain level right now:
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Possible)

PLEASE MARK THE AREAS BELOW, USING THE APPROPRIATE SYMBOLS FOR PAIN AND NUMBNESS.

PAIN "PINK"

NUMBNESS AND TINGLING "BLUE"



MEDICAL HISTORY

Are you allergic to any medications? ☐ Yes ☐ No	
List each allergy:	**Reaction:**
Do you smoke? ☐ Yes ☐ No **How Often?**	**Do you Drink? ☐ Yes ☐ No** **How Often?**
Any illicit drug use? ☐ Yes ☐ No If so, what?	
Marital status	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Do you have any children? ☐ Yes ☐ No	**Are you pregnant? ☐ Yes ☐ No**
Do you have any of the following medical conditions? (Please check all applicable below)	
☐ Anemia/Blood Disorders ☐ Gout ☐ Kidney Problems ☐ High Blood Pressure ☐ Lung Disease ☐ Diabetes ☐ Epilepsy/Seizure Disorder Problems or Ulcers ☐ Sexual Difficulties ☐ Bowel or Bladder Problems ☐ Weight Loss ☐ Other Health or Medical Problems: _____ _____ _____	☐ Arthritis ☐ Fibromyalgia ☐ Heart Disease/Heart Attack ☐ Asthma ☐ Stomach Problems, Gastrointestinal Problems ☐ Cancer, what type?_____ ☐ Thyroid Problems ☐ Heart Disease/Heart Attack ☐ Lung Disease
Please list and date any or all minor or major surgeries:	
Is there a family history for any of the above medical conditions (mother, father, siblings, and/or grandparents)? ☐ Yes ☐ No	
Please identify which medical condition(s) and which family member(s):	
Mother's Date of Birth:	**Deceased? ☐ Yes ☐ No**
Father's Date of Birth:	**Deceased? ☐ Yes ☐ No**

Please list all medications, dose, and how taken, including over the counter medications:		
Medication	**Dose**	**How Taken**

Referring Physician Name	**Referring Physician Phone #**		
Address	**City**	**State**	**Zip Code**
Primary Care Physician Name (If different than above)	**Primary Care Physician Phone #**		
Address	**City**	**State**	**Zip Code**
Preferred Pharmacy Name	**Preferred Pharmacy Phone #**		
Address	**City**	**State**	**Zip Code**

Have you had any imaging done for the condition? ☐ **Yes** ☐ **No** **If Yes, please specify below:**

Type	**Body Part**	**Where**	**Date**
☐ **MRI**			
☐ **CT**			
☐ **X-RAY**			
☐ **Other:_____**			

Patient Name: DOB:

FINANCIAL POLICY

Because of our commitment to provide you with the highest standard of medical care, we want you to be aware of our policies concerning payment of your medical expenses.

At the initial visit and all visits, the patient is responsible for co-payment/co-insurance amount, plus any deductible. **If our office cannot verify insurance benefits, payment is due in full.**

If your insurance carrier sends payment directly to you, then payment in full is due at each visit. Should an overpayment occur on the deductible or percentage amounts charged, we will apply a credit to your account. A refund is available upon request.

If you are waiting for coverage to become effective or have no insurance, payment in full will be expected the day you are seen. For your convenience, we accept VISA, Master Card, Discover, American Express, cash, or check. Due to pending insurance contract status or a decision not to contract with your insurance company, out of network chargers may apply. If you do not have any out-of-network benefits, payment is due in full each visit. It is your responsibility to call your insurance company and obtain this information before receiving treatment and before filing claims for treatment.

We require that an adult (parent or legal guardian) accompany a minor patient unless prior written authorization is given to our office. The adult accompanying the minor s required to pay in accordance with our policies. We do not accept third party assignments nor do we recognize or enforce the terms of divorce or decrees.

There is a **$35.00 service fee on all returned checks in addition to the amount of the check**. NSF (non-sufficient funds) checks must be redeemed with certified funds (cashier's check, credit card, money order, certified check or cash) at or before the next office visit.

Please notify us with at least 24 hour notice if you must cancel your appointment so that we may let another patient have your appointment time. **If you do not provide at least 24 hour notice there will be a "no-show" charge for an office visit of $25.00 and a "no-show" charge for a procedure, including an injection of $100.00.**

It is your responsibility to know your coverage and benefits and if we are a preferred or assigned provider of your plan. Please be aware that some or all services provided for you may not be covered by your specific plan. In the event that your plan does not cover all services, you will be billed for the services that are not covered.

