Woodlands Physical Medicine

Samuel J. Alianell, MD

American Board of Physical Medicine & Rehabilitation
American Board PM&R Subspecialty of Pain Medicine
Gold Designated Pain Management Clinic – Texas Medical Board
3275 College Park Dr., The Woodlands, TX 77384
Ph: 936-321-0214 ~ Fax: 936-271-0219

Private Insurance Patient Profile

Appt Date: _____ ***Reason for Visit:*** _____

Patient Information:

Patient Name: _____ SEX: ( ) Male ( ) Female

DOB: _____ Age: _____ SS#: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Employer Information:

Employer Name: _____ Work Phone: _____

Insurance Information:

Primary Insurance Company: _____

Address: _____

Phone: _____ Fax: _____

Policy ID#: _____ GRP#: _____

PCP/Referring Doctor: : _____ Phone: _____

Secondary Insurance Company: _____

Address: _____

Phone: _____ Fax: _____

Policy ID#: _____ GRP#: _____

Policy Holder: _____ DOB: _____

SS#: _____ Employer: _____

I authorize billing/payment of medical benefits to Woodlands Physical Medicine / Samuel J. Alianell, MD for services rendered.

Patient Signature: _____ Date: _____

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Patient Name: _____ DOB: _____

Insurance Company: _____

Release of Information: I hereby authorize *Samuel J. Alianell, MD PA* to release any or all information acquired in the course of my examination and/or treatment that may be required to process claims for payment, I also authorize the release of information to another doctor or health care facility to which the patient may be transferred.

Initials: _____

Medicare Patient Certification: I certified that the information I have provided to WPM is accurate and correct. As this clinic does accept assigment with Medicare, this information will be used for the purpose of processing my Medicare claims for payment. I understand due to government regulations that if Medicare coverage is available to me I must inform my physician. I also understand, if in addition to Medicare I am covered under ***an Employer Group Health Insurance, Liability, No-Fault Worker's Compensation,*** or any other insurance which may be responsible for payment, ***I must inform the clinic.***

I have read and understand the above statement regarding MEDICARE coverage. ***Initials: _____***

Please ***X*** which applies:

_____ MEDICARE is my ***Primary*** Coverage. _____ This is ***NOT*** a Work Related Condition.

_____ MEDICARE is my ***Secondary*** Coverage. _____ This ***IS*** a Work Related Condition.

_____ I do ***NOT*** have Medicare/ HMO/ Advantage Plans

_____ I do ***NOT*** have Medicaid/HMO

ASSIGMENT OF BENEFITS: I hereby authorize payment to Samuel J. Alianell, MD/Woodlands Physical Medicine for medical services and/or surgical procedures if any , otherwise payable to me for services I have received.

Initials: _____

FINANCIAL OBLIGATIONS: The undersigned hereby unconditionally gaurantees full and prompt payment of all charges incurred as a result of services rendered to me during the course of my medical treatment.

Initials: _____

FINANCIAL DISCLOSURE: Samuel J. Alianell, MD is an owner of Samuel J. Alianell, MD PA, DBA Woodlands Physical Medicine, Woodlands Claims Holdings LLC, DBA Woodlands Pharmacy, and CPRC Holdings LLC, DBA Chronic Pain Recovery Center.

Initials: _____

Signature of Insured/Guardian: _____ Date: _____

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

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that require permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information(PHI): Your PHI may be used and disclosed by your physician, our clinic staff and other outside of our clinic that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills to support you, the operation of the physician's practice and any other use required law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose your PHI as needed in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our clinic. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call your name in the waiting room when your physician is ready to see you. We may use or disclose your PHI as necessary to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization. These situations include as Required by Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors and Organ Donation, Research Criminal Activities, Military Activity and National Security, Worker's Compensation, Inmates, ***Require Uses and Disclosures: Under the Law, we must make disclosure to you and when require by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.***

Other Permitted and Required Uses and Disclosures: Will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or physician's practice has taken an action in reliance on the use or disclosure indicated in this authorization.

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Your Rights: A statement of your rights with respect to your Protected Health Information (PHI).

You have the right to inspect and copy your PHI: Under federal law, however, you may not inspect or copy the following records, psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceedings, and PHI that is subject to law that prohibits access to PHI.

