Today's Date: ______________

Name: (Last, First, Middle)	☐ M ☐ F	Home Phone	Cell Phone

Date of Birth	Age	SS#	Primary Insurance Information: ☐ Group/Medical ☐ Worker's Comp ☐ Auto

Address	City	State	Zip Code

Email Address:	Consent to Text: ☐ Yes ☐ No
Race: ☐ White ☐ African American ☐ Native American/Eskimo/Aleut Asian/Pacific Islander ☐ Other/Specify: ☐ Unknown	**Ethnicity:** ☐ Hispanic or Latino/Spanish ☐ Not Hispanic or Latino/Spanish ☐ Other/Specify: ☐ Unknown

Marital status	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Emergency Contact Name	Emergency Contact #	Relationship

Emergency Contact Address	City	State	Zip Code

Employment Status	☐ Full Time ☐ Part Time ☐ Self-Employed ☐ Unemployed ☐ Active Military ☐ Retired ☐ Student (Full/Part-time)

Name of Patient Employer	Occupation	Employer Telephone #

Is your condition covered under a Workmen's Comp claim?	☐ Yes ☐ No Date of Accident/Injury:_______________

If your condition is a result of a Worker's Comp/Accident/Personal Injury, Please Provide:

Claim Adjuster Name	Claim #	Telephone #

Injured body part(s):

Are you involved in a pain related legal case? ☐ Yes ☐ No If Yes, Please Provide:

Name of Attorney	Telephone #

Advanced Spine and Pain Center

New Patient Questionnaire

Today's Date: ________________

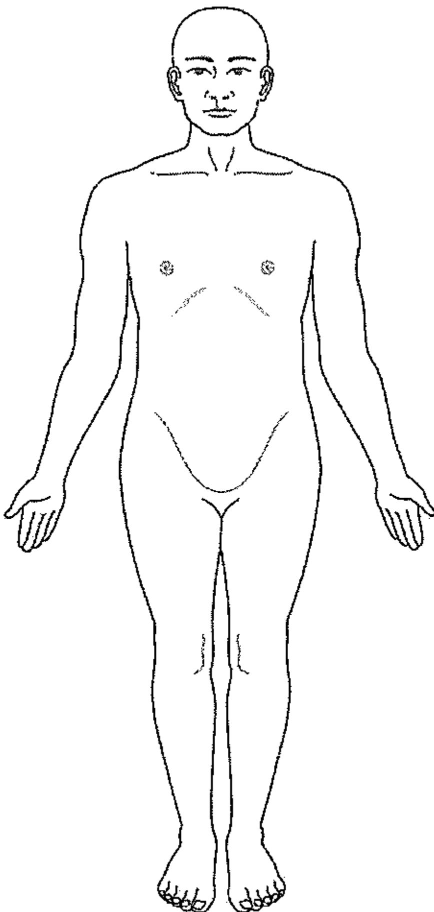
Last Name	First Name	
Reason For Physician Office Visit (Please describe as accurate as possible where your pain is located)		
Is this a Chronic Pain Condition? ☐ Yes ☐ No		
Date symptom(s) and problem(s) began: / /		
How did the pain start or what may have been the cause:		
Does the pain radiate to 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 due to a MVA 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: / /		

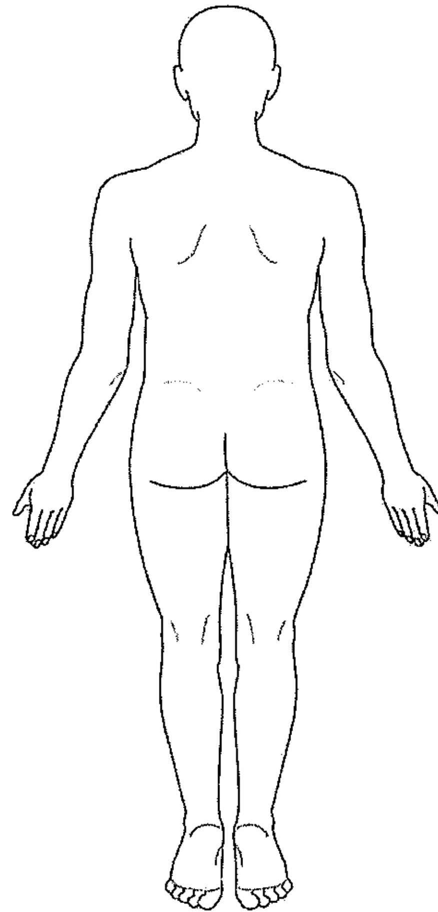
Please indicate any activities that make the pain worse:
Please indicate anything that reduces the pain:
Please circle a number below to indicate your pain level right now:
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Possible)

