Dr. Hassan Chahadeh 9079-C Katy Freeway Houston, TX 77024

Thank you for choosing Interventional Pain Treatment Center.

We shall do our best to provide you with quality and courteous care of your neurological needs.

General Consent for Care & Treatment/Consentimiento general para el cuidado y tratamiento

You have the right to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point, no specific treatment plan has been recommended. This consent form is simply to obtain your permission to perform the evaluation necessary to identify the appropriate treatment &/or procedure for any conditions.

This consent provides us with permission to perform reasonable & necessary medical examinations, testing, and treatment. By signing, you are indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and you consent to treatment at this office or another office under common ownership. The consent will remain effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered. If you have any concerns regarding any test or treatment recommended we encourage you to ask questions.

I voluntarily request a physician, midlevel provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), other healthcare providers, designees as necessary, to perform reasonable and necessary medical examination, testing, treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive, or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the tests or procedures.

***I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.**

_____ _____ _____

Signature of Patient or Representative | Patient Name | Date

Appointment Cancellation Policy/ Poliza de Cancelacion de Cita

We request that appointments be kept as scheduled. Cancellations are accepted **24 hours in advance**.

Please Write Legibly

Patient Name/Nombre:_____ **DOB**/Fecha de nacimiento:_____

Address/Direccion:

_____ **City**/Ciudad:_____ ZIP:_____

Telephone: Home/Casa:)_____ **Cell**/Cellular:_____

Social Security/# de Seguro Social: _____/_____/_____ **Sex**/Sexo: M / F (circle one)

Emergency contact/Contacto en caso de emergencia:_____ Phone:_____

Insurance/Aseguranza: _____ **Policy Holder**:_____

ID/Numero#:_____ **Group**/Grupo#:_____

Additional Insurance/Aseguranza adicional:_____

Attorney/Abogado: _____ Tel#:_____

Date of Injury/Fecha y typo de accidente: ____/_____/_____ **Type of Accident**:_____

Other Doctors/Otros Medicos:_____

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Prior XR/ MRI/ CT? when&where/donde y cuando:_____

Medications&Dose/Dosis:_____

Allergies/Alergias: _____ **Occupation**/Occupacion:_____

Current complaint/Problema actual:_____

_____

Prior treatment for this: ( )Chiropractic ( )Injections ( )Physical Therapy ( )Surgery:_____

What has helped the pain the most:_____

Past Medical Illness/Problemas medica pasada : **Check all that apply**/Marque lo que corresponda:

( )headaches ( )nausea/vomiting ( )dizziness ( )balance problems ( )migrane ( )bleeding disorder ( ) lung problems

( )blurry vision ( )double vision ( )hearing problems ( )difficulty with speech or swallowing ( )stomach ulcers

( )numbness or tingling ( )Urinary or bowel problems ( )high blood pressure ( )aneurysms ( )diabetes

( )heart disease ( )stroke ( )seizure ( ) arthritis ( )cancer _____( ) thyroid or ( ) lung problems ( ) aneurismas

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HIPAA Release of Information

HIPAA dictates that our office must do everything possible to protect your medical information. For this reason please indicate below who we may leave messages with or talk to regarding appointments, prescriptions, test results, surgery dates, and any other medical need we may have. Please list the phone number below where you can most likely be reached during our business day.

***Phone#: _____**

***Is it OK to leave a message? _____yes _____no**

I will allow medical information and test results including abnormal results and appointment information to be relased to the following people:

Name/Nombre Relationship/Relacion Phone/Telefono

_____

_____

_____

_____

***_____I DO NOT WANT medical information, test results, released to anyone BUT myself.**

This form will be valid until revoked by me in writing.

HIPAA Acknowledgement Form

I hereby acknowledge by signature below that I have been given a copy of the HIPAA Privacy Policy for review. I also acknowledge that I have read and been given an opportunity to ask any questions related to my privacy rights.

This form is to be retained in my medical chart until revoked by me in writing.

Patient Name/Su Nombre: _____ **Date**/Fecha: _____

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Accident Survey Date/Fecha: _____

Patient Name/Nombre:_____ **DOB**/Fecha de nacimiento :_____

Date of Injury/Fecha del accidente:_____ **Lawyer**/Abogado: _____

Type of car you were hit by/ tipo de coche que golpeó:_____

Car Driven/coche conducido: _____Which/Cual Hopsital?_____

Circle Type of impact: **TBoned** **Rear Ended** **Front Impact**

Which Chiropractor did you see? ¿Qué quiropráctico lo que viste?: _____

Did you have an MRI? ¿Ha tenido una resonancia magnética ?: _____

Have you had an ESI/injection? ¿Ha tenido una inyección:_____

Have you had surgery? ¿Ha tenido una cirugía?: _____

Where is the pain? ¿Dónde está el dolor?:_____

_____

Lt / Rt Arm **Lt / Rt Leg Neck** **Low Back** **Lt / Rt Shoulder** **Lt / Rt Hip**

Meds taken for pain? ¿Medicamentos que se toman para el dolor?