Your physician is not required to agree to a restriction that you may request. If physicians believe it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you agree to accept this notice alternatively, i.e. electronically.

You have the right to have your physician amend your PHI. If we deny the request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice***.***

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. ***We will not retaliate against you for filing a complaint.***

I _____ acknowledged that I have read the PHI and that I can request a copy of my PHI at any time, if not already received.

Print Name: _____ Date: _____

Patient Signature: _____

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COLLABORATIVE CARE AGREEMENT

OUR MISSION:

Our mission is to always treat patients with dignity and respect as we provide the most effective quality care for those seeking relief from their painful conditions. By restoring function, improving quality of life, and reducing the pain burden together we help our patients get back to life and start.... living more.
We, Woodlands Physical Medicine, will deliver the most remarkable patient experience, in every dimension, every time. We achieve this by providing a comprehensive evaluation, listening to our patients' concerns, and customizing a treatment plan.

OUR METHODS:

We use a multidisciplinary, multi-modal treatment approach to pain. This involves health care providers from different specialties, including orthopedic surgeons, counseling, and physical therapy. We also coordinate care with treating physicians, primary care physicians, behavioral health providers, and other specialists. We use a broad range of treatments, including: over the counter medicines, prescription medications (anti-inflammatories, muscle relaxers, neuropathic medications, opioids), psychotherapy, behavioral health assessment integration, physical therapy, and home exercise and stretching.

OUR RESPONSIBILITIES:

We agree to focus on treating you as a whole person: physically, mentally, and emotionally. We will listen to your concerns, offer education, provide treatment within the scope of our providers' specialties and direct you to appropriate healthcare resources for care outside of this clinic. We will collaborate with such resources in an effort provide you with safe, appropriate, and quality care for your chronic pain and/or musculoskeletal conditions.

YOUR RESPONSIBILITIES:

As our patient, you agree to help facilitate the comprehensive and collaborative treatment for your chronic pain and/or musculoskeletal conditions. You are responsible for communicating your health care concerns and goals, and reporting any changes related to your health or treatments. This includes use of all medications –prescription, over the counter, herbal, and street drugs. You must schedule appointments in a timely manner and make every effort to keep them. Not every patient will need all the treatment measures we offer. However, patients agree to follow our multi-modal approach.

Patient / Guardian Signature: _____ Date: _____

Physician / Primary Prescriber Signature: _____ Date: _____

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COLLABORATIVE CARE AGREEMENT

CONSENT TO TREATMENT AND/OR DRUG THERAPY:

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 to participate, after being informed of the benefits, 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 treatment recommended to you by me, as your pain management physician.

☐ I agree to medication management involving controlled substances.
☐ I DO NOT agree to medication management involving controlled substances

• Note: If you choose to opt out, you do not have to complete the remainder to this document regarding chronic opioid therapy. Chronic opioid therapy is only ONE part of your overall pain management plan - if at any point you discontinue adherence to your overall treatment plan, your provider will no longer prescribe an opioid pain medication. Please be advised that part of our goal may reduce or eliminate your use of pain, sedative, and anxiety medications. The recommendations are made based upon your individual needs.

I HAVE BEEN INFORMED AND understand that I will undergo medical tests and examinations before and during my treatment. Those tests include urine drug tests, for controlled substance drugs, benzodiazepines, muscle relaxers, medicine for nerve pain, and illegal drugs and illegal use of prescription drugs. Additionally, 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. Further details are outlined in the pain agreement.

Please read this agreement carefully. If you do not understand any of the information contained below or require additional clarification on the policies of this office regarding the prescribing of opioid medications, please ask.

You will be required to complete and sign an informed consent and pain management agreement in addition to this agreement before receiving any opioid medications.

Patient Signature: _____ Date of Agreement: _____

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General Medical History

Patient: _____ DOB:_____ Date: _____

Emergency contact name:_____

Relation:_____ Phone number(s):_____

Please give first and last name of the doctors below. If you don't know the first name, please try to give initial.

