Patient Acknowledgement Statement

I understand that services or items that I have requested be provided to me by Pain Specialists of America (as applicable, the "Practice") may not be covered under my insurance as being reasonable or medically necessary for my care. I understand my health plan determines the medical necessity of the services or items I request and receive. I also understand I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable or medically necessary for my care.

Advanced Practitioner Consent for Treatment: The Practice has on staff physician assistants, nurse practitioners, or advanced practice nurses to assist in the delivery of medical care of pain management.

- A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. A nurse practitioner or advanced practice nurse is not a doctor. A nurse practitioner or advanced practice nurse is a registered nurse who has received advanced education and training in the provision of health care. Under the supervision of a physician, a physician assistant, a nurse practitioner, or an advanced practice nurse can diagnose, treat and monitor acute and chronic disease as well as provide health maintenance care.
- "Supervision" does not require the constant physical presence of the supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.
- A physician assistant, a nurse practitioner, or an advanced practice nurse may provide such medical services that are within his/her education, training and experience.
- I have read the above and hereby consent to the services of an advanced practitioner for my health care needs. I understand that at any time I can refuse to see the advanced practitioner and request to see a physician.

Acknowledgment of Care: We are committed to providing compassionate care, especially when it comes to managing chronic pain. Due to the ongoing opioid crisis, we have a policy in place to ensure the safe and responsible prescribing of opioid medications. Before prescribing opioids, we will complete a thorough evaluation, which includes reviewing your medical history, conducting any necessary tests, and ensuring a urine drug screen shows expected results. Opioid prescriptions (such as hydrocodone, oxycodone, or fentanyl) will not be issued during your first visit.

- If instructed to bring imaging reports or films, please ensure they are brought to your appointment. Failure to do so may result in rescheduling.
- If English is not your first language, please inform us at least 48 hours before your appointment if you require a language interpreter. We want to ensure you fully understand your diagnosis and treatment options.

Acknowledgment of Urine Testing Policy: I understand that the Practice reserves the right to perform random urine testing on any patient. I have the right to refuse the urine test but may then not be prescribed any medications or given refills of medications.

Acknowledgment of External Rx History: I understand that the Practice reserves the right to obtain an external Rx history and randomly verify past medications through the Prescription Drug Monitoring Database in order to be prescribed any medications.

Acknowledgment of Late Arrival Policy: If you are unable to make an appointment, the Practice must be notified 24 hours prior to your appointment to reschedule. Failure to notify our office will result in a NO SHOW fee of $25 for an office visit and $50 for a procedure. Frequent NO SHOWS may result in a release from the Practice.

Acknowledgement of Communication: I acknowledge that certain messages related to my care, such as post-procedure instructions, follow-up care, educational materials, and prescription information, may be sent without my explicit consent. For all other communications, I consent to receiving calls, texts, or voicemails from the Practice using the contact information in my patient record, including any forwarded or updated details. This may also include messages to family or designated representatives about my care, appointment reminders, insurance or billing communications, and feedback requests. I authorize these communications, which may be sent via automated systems, even if my number is on a do-not-call registry. I understand that consenting to these communications is not required to receive healthcare services.

Acknowledgment of Receipt of HIPAA Notice of Privacy Practices: I acknowledge that I have received a copy of the HIPAA Notice of Privacy Practices from the Practice. This notice explains how my health information may be used and shared, and outlines my health privacy rights.

Authorization for Access to Protected Health Information (PHI) – HIPAA Privacy Rules: I authorize the Practice to release all PHI, including but not limited to appointment details, test results, treatment plans, and any healthcare-related instructions, to the following individuals. These individuals are permitted to receive and discuss my PHI as needed:

	NAME	RELATIONSHIP	CONTACT NUMBER
1			
2			
3			

_____ _____

Patient/Patient Representative Signature Date

Financial Policy

Thank you for choosing Pain Specialists of America. In order to inform you of our current financial and office policy, please read the document below and sign the financial agreement. Our providers, clinical, and office staff are here to help you in any way possible and strive to make your experience with us pleasant and comforting. Keep a copy of this document for your records and should you have any questions, please do not hesitate to ask one of our associates.

