American Pain and Wellness-Frisco, TX

Date:_____

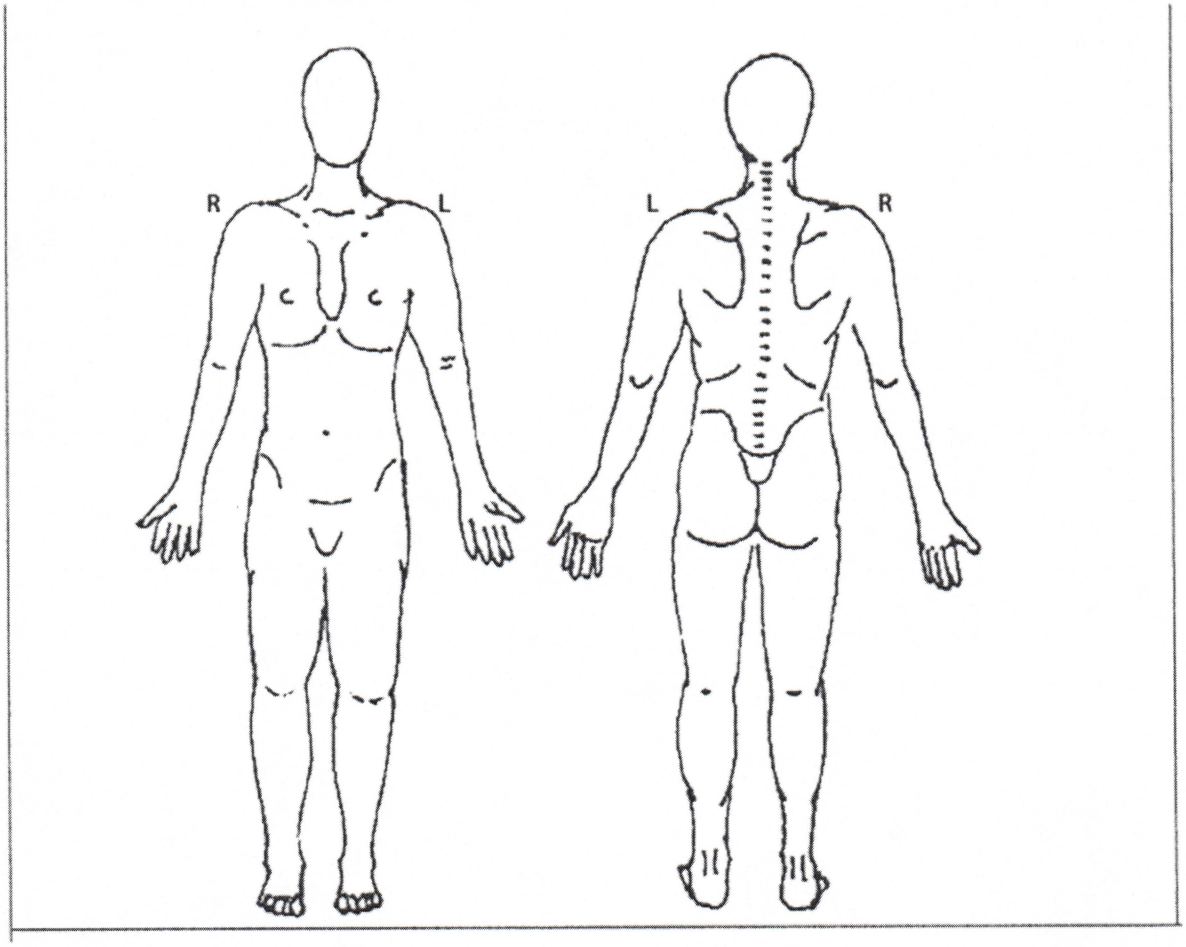
Name:_____ Date of Birth:_____

Primary Care Doctor:_____ Referring Doctor:_____

Height:_____ Weight:_____

Please mark the MAJOR areas of Pain you are experiencing.