Primary Care Physician: _____

Referring Physician: _____

Onset of Symptoms

You are: R Handed L Handed Ambidextrous

Where are you having pain? _____

How long have you had this problem? _____

Is this a legal or third person liability case? No Yes Potential

If Yes, Date of Injury:_____

Work Comp Motor Vehicle Accident Where did you get hurt? Home / School / Work / Store / Car

How did you get hurt? _____

Since your pain began, how has it changed? ☐ Decreased ☐ Increased ☐ Stayed the same

Pain Description

Check all the following that describe your pain:

☐Aching	☐Hot/Burning	☐Shooting	☐Stabbing/Sharp	☐Cramping
☐Numbness	☐Spasms	☐Throbbing	☐Dull	☐Shock-like
☐Squeezing	☐Pin & Needles	☐Tingling		

☐Constant dull/aching background pain with exacerbations as checked above

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What word best describes the frequency of your pain? ☐ Constant ☐ Intermittent

When is your pain at its worst? ☐Mornings ☐During the day ☐Evenings ☐Middle of night

☐ Progressively worsens throughout the day ☐ No Changes- always the same

Pain Description continued

I have: ☐Weakness (from pain) in my: ☐ R arm ☐ L arm ☐ R leg ☐ L leg

☐Specific weakness in my: ☐ R arm ☐ L arm ☐ R leg ☐ L leg

☐ Numbness of my: ☐ arms ☐ hands ☐ legs ☐ feet

☐ Tingling of my: ☐ arms ☐ hands ☐ legs ☐ feet

☐ Leg pain when I walk: ☐ less than a block ☐ 1-3 blocks ☐ >3 blocks

☐ this pain improves if I stand still

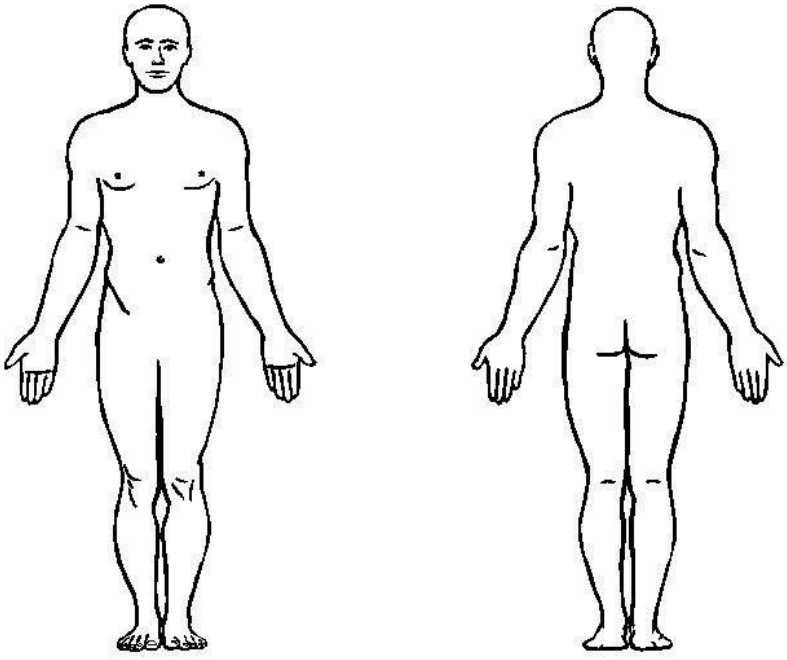
☐ this pain improves only if I sit or lean forward

☐ Bladder (urine) trouble ☐ Loss of urine (accidents) ☐ Can't empty

☐ Bowel trouble ☐ Loss of control (accidents) ☐ Constipation

☐ Pain worst at night

Use this diagram to indicate the location of your pain by marking the drawing with an x wherever you feel pain.



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What Makes your Pain Worse? (Check all that apply)

☐Bending/ Stooping ☐Coughing/Sneezing ☐Driving ☐Lifting ☐ Lying Flat

☐Lying Sideways ☐Physical Activity ☐Sitting ☐Walking ☐Other

☐Going to Bathroom

What aspects of your life are affected by your pain? (Check all that apply)

☐Performing activities of daily living ☐Engaging in a normal lifestyle

☐Performing work-related activities ☐Achieving adequate sleep

What Makes your Pain Better? (Check all that apply)

☐Bed Rest ☐Reducing Activities ☐Bending forward ☐Bending backwards

☐Heat ☐Massage ☐Ice ☐Other

Past Medication Treatment: Which medication have you tried? (check all that apply)

	Did it help?	Y	N
☐Anti-inflammatories: _____		☐	☐
☐Muscle relaxants: _____		☐	☐
☐Opioids/Pain Pills: _____		☐	☐
☐Others _____		☐	☐

Diagnostic Tests and Imaging

Mark all of the following tests you have had that are related to your current pain complaints:

☐MRI of the_____Date:_____ Facility:_____

☐X-ray of the_____Date:_____ Facility:_____

☐CT Scan of the_____Date:_____ Facility:_____

☐EMG/NCVof the_____Date:_____Facility:_____

☐Other testing of the_____Date:_____ Facility:_____

☐I have not had any diagnostic tests performed for my current pain complaints.