_____

_____

Past surgery history: Indicate where in body & year/La historia de la cirugía pasado: indicar en qué parte del cuerpo y el año:

_____

_____

Other current medical problems/Otras problemas:

_____

_____

A/P: (Below is for Office Use Only/A continuación se muestra únicamente para uso de oficina)

ESI:

Or ACDF:

Or RLF:

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Prescription Policy

It is the policy of Intervnetional Pain Treatment Center to deliver quality care and treatment to all of our patients. Taking into account the nature of our specialty we realize that many patients come to us with chronic pain or some level of pain. It is our hope and belief that this pain can be treated conservatively through non-narcotic medication or surgical intervention if required.

Controlled substance medications (i.e. narcotics, tranquilizers, and barbiturates) are very useful but have a high potential for misuse and are therefore **closely controlled by local, state, and federal governments**. They are intended to relieve pain, thus improving function and/or ability to work. Because Dr. _____ is prescribing controlled substance medications to help manage my pain, **I agree to the following conditions:**

1. I am responsible for any controlled substance medications prescribed to me. If my prescription is lost, misplaced, stolen, or if I "run out early" I understand that it will not be replaced.
2. Refills of controlled substance medications:
    a. Will be made only during regular office hours: Monday through Friday
    b. Will not be made as an "emergency", and will require notification at least 24 hours in advance.
3. TRIPLICATE prescription narcotic pain medications will not be administered. IF they are, they will be given in the office.
4. We no longer prescribe SOMA or LORCET.
5. Pain Medication will not be provided to those under care of a pain specialist.
6. It may be deemed necessary by Dr. Velimirovic that I see a **medication-use specialist** at any time while I am receiving controlled substance medications. I understand that if I do not attend such an appointment, my medication may be discontinued or may not be refilled beyond a tapering dose to completion. I understand that if the specialist feels that I am at risk for psychological dependence (addiction), my medication will no longer be refilled.
7. I understand that if I violate any of the above conditions, my prescription for controlled substance medications may be terminated immediately. If the violation involves obtaining controlled substance and medications from another individual, or the concomitant use of non-prescribed, illicit (illegal) drugs, I may also be reported to my physicians, medical facilities, and appropriate authorities.
8. I understand that the main treatment goal is to reduce pain and improve my ability to function and/or work. In consideration of this goal, and the fact that I am being given medication to help me reach my goal, I agree to help myself by the following better health habits: exercise, weight control, and avoidance of tobacco and alcohol.
9. I must also comply with the treatment plan as prescribed by my physician. I understand that a successful outcome to my treatment will only be achieved by following a healthy lifestyle.
10. I agree to have all prescriptions for controlled substances filled at the same pharmacy. Should the need arise to change pharmacies there will be notification.
11. The pharmacy I use is: _____ Ph:_____

***I have read this contract and I fully understand that the consequences of violating this agreement may result in my termination as a patient of this practice.**

Patient signature: _____ **Date:** _____

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Disclosure and Authorization Form for Patient Referral to Other Non-participating Physicians or Facilities Advocacy for patient Freedom of Choice for Provider

Patient Name: _____ **Physician Name:** _____

Diagnosis: _____ *** Physicians: Erwin Lo, David Singleton, Sujin Yu,**

Treatment: _____ **Hassan Chahadeh,**

Patient Plan In-Network: _____

In order to better serve you with the highest quality care and safety at the most affordable costs, sometimes it is necessary to have other additional providers/entities to join our team to complete or continue your medical procedures or treatment in order to ensure speedy recovery for you. We would like to keep you informed of your choice in and our recommendation of these other providers& entities and obtain your informed consent before our referral and scheduling for your next procedure. While no provider/entity could be participating in every managed care network, such as the one your health plan has contracted with, these other providers/entities may or may not be in your health plan network. This Disclosure and Authorization form is used to inform you of our verification that the above name providers/entities are or may be non-participating providers/entities with your health plan.

We have verified your insurance coverage for non-participating providers/entities and the recommended treatment/procedures and obtained pre-certification if applicable for all services as a courtesy to you. Please understand that the insurance verification is not a guarantee of insurance payment according to your health plan. If you have any questions concerning whether you have out of network benefits or your financial obligations under your benefit plan if you use an out of network provider/entity, please call the member services number on your Insurance card.

