FRA—Functional Recovery Associates

Name: _____ Date:_____

DOB: _____ Phone Number:_____

Email Address: _____

Address:_____

_____

Emergency Contact Name:_____

Contact Information:_____

How did you hear about Functional Recovery Associates?_____

Height: _____ Weight: _____

Date of Injury: _____ Body part being seen for:_____

Details of Injury:_____

_____

Medical History:

- Hypertension
- Diabetes
- Heart Disease
- Blood Thinner
- Other:_____

_____

Previous Surgeries:_____

_____

_____

_____

Current Medications:_____

_____

_____

_____

_____

Drug Allergies:_____

_____

_____

Primary Care Physician:_____

Office Contact Information: _____

Current Pharmacy:_____ **Phone Number:**_____

Pharmacy Address:_____

Family History:_____

_____

Review of Symptoms: Please Check all that apply.

- ☐ Eyes
- ☐ Ears, Nose, Throat
- ☐ Lungs, breathing
- ☐ Chest Pain / Heart Disease
- ☐ High Blood Pressure
- ☐ Stomach / Bowel
- ☐ Acid Reflux / Ulcers
- ☐ Bladder / Urinary
- ☐ Diabetes
- ☐ Infection
- ☐ Bleeding / Blood Clots
- ☐ Numbness / Tingling
- ☐ Blackout / Fainting
- ☐ Seizures
- ☐ Stroke
- ☐ Liver / Hepatitis
- ☐ Non – healing wounds
- ☐ Kidney Disease
- ☐ Cancer
- ☐ Depression / Anxiety
- ☐ Balance
- ☐ Other:_____

Social History:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐Domestic Partner ☐ Widow

Tobacco: ☐ Never ☐ Currently (packs per day _____) ☐ Vape ☐ Formerly

Drink Alcohol: ☐Never ☐ Social (drinks per day _____) ☐ Previous Alcoholism

Illicit Drugs: ☐ Never ☐ Formerly ☐ Currently

Do you use assistive device? ☐Cane ☐ Walker ☐ Wheelchair ☐ Other:_____

Do you exercise regularly: ☐ Yes ☐ No Describe:_____

Work Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Student ☐ Disabled

Occupation: _____ Employer:_____

PatientSignature:_____ **Date:**_____

FRA

PAIN ASSESSMENT TOOL

Name_____ Date_____

Date of Birth_____ Allergies to Medications_____

Height_____ Weight_____

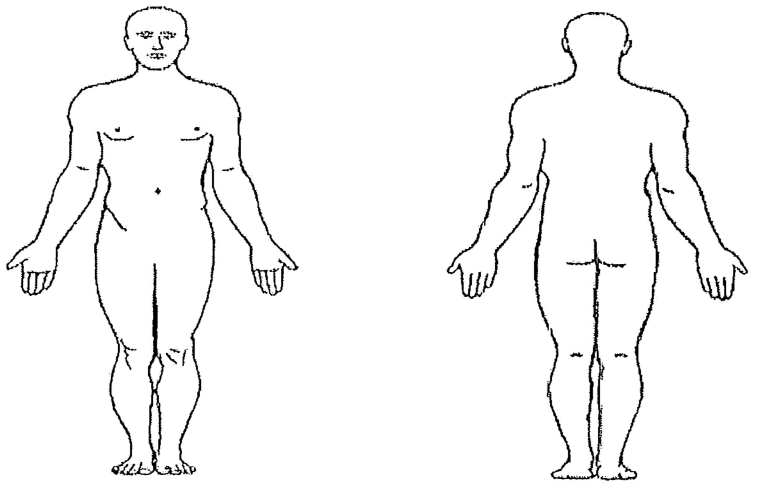
Current Medications
(Please list all current medications, prescription and over the counter, vitamins and herbal remedies).

_____

_____

Where is your pain now? Mark the areas on your body where you feel the sensations described below, using the appropriate symbol.

Aching	Numbness	Pins & Needles	Burning	Stabbing
^^^	===	ooo	xxx	///



Rate your pain. Circle the level of your pain today.

(No Pain)---------- (Worst Possible Pain)

0 1 2 3 4 5 6 7 8 9 10

What words describe your pain? Please circle all that apply.

Aching	Stabbing	Tightness	Throbbing	Dull	Shooting
Deep	Pressure	Squeezing	Cramping	Sharp	Burning

♦ Tom G. Mayer, M.D. ♦ Rory Allen, D.O. ♦ Gregory Powell, M.D. ♦ Albert Vu, D.O.