- Please keep us informed of any address, telephone number, or name changes. If we are unable to contact you regarding your bill, we will refer the balance to our outside collection agency.
- Please notify our office within 24 hours to reschedule or cancel an appointment. This will allow our staff to offer this time slot to another patient in need of an appointment.
- We accept the following forms of payment: credit cards, cashier's checks, money orders, and personal checks.

RETURNED CHECKS

Returned checks will accrue a $50.00, as well as any applicable bank fees to your account.

INSURANCE

- It is your responsibility to know your level of benefits for services provided. Being that our providers are specialist, many services are required to have prior authorizations by the insurance company and/or Primary Care Physician. Please contact your insurance company before your appointment to ensure proper authorization and an estimate of payment due as we aren't certain what the patient balance will be until the insurance company processes your claim.
- Payment of fees, co-pays, co-insurance and deductibles are due at the time of service.
- Co-pays are a requirement placed on you by your insurance company and therefore cannot be waived or reduced. Should you forget or cannot provide your co-pay at the time of visit; you will be asked to reschedule your appointment.
- You are solely responsible for your balance in the form of co-insurance, deductible, or non-covered services as required by your insurance company.
- You will be contacted prior to your appointment and notified of any balance due on your account and will be expected to bring payment to your appointment. You will be required to make arrangements with the financial counselor if you cannot pay the balance in full.
- Should any balance remain unpaid more than 90 days past the processing date with the insurance company, a statement will be sent to the guarantor of the account and payment will be due upon receipt of the statement.

WORKER'S COMPENSATION

- Please keep in contact with your adjuster prior to and after your appointment to receive any pertinent information regarding your claim and injury.
- Authorizations may be required for certain procedures and could take up to 1 week to obtain.
- Should your case become closed, undergo peer review, or determined that Maximum Medical improvement has been met you must contact your referring physician and adjuster for written approval before scheduling any appointment or services.

Assignment of Benefits

I hereby authorize the release of any medical or other information necessary to process claims related to my treatment. I further authorize and direct payment of medical benefits directly to provider and/or facility for services rendered to me by the provider.

I understand that this authorization does not relieve me of my financial obligation for any charges not covered by my insurance plan. I agree to be financially responsible for any co-payments, deductibles, co-insurance, or other amounts not paid by my insurance company.

I acknowledge that I am responsible for providing accurate and up-to-date insurance information and that failure to do so may result in my being billed directly for services.

This assignment of benefits will remain in effect until revoked by me in writing. A photocopy of this authorization is to be considered as valid as the original.

_____ _____

Patient/Patient Representative Signature Date

Notice of Privacy Practice

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.

Information about you and your health is personal, and we are committed to protecting your privacy. This notice tells you about our privacy practices, the ways in which we may use and share your health information, and how you can get access to your health information. This notice also describes your rights and our responsibilities regarding the use and disclosure of health information.

Our Uses and Disclosures

We typically use and share your health information in the following ways:

Treat you: We can use your health information and share it with other professionals who are treating you. Examples: we will share health information about you with an ambulatory surgical center where you are scheduled for a procedure; we will share your health information with a physician to whom you have been referred for further treatment.

Bill for our services: We can use and share your health information to bill and receive payment from health plans and other entities. Example: we will share your health information with your health insurance plan so it will pay for services we provide to you.

Run our organization: We can use and share your health information to run our operations, train medical students, improve your care and contact you when necessary. Examples: we may call you by name in the waiting room when your physician is ready to see you; we may use your health information in our quality improvement reviews.

We can also de-identify your health information and use and disclose such de-identified information for any purpose.

Communicate regarding treatment alternatives or appointment reminders: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related services that may be of interest to you.

How else can we use or share your health information? We are allowed or required to share your health information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information, see: https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues: We can share information about you for certain situations, such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research: We can use or share your information for health research.