A= ACHE P= PINS & NEEDLES B= BURNING S= STABBING N= NUMBNESS O= OTHER



Thinking back over the last 30 days, rate your pain at its lowest, highest and most consistent by circling the numbers below.
(You may do this when you print your forms or come in for your appointment)

0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

Description of Injury: _____

_____

My pain is increased by only: Check ONLY the descriptors which usually worsen your pain.

Sitting ☐ Standing ☐ Bending Backwards ☐ Bending Forwards ☐ Walking Up Steps ☐

Walking Down Steps ☐ Sneezing ☐ Coughing ☐ Stress ☐ Straining ☐

Sleeping on Stomach ☐ Weather Changes ☐ Sexual Activity ☐ Other _____

My pain is improved by: ONLY check the descriptors which usually relieve your pain.

Sitting ☐ Relaxing ☐ Leaning Forward ☐ Lying on back ☐ Hot packs ☐ Cold Packs ☐

Medications ☐ Sleeping ☐ Lying on Side ☐ Fetal Position ☐ Other: _____

Please Indicate Below if you have tried any of these additional treatments:

□ Physical Therapy □ Heat/Ice □ Over the Counter NSAIDs

□ Activity Restriction □ Home Exercise Program □Chiropractic Care

Do you Currently Exercise Regularly? If so, What Type and How Often?

_____

Please Indicate if you have had any of the Below Listed Diagnostics?

□ X-ray □ CT scan □ MRI □ EMG/NCS □ Doppler □ Bone Scan

Please List All Prior Surgical History Below:

_____

_____

_____

_____

Please List Family Medical History Below:

_____

_____

Social History

	How often per week?	How many years?	Have you quit? if so, when?
Smoking			
Alcohol			
Illegal Substances			

Past Medical History

Do you have any of the medical following conditions?

Cardiac: Arrhythmia ☐ Heart Attack ☐ Blocked Arteries ☐ High Blood Pressure ☐ High Cholesterol ☐

Other: _____

Pulmonary: Asthma ☐ Emphysema ☐ Bronchitis ☐ Sleep Apnea ☐ Smoker ☐

Other: _____

GI: Ulcers ☐ Reflux ☐ Diverticulitis ☐ Gall Stones ☐ Liver Disease ☐ Irritable Bowel ☐
Inflammatory Bowel ☐ Crohn's/Ulcerative Colitis ☐

Other: _____

GU: Kidney Disease ☐ Kidney Stones ☐ Endometriosis ☐ Fibroids ☐ Prostate Problems ☐

Other: _____

Endocrine: Diabetes ☐ Thyroid Disease ☐ Adrenal Disease ☐

Other: _____

Rheumatological: Osteoarthritis ☐ Ankylosing Spondylitis ☐ Rheumatoid Arthritis ☐
Polymyalgia Rheumatica ☐ Fibromyalgia ☐ Systemic Lupus ☐ Erthromitosis ☐

Other: _____

Hematological: Anemia ☐ Low Platelets ☐ Bleeding Disorder ☐

Other: _____

Neurological: Seizures ☐ Multiple Sclerosis ☐ Parkinson's ☐ Tremors ☐ Stroke ☐ Neuropathy ☐

Other: _____

Psychological: Anxiety ☐ Depression ☐ Excessive Alcohol Use ☐ Substance Abuse ☐

Other: _____

Review of System: Check those that apply on a REGULAR basis

General: Weight Loss ☐ Weight Gain ☐ Fever ☐ Chills ☐ Insomnia ☐

HEENT: Eye Problems ☐ Ear Problems ☐ Nose Problems ☐ Throat Problems ☐

Cardiac: Chest Pain ☐ Fainting Spells ☐ **Pulmonary:** Shortness of Breath ☐ Cough ☐ Bloody Sputum ☐