Pain Treatment History

How do the following treatments impact you pain? **if you haven't tried it, leave it blank**

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Treatment	No Relief	Temporary Relief	Excellent Relief	Dates: (ok to approximate)
Chiropractic				
Injections (describe)				
Physical Therapy				
Surgery Details:				
Traction				
Spinal Cord Stimulator				

Please describe any further details regarding previous pain treatments:

_____

_____

☐ I have not had any prior treatments for my current pain complaints.

What other specialists have you seen regarding your pain?_____

Allergies

Do you have any known drug allergies? ☐ YES ☐ NO If so, please list all medications, topical allergies or medical equipment you are allergic to and the reaction it caused:_____

Current Medications

Please list all medication you are currently taking. Attach an additional sheet, if required.

Medication Name	Dose	Frequency		Medication Name	Dose	Frequency

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Past Surgical History

Please list any surgical procedures you have had done in the past, including the date, type, and any details.

Surgeries or Hospitalization	Year	Complications (if any)

☐ I have never had any surgical procedures.

Family History

Has anyone in your family had: Check all that apply

☐ Diabetes ☐ Heart Attack Female under 65 ☐ Cancer ☐ Bleeding Disorder

☐ Headaches ☐ Heart Attack Male under 55 ☐ Arthritis ☐ Osteoporosis

☐ Stroke ☐ Anesthesia problems ☐ High Blood Pressure

☐ Other medical problems:_____

☐ I have no significant family medical history

Social History

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

Children: ☐ Yes ☐ No

Are you capable of becoming pregnant? ☐ Yes ☐ No *if so, are you currently pregnant?*

_____

Do you live alone? ☐ Yes ☐ No *If no, who do you live with?*

_____

Do you wear: □ Glasses □ Contacts

Social History continued

Occupation:_____

What kind of work? ☐ Physical ☐ Sedentary ☐ Retired ☐ Homemaker

☐Regular Duty ☐Light Duty ☐Off Work- since Date:_____Reason:_____

Alcohol Use: ☐ Daily Limited Use ☐ History of Alcoholism ☐ Never Drinks Alcohol

☐Drinks Alcohol Socially ☐ Drinks Alcohol Occasionally

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Tobacco Use: ☐ Current Tobacco User ☐ Former Tobacco User ☐ Have never Used Tobacco

# of packs/day_____ for _____years

Illegal Drug Use: ☐ Yes ☐ No *if yes, what?*_____

Have you ever abused narcotic or prescription medications? ☐ Yes ☐ No

*if yes, what?*_____

Exercise: ☐ daily ☐weekly ☐monthly ☐ rarely ☐never *What type?*_____

Past Medical History

Check all that apply:

☐Anemia	☐Diabetes Diabetic Foot	☐Hypothyroidism	☐Poor Circulation
☐Angina	☐Ulcer	☐Irregular Heart Beat	☐High Blood Pressure
☐Anxiety	☐Dialysis	☐Kidney Failure	☐Pulmonary Embolism
☐Asthma	☐Diverticulitis	☐Liver Problems	☐Reflux
☐Bleeding Disorder	☐Emphysema	☐LMP:	☐Rheumatoid
☐Blood Clot	☐GI Bleed	☐Lupus	☐Seizures
☐Cancer: Type/Status	☐Heart Attack	☐Migraines	☐Sleep Apnea
☐Chronic Back Pain	☐Hepatitis A, B, C	☐Neurological Disorder	☐Stroke
☐Congestive Heart Failure	Urinary Tract Infection	☐Numbness/Tingling	☐Ulcers
☐Depression	☐HIV	☐Other:	

_____

Current Medical Health

Overall level of physical health is:

☐Excellent ☐ Very Good ☐ Good ☐ Fair ☐Poor Immunizations up to date? ☐Yes ☐No

Have you ever had any complications from surgery? ☐ Yes ☐ No

Have you ever had any problems with anesthesia? ☐ Yes ☐ No

If yes, describe: _____

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Review of Systems

Mark the following symptoms that you currently suffer from. Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.