Food and Drug Administration (FDA): We may share health information with the FDA relative to adverse events with respect to food, medications, devices, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs or replacement.

Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations. Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' comp, law enforcement & other government requests: We can use or share health information about you

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record:

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Please contact the office directly where you receive care.
- We will provide a copy or a summary of your health information in accordance with applicable state and federal requirements. We may charge a reasonable, cost-based fee.
- If you ask that we send a copy of your medical record/other health information to someone other than you, we may ask you to complete a written auth. You may revoke an authorization to use or disclose your health information except to the extent that action has already been taken in reliance on your authorization. To revoke your authorization, send written notice to:
  Privacy Officer, Daniel Frederick, MD
  4100 Duval Road, Bldg 3, Suite 200, Austin, TX 78759. Phone: 855.876.7246

Ask us to correct your medical record: You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications: You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. You may also view a copy of this notice on our website.

Ask us to limit what we use or share:

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

File a complaint if you feel your privacy rights have been violated.

- You can complain if you feel we have violated your privacy rights by contacting the office where you receive care directly.
- You can also contact our Privacy Officer:
  Privacy Officer, Daniel Frederick, MD
  4100 Duval Road, Bldg 3, Suite 200, Austin, TX 78759. Phone: 855.876.7246
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Effective Date: 5/2022

Pain Specialists of America

Today's Date: _____

Location of Care: _____

PATIENT'S PERSONAL INFORMATION

Name: _____ Preferred Name: _____
Last Name First Name M.I.

Date of Birth: ____/____/____ Gender: ☐ Male ☐ Female ☐ Other _____

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

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

SSN: ____ - ____ - ____ Driver's License # & State: _____

Employer: _____ Employer Phone: _____

E-Mail Address: _____

Preferred Method of Communication? * ☐Home phone ☐Cell Phone ☐Work Phone ☐E-Mail/Patient Portal

*If an email or phone number is provided, you may receive various types of communications from the Practice. To opt out, fill out Communication Consent at the clinic.

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined to Specify Preferred Language: _____

Race: ☐American Indian ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White Other _____

Referring Physician: _____ Primary Care Physician: _____

Other Healthcare Providers: _____

Emergency Contact: _____ Relationship: _____

Emergency Phone: _____ Phone Type: _____

PATIENT'S RESPONSIBLE PARTY INFORMATION

Name: _____ Date of Birth: _____

Address: _____

Phone: _____ SSN: _____ Relationship: _____

INSURANCE INFORMATION

Primary Insurance Name: _____

Insured Name: _____ DOB: _____ SSN: _____

Relationship to Patient: _____ ID #: _____ Group #: _____

Secondary Insurance Name: _____

Insured's Name: _____ DOB: _____ SSN: _____

Relationship to Patient: _____ ID #: _____ Group #: _____

***Please provide card(s) to the front desk**

Is there an ongoing lawsuit related to your visit today? ☐YES ☐NO Are you currently under worker's compensation? ☐YES ☐NO

Pain Specialists of America

Patient Medical History

Patient Name & DOB: _____

PAIN EVALUATION

Location of pain _____

Onset of pain _____(days/weeks/months/years) Cause of pain _____

☐ Accident ☐ Work Injury Your occupation _____

Referring _____Primary Care Provider _____

Other physicians/specialties you have seen for this pain, including other pain management clinics & surgeons:

_____

Characteristics of your pain: ☐ Constant ☐ Intermittent ☐ Sudden ☐ Gradual

Pain Intensity: 0 – no pain 2 3 4 5 6 7 8 9 10 – worst imaginable pain

Your pain is: ☐ Aching ☐ Burning ☐ Electrical Shocks ☐ Numbness ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Tingling

Does it radiate? ☐ Yes ☐ No Other _____

What makes your pain worse? _____

What makes your pain better? _____

Do you have: ☐ Localized Weakness ☐ bowel incontinence ☐ bladder incontinence

Which of the prior treatments or tests have you had? **Include date of service and results**