GI: Blood in stool ☐ Constipation ☐ Diarrhea ☐ Loss of Bowel ☐

GU: Difficulty Urinating ☐ Loss of Urine ☐ Bloody Urine ☐

Musculoskeletal: Joint Pain ☐ Muscular Pain ☐ Osteoporosis ☐

Neurological: Seizures ☐ Tremors ☐ Weakness ☐ **Psychiatric:** Depression ☐ Anxiety ☐

Please List Any and ALL Medication, Food and Environmental ALLERGIES Below:

_____

_____

Please List All Current Medications Below:

Medication:	Dosage:	Frequency:

Please List Pharmacy Name and Contact Information Below:

_____

_____

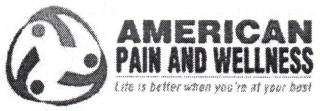
Employment Status: □ Full Time □ Part Time □ Retired □ Disabled □ Student

Job Title:_____ Employer:_____

Patient Signature:_____ **Date:**_____

AMERICAN PAIN AND WELLNESS

Life is better when you're at your best



Date: _____

Patient Information

Name _____ SSN _____ Gender [ ]

Address _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Date of Birth _____ Marital Status [ ] E-Mail _____

Guarantor Information (If the patient is not the guarantor, please complete this section)

Name _____ SSN _____ Gender [ ]

Address _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Date of Birth _____ Marital Status [ ] E-Mail _____

Guarantor Relationship [ ]

PRIMARY INSURANCE

Insurance Company Name _____ Insurance Co Phone _____

Policy Holder Name _____ Date of Birth _____

ID/Subscriber Number _____ Group Name/Acct# _____

SECONDARY INSURANCE

Insurance Company Name _____ Insurance Co Phone _____

Policy Holder Name _____ Date of Birth _____

ID/Subscriber Number _____ Group Name/Acct# _____

How did you hear about us? _____

Name of Referring Physician, Patient, source, etc. _____

_____ _____

I certify that the above information is accurate and I understand that I am responsible for payment of all charges to American Pain and Wellness regardless of quoted insurance benefits and eligibility.

Date

AMERICAN PAIN AND WELLNESS
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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 American Pain and Wellness-Frisco, TX 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: _____

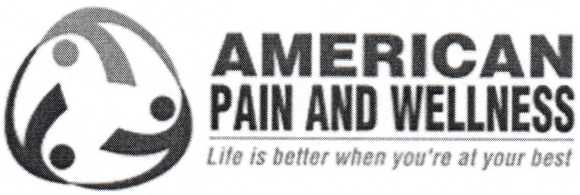
Patient Information:

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: _____



American Pain and Wellness-Frisco, TX
Financial Policy

Name:_____ Date of Birth:_____

American Pain and Wellness-Frisco, TX is committed to providing you with the best possible care. This goal is best achieved if everyone is aware and understands of our financial policy.

I. Financial Policy

A. Self-pay patients are expected to pay for services received in full at the time of service. We accept the following forms of payment: Cash, MasterCard, American Express and Visa. The self-pay office visit rate is $150.00, and this does need to be paid up front and does not cover any other services that might be performed during the office, such as in office injections or urine drug screens.

B. 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. Any outstanding balances are due within 30 days unless prior arrangements have been made with our billing department. Any services not paid by your insurance carrier for whatever reason within 90 days will become the patient's responsibility. All patient balances over 120 days will be sent to a collection agency. In the event your insurance carrier determines a rendered service to be "not covered, experimental or not medically necessary" the patient will be responsible for payment.

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

D. Forms: All insurance, disability, employer, accommodation forms and/or paperwork will need to be completed at an office visit. This policy allows for the provider and patient to have an open dialogue about the paperwork to ensure the correct information is entered, to reduce communication between the patient and our office over errors and to allow the patient to leave the office with the original paperwork completed.

E. 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. The No-Show fee applies for both in office appointments and procedures.