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 ☐ 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**	**Facility**	**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**

Long-Term Controlled Substance Therapy for Chronic Pain

(A consent form from the American Academy of Pain Medicine)

The purpose of this agreement is to protect the access to controlled substances and to protect our ability to prescribe for you.
The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers and barbiturate sedatives is controversial because uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.
Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the Physician whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

1) All controlled substance must come from the Physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward interactions or poor coordination of treatment).

2) All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies our office must be informed. The pharmacy that you have selected is: ______________________________ Phone: ____________________________.

3) You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.

4) The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposed of maintaining accountability.

5) **Prescriptions are to be used ONLY as written. Use of increased amount of medication, without consultation with our physician will not be allowed.**

6) You may not share, sell or otherwise permit others to have access to these medications.

7) These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.

8) **Unannounced urine or serum toxicology screens may be requested, your cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorder.**

9) **Long acting narcotics will be administered for chronic pain problems. Our goal is the discontinuation of short acting narcotics and narcotic mixtures (Percocet, Lortab, Vicodin, and Norco). "Rescue doses: of short acting narcotics will not be routinely prescribed.**

10) **Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with our medication and prescription.**

11) Original containers of medications should be brought in to each visit.

12) Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.

13) Prescriptions may be issued early if the Physician or patient will be out of town when a refill is due. These prescriptions contain instructions to the pharmacist that they not be filled prior to the appropriate date.

14) **If the responsible legal authorities have questions concerning your treatment, as might occur, for example if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.**

15) It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.

16) **Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours and on weekends.**

17) It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit.

18) The risks and potential benefits of these therapies are explained elsewhere (and you acknowledge that you have received such explanation).

19) **Termination terms will include a written letter to you and fulfillment of your medical narcotic prescriptions, for one month after the date of termination. You may also be referred to an evaluation for drug dependency, and if appropriate, be referred for detoxification.**

20) You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand and accept all of its terms.

Your pain is **YOUR** responsibility. Making appointments for medication refills is **YOUR** responsibility. We will provide medical support in our quest to minimize your pain. You must make new efforts to improve SLEEP HABITS, NURTITION, BODY WEIGHT, CONDITIONING AND PSYCHOLOGICAL STATE. Narcotics are not the answer to chronic pain, but can be used effectively to improve your pain.

You affirm that you have full right and power to sign and are bound by this agreement, and that you have read, understand and accept all of its terms.

Physician Signature

Date: ____________________

Patient Signature

____

Patient Name (printed)

____

NOTICE TO PATIENTS

All Class 2 Narcotic or Triplicate prescription medications require a courtesy call 72 hours prior to refill dates. This will help us to dispense your prescription in a prompt and timely manner to better serve our patients.

All prescriptions are sent electronically between 9am-4pm, Monday-Thursday. Please allow up to 24-48 hours for your prescription to be processed.

Please keep in mind, if someone other than the patient will be picking up the prescription, we require identification, as well as some form of identification from the patient. We will not release the prescription without these 2 forms of identification.

Thank you for your consideration.

______________________________ ______________

Signature of Patient or Legal Representative Date

____

Patient Name (printed)

ADVANCED
SPINE AND PAIN
CENTER

NOTICE OF PRIVACY PRACTICE

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.

____

Signature of Patient or Legal Representative

____

Date

____

Name of Patient of Legal Representative

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 re-disclosure 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