☐ MRI ☐ CT ☐ X-ray _____ ☐ EMG/Name Test_____

Previous Meds: ☐ Anti-Inflammatory ☐ Muscle Relaxers ☐ Neuropathic ☐ Opioids ☐ Other_____

List Prior Tried Medications: See Chart on next page

☐ Injections_____ ☐ Epidural ☐ mbb/RFA

☐ Chiropractic Treatment_____ ☐ Brace

☐ Acupuncture_____ ☐ TENS

☐ Physical Therapy _____

☐ Massage Therapy_____ ☐ Cognitive Behavioral Therapy

Other _____

Please list any chronic illness/medical conditions: _____

_____

Please list any prior surgeries & date: _____

Do you have a family history of any kind of illness? Family History: ☐ DM ☐ Cardiac ☐ Stroke ☐ Other _____

Are you allergic to: ☐ Tape ☐ IV Iodine ☐ Latex ☐ Topical Iodine ☐ Shellfish Your reaction: _____

Please list any medication allergies and reactions:_____

_____

Pain Specialists of America

Patient Name & DOB: _____

Current Pharmacy: _____ Phone Number: _____

Address: _____

CURRENT MEDICATIONS **ADDITIONAL MEDICATION LIST: YES NO (Circle one)**

*List pain medications and blood thinners first. Check boxes below of current medications *If you need more space, request RX sheet.

Medication (ex. Ibuprofen)	Dosage (ex. 400 mg)	Frequency (ex. three times a day)

PLEASE CHECK ✓ ALL PREVIOUSLY TRIED MEDICATIONS										
	☐	Amitriptyline	☐	Lyrica	☐	Celebrex	☐	Tylenol	☐	Flexeril
	☐	Effexor/Venlafaxine	☐	Gabapentin	☐	Ibuprofen	☐	Codeine	☐	Robaxin
Other:			☐	Topamax	☐	Naproxen	☐	Nucynta	☐	Tizanidine
Other:			☐	Cymbalta	☐	Meloxicam	☐	Tramadol	☐	Hydrocodone

Any tobacco use? ☐Yes ☐No If yes, how many per day?_____ Years?_____ Ex user, date quit _____

Any alcohol use? ☐Yes ☐No Type: _____ How much? _____How often? _____

Do you have a history of or current drug use? ☐Yes ☐No If yes, which type of drug? _____

FEMALE PATIENTS ONLY

☐ I am **NOT** pregnant ☐ I am _____weeks pregnant Name of OB/GYN _____

REVIEW OF SYSTEMS ✓**CHECK** ALL that you have experienced in the last month

General: ☐ Fever ☐ Chills ☐ Weight Loss ☐ Weight Gain ☐ Recent Infections
Eyes/ENT: ☐ Blurred Vision ☐ Double Vision ☐ Decreased Hearing ☐ Difficulty Swallowing
Cardiovascular: ☐ Chest pain ☐ Palpitations ☐ Fainting ☐ Peripheral edema
Respiratory: ☐ Cough ☐ Shortness of breath
Gastro: ☐ Constipation ☐ Abdominal pain ☐ Bowel incontinence ☐ Nausea ☐ Vomiting
Genitourinary: ☐ Bladder incontinence ☐ Difficulty with Urination
Musc-skeletal: ☐ Joint pain ☐ Swelling ☐ Spasms ☐ Cramps
Skin: ☐ Rash ☐ Open Sores/Wound
Heme/lymph: ☐ Bleeding ☐ Easy Bruising
Neurological: ☐ Falls ☐ Tremors ☐ Limb Weakness ☐ Loss of balance
Psychiatric: ☐ Untreated Depression ☐ Uncontrolled Anxiety ☐ Hallucination ☐ Suicidal Thoughts
Immunologic: ☐ Hives ☐ Persistent infections ☐ Covid

PLEASE MARK ANY AREA(S) ON THE BODY WHERE YOU FEEL PAIN & Additional Notes

_____

_____

_____