General Health: ☐Fever/Chills ☐Fatigue ☐Sleep Problems

Eyes: ☐Blurry vision ☐Double vision

Ears/Nose/Throat: ☐Decreased hearing ☐Sore throat ☐Ears ringing ☐Sinus Problems

Cardiovascular: ☐Chest pain ☐Fainting ☐ Irregular Heartbeat ☐ Swelling in feet

Respiratory: ☐Shortness of breath ☐Cough ☐Wheezing

Gastrointestinal: ☐Heartburn/Constipation ☐Nausea/Vomiting/Diarrhea ☐Rectal Bleeding

Genitourinary: ☐Pain on urination ☐Incontinence ☐Increased frequency

Musculoskeletal: ☐Joint Swelling ☐Joint Stiffness ☐Muscle Spasms ☐ Joint Pain

Dermatological: ☐Rash ☐Itching

Neurological: ☐Numbness/Tingling ☐Loss of balance ☐History of Seizures

Psychological: ☐Anxiety ☐Depression

Endocrine: ☐Weight change ☐Thirsty all the time

Allergy/Immunology: ☐Hives ☐Hay fever

Hematology: ☐Easy bruising ☐Bleeding ☐Edema ☐Enlarged lymph nodes

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NAME:_____ **DATE:**_____

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○

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	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

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

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2026 PATIENT INFORMATION

We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Policy that we require you to read, ***initial all*** and ***sign prior*** to any treatment.

REGARDING PRIVATE INSURANCE:

- We will gladly bill your insurance company directly if you have provided us with all the necessary information to do so. Your contract for health insurance is between you and your insurance company. We are not a party to the contract. The services that you receive, and the bill, is an agreement between you and Dr. Samuel Alianell MD PA. It is ultimately your responsibility to see that your bill is paid in full. Agreements between insurance companies vary greatly and it is your responsibility to pay in a timely manner. If your insurance company does not pay Dr. Samuel Alianell, MD PA, it will be your responsibility to contact them. We will look to you for payment, not the insurance carrier, unless you are covered by worker's compensation. ***Please advise the clinic if you are changing your insurance, as we may not be providers.*** **Initials: _____**

REGARDING WORKERS COMP INSURANCE:

- Any correspondence, denial of care, or changes during the course of workers' comp injury treatment needs to be communicated to our office immediately. Failure to notify us could result in workers' compensation denial of benefits. **Initials: _____**

REGARDING INSURANCE WHERE WE ARE A PARTICIPATING PROVIDER:

- All copayments and deductibles are due ***prior*** to treatment. We cannot bill you for your copayment of deductible as your insurance contract requires us to collect it at the time of service. In the event that your coverage changes to a plan where we are not the participating provider, refer to the paragraph above. **Initials: _____**

- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under certain medical insurances. **Initials: _____**

Woodlands Physical Medicine

Samuel J. Alianell, MD

American Board of Physical Medicine & Rehabilitation
American Board PM&R Subspecialty of Pain Medicine
Gold Designated Pain Management Clinic – Texas Medical Board
3275 College Park Dr., The Woodlands, TX 77384
Ph: 936-321-0214 ~ Fax: 936-271-0219

PAYMENT FOR SERVICES:

- Initial new patient evaluation fee $345
- Follow -up evaluation fee $210 **Initials: _____**

- **PAYMENTS:**
  Payment is due in full at the time of service for those without insurance coverage. I understand that in accordance with law, as well as many participation agreements with third-party payers, Woodlands Physical Medicine does not waive, fail to collect, or discount co-payments, deductibles, coinsurance, or other patient financial responsibility. I understand that Woodlands Physical Medicine may verify insurance coverage and benefits prior to services being rendered and that any out-of-pocket expenses, to include but not limited to co-payments, co-insurance, deductibles and noncovered services***, will need to be paid at the time services are rendered***, ***no deferral of payment*** is allowed. If we bill your insurance and reimbursement is 100% denied, we will bill you for our self-pay rates. On occasion, certain procedures may not be reimbursed by your insurance company. If it is expected that insurance will not cover, payment is due at the time of service. **Initials: _____**