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT

AS REQUIRED BY THE TEXAS MEDICAL BOARD

REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9, CHAPTER 170

Developed by the Texas Pain Society, September 2007 (www.texaspain.org)

NAME OF PATIENT: _____ DATE: _____

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to use the drug(s) recommended to you by me, as your physician. For the purpose of this agreement the use of the word "physician" is defined to include not only my physician but also my physician's authorized associates, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat my condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician (name at bottom of agreement) to treat my condition which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent to administer or prescribe the 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).

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 have been informed that the drug therapy that my physician may prescribe for me may involve using a drug that the Federal Food and Drug Administration may not have been asked by the manufacturer to review for safety for effectiveness for my condition. Current medical literature shows that such "off label" use may be beneficial to some patients and I understand that recommended dosages for treating chronic pain are often exceeded in order to balance the benefit and risk to the patient.

I understand that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of medications to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

PAIN MANAGEMENT AGREEMENT:

I UNDERSTAND AND AGREE TO THE FOLLOWING:
That this pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called 'narcotics, painkillers', and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). **Therefore, medication(s) will only be provided so long as I follow the rules specified in this Agreement.**

My physician may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior:

- My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the **medication(s) may be discontinued**.
- I will **disclose** to my physician **all medication(s)** that I take at any time, prescribed by any physician.
- I will use the medication(s) **exactly as directed by my physician**.
- I agree **not to** share, sell or otherwise permit others, including my family and friends, to have access to these medications.
- I will **not allow or assist in the misuse/diversion of my medication; nor will I give or sell them** to anyone else.
- All medication(s) must be obtained at **one pharmacy, where possible**. Should the need arise to change pharmacies, my physician must be informed. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my physician to release my medical records to my pharmacist as needed.
- I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money. **If either are lost or stolen, they may NOT BE REPLACED.**
- Refill(s) **will not be ordered before the scheduled refill date**. However, early refill(s) are allowed when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.
- I will receive medication(s) **only from ONE physician** unless it is for an emergency **or** the medication(s) that is being prescribed by another physician is approved by my physician. Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.
- If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then **my physician may try alternative medication(s) or may taper me off all medication(s)**. I will not hold my physician liable for problems caused by the discontinuance of medication(s).
- I **agree to submit to urine and/or blood screens** to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), treatment for chronic pain may be terminated. Also, a consult with, or referral to, an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an addictionologist or a physician who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.

- I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize **that my active participation** in the management of my pain is extremely important. I agree to **actively participate in all aspects of the pain management program** recommended by my physician to achieve increased function and improved quality of life.
- I agree that I **shall inform any doctor** who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.
- I hereby give my physician **permission to** discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).
- I must take the medication(s) as instructed by my physician. **Any unauthorized increase** in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.
- I must **keep all follow-up appointments** as recommended by my physician or my treatment may be discontinued.

I 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.**

_____

Patient Signature

_____

_____

Name and contact information for pharmacy

- Tom G. Mayer, M.D.
- Rory Allen, D.O.
- Gregory Powell, M.D.
- Albert Vu, D.O.

Authorization for Release of Information

Patient Name_____ Date of Birth_____

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPPA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize FRA and/or my physician to release my medical and/or billing information to the following individual(s):

1.Name: _____Relation to Patient: _____

Contact Information: _____

2. Name: _____ Relation to Patient: _____

Contact Information: _____

3. Name: _____ Relation to Patient: _____

Contact Information: _____

Patient Information:

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to being disclosed by the above recipient.

You have the right to revoke this consent in writing.

Signature: _____Date: _____

Tom G. Mayer, M.D
Rory Allen, D.O.

PRIDE

Gregory Powell, M.D.
Albert Vu, D.O.

Conquering Pain thru Function

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION FROM MEDICAL RECORDS

NAME:_____ DOB:_____
SS#: _____

I, the undersigned, hereby authorize the physicians and their agents and employees of PRIDE, in accordance with the laws of the State of Texas, to furnish to any insurance carrier, attorney, employer, or State/Federal Agency, or any agent or representative who is identified by the organization, with all necessary information which this party should request from the medical records compiled by the above named doctor in his office during the course of my treatment with my physician and with PRIDE, for the purpose of evaluating and treating my medical condition.

The medical records from which this information may be obtained includes but is not limited to: 1) office records; 2) laboratory reports; 3) x-rays and interpretive reports; 4) nurses and therapists notes; 5) physician order sheets; 6) medication charts; and 7) any other reports kept for clinical purposes as part of normal medical practice and business activities of the physician's office and PRIDE.

I hereby authorize the release of this information for the purposes of: 1) obtaining payment on the account of the above named physician whose services were provided to me; 2) medical audit, utilization review, or quality assurance review, which may be the objective of the release of this information for which purposes my insurance company may wish to review these record.