F. No Show Fees:

$50.00 — No-Show Fee for in office appointments.
$250.00 — No-Show Fee for any procedures performed outside of our office.

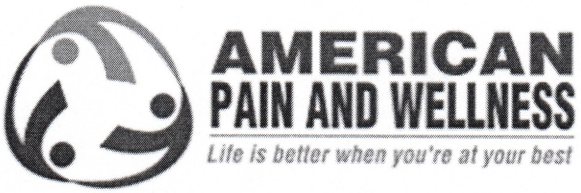
We reserve the right to apply No-Show fees on a case-by-case basis

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 all charges related to my diagnosis and treatment, whether my insurance covers these services. I understand office policy is to collect all Co-pays, Coinsurance, and Deductibles due at the time of service.

Patient/Guarantor Signature:_____

Date:_____



American Pain and Wellness-Frisco, TX
Informed Consent & Pain Management Agreement

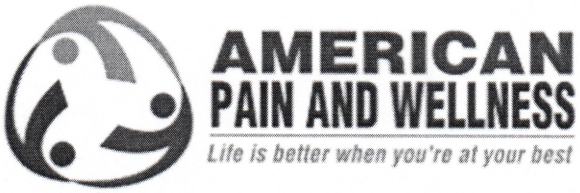
Name:_____ Date of Birth:_____

TO THE PATIENT, AND/OR PATIENTS DESIGNEE, SURROGATE OR GUARDIAN: As a patient, you have the right to be informed about your condition and the recommended medical, diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug or allow a procedure after knowing the therapeutic results desired and the risks and hazards involved as well.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician (named at the end 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) and/or to conduct therapeutic procedures, if applicable, as an element in the treatment of my chronic pain. I understand that these medication(s) may include opiate/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 applicable alternative methods of treatment, if any, 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 of taking these medication(s). Applicable alternative therapies (in addition to or instead of drug therapy), have also been explained to me. I have been informed and understand that I will undergo medical testing and examinations during my treatment. I hereby give permission to perform medical tests, drug tests, and/or psychological tests including the taking of body fluid as may be directed or determined to be necessary by the physician at any time. Any refusal by me may lead to termination of the patient physician relationship. The presence of any unauthorized substances within the urine drug screen results will result in being discharged from the practice.

FOR ALL PATIENTS; 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, excessive drowsiness, itching, urinary retention, (inability to urinate), orthostatic hypotension (low blood pressure), arrhythmia (irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence, addiction or even death. I also understand that impairment of my motor skills may occur. I agree to notify my physician immediately of any side effects from taking the medication(s).

The goal of my treatment is to gain control of my pain to live a more productive and active life. The goal of taking medication(s) on a regular basis is to reduce pain so that I can enjoy an improved quality of life. I realize that the treatment may require prolonged or continuous use of medication(s), and that an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored especially for me. I

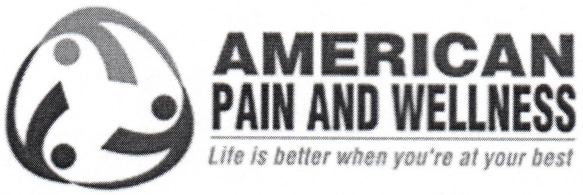


understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time and that I will immediately notify my physician of any discontinued use of medications prescribed. I also understand and acknowledge that I have been made aware of possible effects of stopping the use of the prescribed drug(s). I understand that no representation, warranty, or guarantee has been made to me as to the results of any proposed drug therapy or treatment. I have been given the opportunity to ask questions about my condition, the risks and hazards of such drug therapy, treatment and procedure(s), and applicable alternative treatments, if any. I believe that I have sufficient information to give this informed consent and I represent that all my questions have been answered. Alternative methods of treatment, the possible risks and benefits involved, and the possibilities of complications have been explained to me.