FEES:

- **PRIOR AUTHORIZATIONS:**
  If your insurance company requires a Prior Authorization, there is a ***$20 charge***. This is a service not included in your office visit. The ***charge is $14*** if you provide the form to be completed (obtained from your insurance company).
  ALL FEES MUST BE PAID BEFORE WE WORK ON ANY PRIOR AUTHORIZATION.
  Initials: _____
- **CHECK RETURNS:**
  A ***fee of $35*** will be charged for each check returned for insufficient funds.
  Initials: _____
- **MEDICAL RECORDS RELEASES:**
  Please allow 30 days for your records request to be processed. We require your *written* authorization before releasing records to anyone other than your referring doctor or to your insurance company. Our fee for producing medical records at your request is:
- $25 for the first 25 pages
- $0.50 for additional page
  These records can be picked up by the patient.
  This fee must be received before records are released. **Initials: _____**

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- **URINE DRUG TESTING (UDT):**

  Self-pay patients, if you undergo urine toxicology testing, a fee of $10 will be charged to any patient that is self-pay. If the **UDT** is inconsistent with your therapy, additional diagnostic testing may be necessary to evaluate the compliance of your medication management, ***resulting in additional fees***. **Initials: _____**

  Insured patients, if you undergo urine toxicology testing, your insurance will be billed accordingly. In addition, many of our lab results are also sent to an in-network confirmatory lab for additional information on the quantitative results of the specimen. If your medical insurance ***does not cover*** urine drug testing, you will be billed for the testing charges. **Initials: _____**

- **LABS- LABORATORY TESTING:**

  As part of your care, clinical laboratory testing is recommended at least every 6 months or as needed depending on your medical condition. If labs are not completed by your next follow-up visit your medication refills may be placed on hold. **Initials: _____**

- **NO SHOW & LATE CANCELLATION:**

  If you are unable to keep your appointment, please call the office ***24 hours in advance***. If less than 24 hours' notice is received, a ***charge of $25 will be incurred***. The intent of the fee is to ensure access to Dr. Alianell for patients who need care. This appointment was set aside for you and when you no show or cancel with less than 24 hours' notice, another patient who is in pain cannot receive the care they need. With 24 hours' notice, we are often able to fit a patient in who might otherwise have to wait.

  Initials: _____

PRESCRIPTION:

- **RELEASE OF MEDICATOINS:**

  Prescriptions are e-scribed sent to your preferred pharmacy on the day of your appointment. ***The release date*** will be determined based on ***your last pickup date***, as outlined by your ***TPMP***, which typically falls within 28-30 days. Please note that ***prescriptions may not be transmitted until the end of the day***, so plan your appointments accordingly. We recommend 3-4 days in advance to address any potential issues with your pharmacy or insurance in a timely manner.

  Initials: _____

I acknowledge that I have read and agree to the information on these pages.

Printed Name: _____

Signature: _____Date_____

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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)

Patient Name: _____ 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.

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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**

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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 consume **alcohol** while I am taking pain medication.

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.**

I _____ acknowledge that I have read the *Informed Consent and Pain Management Agreement* and that I can request a copy of the pain agreement at any time, if not already received.

_____
Patient Signature Date

_____
Print Name

_____
Physician Signature (or Appropriately Authorized Assistant)

_____
Pharmacy Name and Phone#

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AUTHORIZATION TO RELEASE INFORMATION

PATIENT INFORMATION:

Patient Name:		**Date Of Birth:**
Address:		
City:	**State:**	**Zip:**
Ph#:	**Cell#:**	

RELEASE HEALTH INFORMATION FROM:	**HEALTH INFORMATION RELEASED TO:**
Doctor/Clinic/Hospital: _____ **Address:** _____ **City:** _____ **State:** _____ **Zip:** _____ **Office#:** _____ **Fax#:** _____	**WOODLANDS PHYSICAL MEDICINE** SAMUEL J. ALIANELL, MD 3275 COLLEGE PARK DR. THE WOODLANDS, TX 77384 OFFICE: 936-321-0214 FAX: 936-271-0219