If your insurance has not paid your account in full within 120 days, you will be billed the balance. Bills that are not paid within 90 days of the first billing will be transferred to an outside collection agency unless other arrangements have been made. We will make every effort to work with you so please contact our office manager if there a need for a payment plan or there are problems prior to 90 days. If you are unable to keep your account current, we will not be able to provide additional medical services to you unless prepayment is made for services.

In the event that payment is not made on this account and it is placed with a licensed a collection agency, you agree to pay the fees of the collection agency equal to maximum of 40% of our outstanding balance at the time the account is placed with the collection agency interest of 40% per year will be accrued on the principal balance. Should legal action be necessary to collect the account, you agree to pay attorney fees and court cost incurred for collection.

I have read and understood the foregoing Financial Policy and agree to abide by the terms of the policy.

I hereby authorize **Advanced Spine and Pain Center** to release to my insurance company any information acquired in the course of my examination or treatment which is necessary to process claims for services rendered. I hereby authorize and direct my insurance carrier to pay directly to the Physician any benefits due me under my insurance plan. I certify that the information above is correct and I understand that any remaining balance after contractual discounts are taken into consideration will be my responsibility. **IF ANY OF THE GIVEN INFORMATION IS INACCURATE OR INCOMPLETE AND THIS CAUSES CLAIMS TO BE UNPROCESSABLE OR DENIED, I UNDERSTAND THAT THE UNPAID BALANCES ARE MY RESPONSIBILITY.**

By signing this below I have reviewed and agreed to non-covered services agreement. If I am requesting medical records for myself, I agree to pay the applicable fees for copying.

Print Name	**Signature**	**Date**

Witness Name	**Witness Signature**	**Date**

Advanced
Spine and Pain Center

21 Spurs Lane, Suite 240
San Antonio, TX 78240
Office: 210-690-0777
Fax: 210-690-0779

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT
AS REQUIRED BY THE TEXAS MEDICAL BOARD
REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9, CHAPTER 170
3Rd Edition: Developed by the Texas Pain Society, April2008 (www.texaspain.org)

NAME OF PATIENT: _____ DATE: _____

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 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 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 (name at bottom of agreement) 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/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).

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 random 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.

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 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/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.

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS 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.

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), 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 my physician**.
- 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.**
- 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.
- I will receive 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.
- 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).
- 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 will **not operate any vehicle or heavy equipment** while taking prescribed medications.

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 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.**

NOTICE OF PRIVACY PRACTICES

Effective: September 23, 2013

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.

Advanced Spine and Pain Center uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of Advanced Spine and Pain Center.

How Advanced Spine and Pain Center May Use or Disclose Your Health Information

For Treatment. Advanced Spine and Pain Center may use your health information to provide you with medical treatment or services. For example, our providers and staff will record information in your record that is related to your treatment. This information is necessary for our providers to determine what treatment you should receive. Our providers will also record actions taken by them in the course of your treatment and note how your respond to the actions.

For Payment. Advanced Spine and Pain Center may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, we may send a bill to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For Health Care Operations. Advanced Spine and Pain Center may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of our staff and others to:

- Evaluate the performance of our staff;
- Assess the quality of care and outcomes in your case and similar cases;
- Learn how to improve our services; or,
- Determine how to continually improve the quality and effectiveness of the health care we provide.

Appointments and Patient Recall Reminders. Advanced Spine and Pain Center may use your information to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. We may contact you by telephone, in writing, email, or otherwise and may involve leaving a message which could potentially be picked up by others.

Others Involved in Your Care. We may disclose information about you to others who may be involved in your medical care. Unless you clearly instruct us to the contrary, we may disclose information to a friend or family member who is involved in your medical care.

Required By Law. Advanced Spine and Pain Center may use and disclose information about you as required by law. For example, Advanced Spine and Pain Center may disclose information for the following purposes:

- For judicial and administrative proceedings pursuant to legal authority;
- To report information related to victims of abuse, neglect or domestic violence; and,
- To assist law enforcement officials in their law enforcement duties.

Written Authorization. Other uses or disclosures not covered by this Notice or the applicable laws may be made with your specific written permission. You may revoke your written permission at any time and we will immediately cease such uses or disclosures. You understand that we cannot take back any disclosures already made prior to your revocation.