Compliance & Disclosure under Texas Occupations Code –Section 102.006

In compliance with Section 102.006 of Texas Occupations Code in connection with my informed consent and personal choice of doctors and facility solely based on the quality and safety of care, reputation and patient satisfaction, and my knowledge in decision-making in exercising my rights with respect to the in-network or out-of-network coverage and cost sharing, my attending doctor/facility have disclosed to me at the time of initial contact and at the time of referral with respect to the choice of a doctor or facility solely in the interest of my healthcare quality and safety, as a result of my informed consent and personal choice of providers/entities/facilities: (A) affiliation, if any, with the doctor or facility for whom the patient is referred and (B) that he/she will receive directly or indirectly remuneration for referring upon my such request and exercising my right of freedom of choice for the providers and facility under the in-network or out-of-network coverage as provided by my health plan, as protected by all applicable federal and state laws, including Medicare, ERISA, PPACA.

Doctor or Facility with affiliation and remuneration : Erwin Lo, MD, Sujin Yu, MD, David Singleton, MD, Baominh Vinh, MD, Hassan Chahadeh, MD, Bratislav Velimirovic, MD, Karan Madan, MD, Scott Lin, MD, Lance LaFleur, MD, Purvi Patel, MD, Pin Oak Medical Center, Katy Pain & Spine, Trinity Pearland Medical Center, Country Place Medical Center, Interventional Pain and Treatment Center, Brain and Spine Center, Woodlands Way Medical Center, I45 Medical Center, League Line Medical Center, North Mesa Medical Center, Southeast Texas Medical Center Victory Campus, Steeplechase Medical Center, Northwest Houston Medical center, Dowlen Center for Pain, Metropolitan Park Medical Center, Victory Medical Center Houston, True Island Medical Center. Any other physicians contracted by or affiliated with these providers/entities. Any other Physician Owned Entity that may have been referred to by these providers/entities.

*I certify that the Advocacy for Patient Freedom of Choice for Providers with the above specific disclosure from my providers is in full compliance with the Section 102.006 of Texas Occupations Code, in a manner otherwise permitted under Section 102.001, in accepting remuneration to advocate, protect, secure, or solicit a patient or patronage for a person licensed, certified, or registered by a state health care regulatory agency.

*I certify that I was informed of the effective alternative resources reasonably available at the time of my decision-making, and my option to use one of the alternative resources, and that I was assured by my attending physician that I will not be treated differently by the physician and his staff if I choose an alternative provider or entity.

*I certify that my attending physician has made referrals to the other non-participating providers or entities based only on the needs of my individual healthcare, the medical community standard of care and my informed choice for quality and safety of the care that I will be expecting and receiving and for provider's professional reputation and patient satisfaction in order to provide me with quality and affordable healthcare that I personally expected under my health plan for out-of-network coverage.

***I have read and fully understand the Disclosure and Authorization Form. I hereby authorize this referral to non-participating and out-of-network providers/entities as named above.**

_____ _____ _____

Signature **Patient Name** **Date**

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Medical and Surgical Procedures

TO THE PATIENT: You have the rights as a patient to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. The disclosure is not mean to scare or alarm you, it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I voluntarily request Dr. _____ as my physician and such associates and other health care providers as they may deem necessary, to treat my condition which has been explained to me as:

_____

_____I understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I voluntarily consent and authorize these procedures: _____

_____I understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I authorize my physician, and such associates, technical assistants, and other health care providers to perform such other procedures which are advisable in their professional judgment.

_____I understand that no warranty of guarantee has been make to me as to result or cure.

Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. I realize that common to surgical, medical, or diagnostic procedures is potential for infection, blood clots in veins, lungs, hemorrhage, paralysis, allergic reactions and even death can occur. I also realize that the following risks and hazards may occur in connection with this particular procedure.

_____I understand and acknowledge that my physician selects the medically appropriate devices and or products for my procedure and treatment, and that the devices and/or products used may be part of a cost savings program implemented by the facility and my physician. I understand that I may request to review the cost savings measures related to my procedure/treatment.

_____I have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved, and believe that I have sufficient information to give this informed consent.

****Article 1: AGREEMENT TO ARBITRATE:** It is understood that any dispute to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

By signing this contract you are agreeing to have any issue of medical malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial. See article 1 of this contract. *

Doctor or Facility with affiliation and remuneration: Hassan Chahadeh MD, Erwin Lo MD, Sujin Yu MD, David Singleton MD, Interventional Pain & Treatment Center, Brain and Spine Center, Woodlands Way Medical Center, I45 Medical Center, League Line Medical Center, Southeast Texas Medical Center Victory Campus, Katy Freeway Medical Center, Spinetech ASC, Dowlen Center for Pain, True Island Medical Center.

_____***Accept Assignment. You, the patient, agree to release payment from the insurance company to our facility. Should you receive funds from your insurance company for services rendered, you agree to immediately forward payment to the treating facility.***

_____***I certify this form has been fully explained to me, that I have read it, that the blanks have been filled in, and that I understand its content.***

_____	_____	_____	_____
Signature of Patient or Representative	Patient Name	Date	Time
_____	_____	_____	_____
Signature of Witness	Patient Name	Date	Time