RELEASE HEALTH INFORMATION FROM:	**HEALTH INFORMATION RELEASED TO:**
WOODLANDS PHYSICAL MEDICINE SAMUEL J. ALIANELL, MD 3275 COLLEGE PARK DR. THE WOODLANDS, TX 77384 OFFICE: 936-321-0214 FAX: 936-271-0219	**Doctor/Clinic/Hospital:** _____ **Address:** _____ **City:** _____ **State:** _____ **Zip:** _____ **Office#:** _____ **Fax#:** _____

MEDICAL INFORMATION TO BE RELEASED

○ **COMPLETE MEDICAL RECORDS**	○ **Billing Records**	○ **X-Ray / MRI Reports**
○ **History & Physical**	○ **Progress Notes**	○ **Lab Reports / Results**
○ **Mental Health**	○ **HIV Related**	○ **Operative Report**
○ **Other**		

ACKNOWLEDGEMENT:

Dr. Samuel J. Alianell is hereby released from legal responsibility or liability for the release of the records to the extent indicated and authorized herein. I also understand that I may revoke this authorization at any time and that in any event this authorization will automatically expire as described below.

I authorize the release of my medical information as specified above. This authorization will expire **ONE YEAR** from the date of my signature or otherwise specified by the date, event or condition as follows.

Signature of Patient, Parent or Guardian: _____ Date: _____

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Consent for Appointment Reminders and Other Healthcare Communications

Patients in our practice may be contacted via phone, email, and/or text messaging to remind you of an appointment, and to provide general health reminders/information as needed. Our service uses a toll-free number to place these calls with an area code (855). If you would like to receive this feature please read, complete, and sign the consent below.

Name: _____

I consent to receiving appointment reminders and other healthcare communications to ***my email.***
The ***email that I authorize*** to receive email messages for appointment reminders and general health communications is_____.

Initials: _____

I consent to receive ***text messages*** from the practice to ***my cell phone***. The ***cell phone number that I authorize*** to receive ***text messages*** for appointment reminders and general health reminders/information is:

(_____) _____-_____

Initials: _____

I consent to receive ***voice messages*** from the practice to my phone number. The ***phone number that I authorize*** to receive ***voice messages*** for appointment reminders and general health reminders/information is:
(_____)_____-_____ or

□ Use same as above cell phone number

□ I decline receiving appointment reminders and other healthcare communications at this time.

Initials: _____

Text message, e-mail, and telephone reminders are a courtesy service only. You are responsible for your appointment whether or not your reminder was received.

Patients Signature: _____Date: _____

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FAMILY AND FRIENDS AUTHORIZATION RELEASE CONTACT FORM

People who are involved in your care (family, friends, other doctors, etc.) may inquire about your treatment, lab results, prescriptions, and other medical information/records. Please let us know what people we may share information with.

(Please note: In emergency situations or other situations outlined in our Notice of Privacy Practice we may share information with others who are not specifically listed on this form.)

Please list the authorized persons including Spouse, Family, Friends, Previous Treating Physicians, and other doctors/specialists with whom we may share your information:

Name:	**Phone:**	**Relationship:**	**Release of:**

What is the best phone number for us to contact you? _____
What is this number (home, work, cell, other)? _____

From time to time, we will leave a message for you on an answering machine, voice mail, or with another individual in your absence. Is it okay for such messages to include details (such as diagnosis and medication information) at this number? _____

What other ways may we contact you? Please list any that are acceptable ways to reach you.
Home phone number: _____
Is it okay to leave a detailed message at this number in your absence? _____
Work number: _____
Is it okay to leave a detailed message at this number in your absence? _____
Cell Phone number: _____
Is it okay to leave a detailed message at this number in your absence? _____
Other: _____
Is it okay to leave a detailed message at this number in your absence? _____

ACKNOWLEDGMENT:

Woodlands Physical Medicine/Dr. Samuel J. Alianell, MD is hereby released from legal responsibilities or liability for the release of medical information/records to the extent indicated and authorized herein. I also Understand that I may revoke this authorization at any time, and in any event this authorization expires as described below.

By signing below, I authorize the release of my medical information/records to the person(s) named above. This authorization will expire ***ONE YEAR*** from the date of my signature or if I revoke authorization before signature date.

Patient Signature: _____ **Date:** _____