Public Health. Advanced Spine and Pain Center may use and disclose your health information for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Decedents. Advanced Spine and Pain Center may use and disclose your health information to funeral directors, medical examiners, or coroners to enable them to carry out their lawful duties.

Organ/Tissue Donation. If you are an organ donor, Advanced Spine and Pain Center may use and disclose your health information for cadaveric organ, eye or tissue donation purposes.

Research. Advanced Spine and Pain Center may use and disclose your information for research purposes when the research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Health and Safety. Advanced Spine and Pain Center may use and disclose your health information to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions. Advanced Spine and Pain Center may use and disclose your information for specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of your information.
Workers Compensation. Your health information may be used and disclosed to comply with laws and regulations related to Workers Compensation.

Inmates. If you are an inmate or under custody of a law enforcement official, we may release information about you to the correctional institution or law enforcement official: (1) for the institution to provide you with healthcare; (2) to protect your health and safety or that of others; or, (3) for the safety and security of the correctional institution.

Your Health Information Rights

You have the right to:

- Request a restriction on certain uses and disclosures of your information; however, Advanced Spine and Pain Center is not required to agree to a requested restriction unless you specifically request that Advanced Spine and Pain Center refrain from disclosing information to your health plan for services in which you have paid in full, out of pocket.
- Obtain a paper copy of the Notice of Privacy Practices upon request;
- Inspect and obtain a copy of your health record as permitted by law;
- Obtain an electronic copy of your health information to the extent that it is maintained in an electronic medical record;
- Request an amendment of your health record;
- Request communications of your health information by alternative means or at alternative locations;
- Receive an accounting of disclosures made of your health information; and,
- Receive notification upon a breach of any of your unsecured health information.

Obligations of Advanced Spine and Pain Center
Advanced Spine and Pain Center is required to:

- Maintain the privacy of protected health information;
- Provide you with this notice of its legal duties and privacy practices with respect to your health information;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed;
- Accommodate reasonable request you may make to communicate health information by alternative means or at alternative locations; and
- Obtain your written authorization to use of disclose your health information for reasons other than those listed above and/or permitted by law.

Complaints
You may complain to Advanced Spine and Pain Center and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint. To file a complaint with Advanced Spine and Pain Center contact our Privacy Official. All complaints must be in writing.

Changes to this Notice
We reserve the right to change this Notice at any time and to make the revised Notice effective for health information we already have about you. We will post a copy of the current Notice in our waiting room. You may request a copy of this Notice at any time.

Contact Information
If you have any questions or complaints, please contact:
Privacy Officer
Advanced Spine and Pain Center
21 Spurs Lane, Suite 240
San Antonio, Texas 78240

PATIENT NAME: _____ **DOB: _____**

PLEASE SIGN BOTH BELOW TO CONFIRM RECEIPT OF NOTICES

The undersigned acknowledges receipt of Informed Consent and Pain Management Agreement of Advanced Spine and Pain Center on the dated noted below.

_____
Patient Signature

_____
Date

_____
Physician Signature (or Appropriately Authorized Assistant)

_____
Primary Care Physician Name and Signature

_____
Name and contact information for pharmacy

The undersigned acknowledges receipt of the Notice of Privacy Practices of Advanced Spine and Pain Center on the dated noted below.

_____
Signature of Patient or Legal Representative

_____
Printed Name

_____
Date

Advanced
Spine and Pain Center

21 Spurs Lane, Suite 240 | San Antonio, TX 78240 | Office: 210-690-0777 | Fax: 210-690-0779

Authorization for Release of Patient Health Information

Authorization to Disclose Health Information

Patient Name: _____ Medical Record Number: _____

Date of Birth: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:

   _____

   Address_____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

   Medication list
   Immunization record
   History and physical
   Discharge summary
   Laboratory results from (date) _____to (date) _____
   X-ray reports from (date) _____to (date) _____
   Consultation reports from (date) _____to (date) _____
   Entire record
   Other _____
   _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by the following individual or organization:

   _____

   Address_____

   For the purpose of_____

6. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and resent my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____. If I fail to specify an expiration date, event, or condition, this authorization will expire in (12) twelve months.
7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about a disclosure of my health information, I can contact the *Health Information Department.*

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative, Relationship to Patient Signature of Witness