PAIN MANAGEMENT AGREEMENT:

IN ADDITION TO THE CONSENT ABOVE, I ALSO UNDERSTAND AND AGREE TO THE FOLLOWING: This Pain Management Agreement relates to my use of all medication(s) (i.e., opioids, also called narcotics, painkillers, and other prescription medications) for chronic pain prescribed by my physician. I understand that there are federal and state laws, regulations and, policies regarding and strictly limiting the use and prescribing of controlled substance(s). Therefore, I understand and acknowledge that medication(s) will only be provided so long as I follow the rules specified in this agreement and the terms of any prescription that I, may receive. My physician may at any time choose to discontinue the medication(s) in physician sole discretion. Failure to comply with any of the following rules may cause discontinuation of medication(s) and/or any discharge from care and treatment. Discharge will be immediate for any criminal behavior.

1. I will disclose to my physician all medication(s) that I take regardless of prescribing doctor, dentist or healthcare provider as it pertinent to my treatment.
2. I will disclose to my physician all over-the counter supplements, herbs, pills, ointments, patches or other aids or substances that I take or use for any reason, at any time.
3. I will use the medication(s) exactly as prescribed by my physician.
4. I agree not to share, sell or permit others, including my family or friends to have access to or ingest my medications at any time.
5. 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.
6. 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. This applies to weekends, vacations, work travel and holidays in which our office maybe closed.
7. I will receive pain medication(s) from only ONE physician. If we receive information that you have been receiving medication(s) from another provider, we reserve the right to stop prescription management and discharge you from our practice for violation of this contract.
8. I recognize that my active participation in the management of my pain is extremely important. I agree to actively participate in all aspects of my pain management program as recommended by my physician to attempt to achieve increased function and improved quality of life.



9. 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 adverse effects with pain medications and even cause harm.
10. I hereby give my physician permission to discuss all diagnostic and treatment details with my primary care doctor(s), pharmacists), and any other treating healthcare provider regarding my use of medications prescribed by my physician(s) or by other doctors.
11. I agree to take the medication(s) precisely as instructed by my physician. Any unauthorized increase in the dose of medication(s) or the method of taking the medication or the frequency of taking the medication may be a cause for discontinuation of the treatment by my physician. We reserve the right to stop prescription management and discharge you from our practice for violation of this contract if you take the medication(s) not as prescribed.
12. I agree to keep all follow-up appointments as recommended by my physician or my treatment may be discontinued.
13. I agree to keep all follow-up appointments with any other medical care provider prescribed or recommended by my physician or my treatment may be discontinued.

I certify, represent, and warrant that:

1. I am not currently using illegal drugs or abusing prescription medication(s) and that I am not undergoing treatment for substance dependence (addiction) or abuse. I have read this contract in its entirety before signing.
2. I am not and have never been involved in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) or illegal substances (marijuana, cocaine, heroin, or other drugs or narcotics).
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 my consent to this Pain Management Agreement between me and my provider.
4. I have been informed of the potential side effects of the medication(s) that may be prescribed for the treatment of my chronic pain, including any medications prescribed for off-label treatment. I fully understand the explanations regarding the benefits and the risks of these medication (s) and I voluntarily and knowingly agree to the use of these medication(s) in the treatment of my chronic pain

Read, Agreed and Accepted on the date below by:

Patient Signature:_____ Date:_____

AMERICAN PAIN AND WELLNESS

"Life is better when you're at your best"

www.painandwellness.com

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as a part of the provision of healthcare services, **American Pain and Wellness** creates and maintains health records and other information describing, among other things, my health history, symptoms, examination, test results, diagnoses, treatment and any plans for future care or treatment.

I acknowledge receipt of this **Notice of Privacy Rights** which I have reviewed and give my permission to **American Pain and Wellness** to use and disclose my health information in accordance with the regulations.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations.

_____

Printed Name

_____

Signature

_____ _____

Social Security Number Date

_____

Staff Witness