Date_____ Patient's Signature_____

PRIDE
Conquering Pain thru Function

♦ Tom G. Mayer, M.D.
♦ Rory Allen, D.O.
♦ Gregory Powell, M.D.
♦ Albert Vu, D.O.

Financial Policy and Payment Agreement

PRIDE and the physicians named above are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive the maximum allowable benefits. In order to achieve these goals, however, we need your assistance and your understanding of our financial payment policy.

I. Financial Policy.

a. Self-pay patients are expected to pay for services received in full at the time of service. Any financial arrangements must be made before you see the physician. We accept the following forms of payment: Cash, MasterCard and Visa.

b. As a courtesy to you, we will file your insurance claim form for reimbursement. However, in order to do this, we must have current insurance information for each visit. Charges not paid by your insurance company within 90 days will become due and payable by you. Patients who do not provide current insurance information will be treated as self pay (see above). **We make every attempt to obtain correct reimbursement information from your insurance carrier, however, the amount paid at the time of the visit is an estimate only and upon receipt of payment and the explanation of benefits (EOB) from your carrier, you may owe additional monies or be due a refund.** If you dispute the information provided on your EOB, it is your responsibility to contact your carrier (member phone number is on the back of your card) to resolve any issues. We are obligated to obey the EOB sent to us.

c. If your insurance plan requires a referral or authorization from your primary care physician, we will need to receive the authorization before you see our physician. If you have not received an authorization prior to your arrival at our office, we have a telephone available for you to call your primary care physician or insurance company to get the required authorization.

d. In the event your insurance company determines a service to be "not covered," you will be responsible for payment. We try to inform patients when services may not be covered; however, it is the patient's responsibility to understand their health insurance limitations.

e. We will bill for Workers' Compensation services that have been pre-authorized by your employer or Workers' Compensation insurance carrier.

f. **Appointment No-Show Fee:** We understand that sometimes appointments must either be cancelled or rescheduled. Because we provide specialized services, we ask that you provide at least a 24 hour prior notice for cancellations or rescheduled appointments. Your failure to provide us the requested 24 hour notice will result in a No-Show fee; this fee will be due at the time of your next appointment.

No Show Fees:

- $75.00 – New evaluation appointment No-Show
- $50.00 – Re-check appointment No-Show

g. **Additional Fees:** We charge additional fees as outlined below

- $50.00 - Non-emergency After Hours Call
- $50.00 - Prescription pick – up
- $50.00 - $175.00 - Completion of Forms/Paperwork-- completed during separate appointment.

*** ***Please be aware that any balance on your account over 90 days is subject to intensive collection procedures and may result in denial of future care until overdue balances are paid in full.***

II. Payment Agreement.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account. I accept full responsibility for any and all charges related to diagnosis and treatment, whether or not my insurance covers these services. I agree that my physician is not ultimately responsible for collection from my insurance company. I understand that my physician cannot file Medicaid, Managed Care Medicare or Secondary Insurances. Office policy is to collect all Co-pays, Coinsurance, and Deductibles due at the time of service. I agree to pay IN FULL within 30 days of receipt of notice all balances due such as non-covered services, coinsurances, deductibles and co-payments not paid by my insurance company in addition to any fees charged against my account. **Assignment of Benefits:** I authorize my insurance carrier to pay benefits directly to my physician on any unpaid services on my behalf.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ, OR HAS BEEN READ, THE FOREGOING; UNDERSTANDS THE FOREGOING; HAS RECEIVED A COPY THEREOF; HAS BEEN GIVEN THE OPPORTUNITY TO ASK ANY QUESTIONS THEY MAY HAVE CONCERNING THE FOREGOING; AND THAT HE/SHE IS THE PATIENT OR DULY AUTHORIZED REPRESENTATIVE OF THE PATIENT. THE UNDERSIGNED, HAVING READ AND UNDERSTOOD THE AGREEMENT, ACCEPTS THIS FINANCIAL POLICY AND PAYMENT AGREEMENT.

Patient Name (Please Print) _____

Patient's Signature /Date _____ **Date:** _____

_____

Responsible/Authorized Representative (Guarantor) Relationship to Patient

_____ **Date:** _____

Guarantor Signature/ Date

Tom G. Mayer, M.D.
Rory Allen, D.O.

PRIDE

Conquering Pain thru Function

Gregory Powell, M.D.
Albert Vu, D.O

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I, _____, have reviewed a copy of this office's Notice of Privacy Practices.

_____
Please print name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

_____
_____
_____
_____