NORTH HOUSTON PAIN CENTER, LLC.

Welcome to Our Practice

Thank you for choosing North Houston Pain Center, LLC. Please make sure you complete all required new patient paperwork prior to your visit.

- If you take any medications daily please bring a medication list with you.

- Also please bring your insurance cards and ID, so that we may make a copy of them. If you are part of an HMO or any other managed care program please contact your primary care doctor for an insurance referral. If we do not receive the referral prior to your appointment, you will have to be rescheduled.

- You will also need to bring in any copy of MRI reports and CD disc, X-ray report or any other diagnostic studies that you may have had done. If possible, please fax, email, or mail to our facility. This will help us provide more efficient quality of care for you at the time of service. Our fax number is 281-446-4664.

- If you are unable to complete the New Patient paperwork prior to your office visit, please arrive 45 minutes early or your appointment will have to be rescheduled.

- Please note your first visit will be a consultation.

- If you have any additional questions please do not hesitate to contact our office. Phone number is 281-446-4878

We require at least 24 hours notice for cancellations and rescheduling of appointments. Failure to do so, will result in a $50.00 no show/ cancellation fee.

We look forward to providing quality care at

North Houston Pain Center, LLC

NORTH HOUSTON PAIN CENTER, LLC

New Patient Intake Information

Date: _____

Name: _____

Date of Birth: _____ Age: _____ Social Security #: _____

☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other

Race: ☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander ☐ Black or African American ☐ Native Hawaii or Pacific Islander ☐ White ☐ Refuse to Report ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Refuse to Report

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Preferred Phone: ( ) _____ ☐ Home ☐ Cell ☐ Work

Secondary: ( ) _____ ☐ Home ☐ Cell ☐ Work

Home Address: _____

City/State/Zip: _____

Email: _____

Emergency Contact/ Authorized HIPPA Contact Information

Emergency Contact: _____

Emergency Contact Phone: ( ) _____ Relationship: _____

Referral Information

Primary Care Physician: _____ Phone: ( ) _____

Referring Physician: _____ Phone: ( ) _____

Preferred Pharmacy

Pharmacy Name: _____ Phone: ( ) _____

Street Address: _____

City/State/Zip: _____

Guarantor if different from patient:

Guarantor Name: _____ Relationship to Patient: _____

Address: _____

Social Security Number: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Primary Insurance Plan

Insurance Company Name: _____ Plan: _____

Policy ID Number: _____ Group#: _____

Phone: ( ) _____

Insured Name: _____ Relationship to Patient: _____

Secondary Insurance Company: _____

Policy Number: _____ Group#: _____

Phone Number: ( ) _____

Insured Name: _____ Relationship to Patient: _____

General Consent and Authorization for Treatment, Evaluation, and Information Release
This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. The consent will remain fully effective until it is revoked in writing. You have the right to discontinue services at any time.

I certify that my Medical History is complete and accurate to the best of my knowledge and ability.
I voluntarily request that North Houston Pain Center, LLC provide pain management care, treatment, and services to me, as deemed reasonable and necessary by the assigned healthcare provider(s). I consent to reasonable and necessary medical examination, evaluation, testing and treatment which may include diagnostic, radiology and laboratory procedures. I understand I may be asked to provide urine, oral swab, and/ or blood samples. I have the right to refuse specific tests, but understand this may impact my pain management treatment. If invasive interventional treatment is recommended, I will be informed of the benefits and risk prior to performance of such treatment and will be provided with a separate consent form outlining such benefits and risk.

North Houston Pain Center, LLC works with the patient to minimize difficulty in the payment of fees for service. Upon arriving to your appointment, you will be asked to pay those minimal unmet deductible amounts and/or co-insurance amounts in which your insurance company authorizes to be collected. Please ensure the primary and secondary information above is correct.

Authorization to Release Information: The undersigned hereby authorizes North Houston Pain Center, LLC. To release all information pertaining to the patient's treatment to his/her insurance company or companies and to any other physician, healthcare provider, or facility to whom the patient is being referred.

Assignment of Benefits: I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plan to: North Houston Pain Center, LLC, for services issued by the practice.

Financial Responsibility: I understand that I am financially responsible for all services received at North Houston Pain Center, LLC, regardless of my insurance coverage.

BY SIGNING BELOW, I AM AGREEING TO THE CONSENTS AND RELEASES DESCRIBED ON THIS FORM. I HAVE READ THIS CONSENT AND HAVE BEEN ABLE TO ASK QUESTIONS.

Print Name of Patient or Representative: _____

Patient Signature: _____ Date: _____

Designated Representative Signature: _____ Date: _____
(If patient unable to sign)

NORTH HOUSTON PAIN CENTER, LLC

Thank you for choosing North Houston Pain Center, LLC. Please fill out the below questionnaire to help our physician provide the best care for you.

Patient Name: _____ Date: _____

HISTORY

Past Medical History (Circle all that apply)

Head:
Trauma

Eyes:
Blindness
Cataracts
Glaucoma
Wears Glasses/Contacts

Ears:
Hearing Aids
Hearing Aids
Deaf

Nose/Sinuses:
Allergic Rhinitis
Sinus Infection

Mouth/Throat/Teeth:
Dentures

Cardiovascular:
Aneurysm
Angina
DVT
Dysrhythmia
HTN
Murmur
Myocardial Infarction
Other Heart Disease
Peripheral Vascular Disease

Respiratory:
Asthma
Bronchitis
COPD
Pleuritis
Pneumonia

GI:
Cirrhosis
GERD
Gallbladder Disease
Heartburn
Hemorrhoids
Hepatitis
Hiatal Hernia
Jaundice
Ulcer
Hepatitis A/B/C

Genitourinary:
UTI(s)
Hernia
Incontinence
Nephrolithiasis
Other Kidney Disease
STDs

Musculoskeletal:
Arthritis
Gout
M/S Injury
Chronic Joint Pain
Chronic Back Pain
Chronic Neck Pain

Skin:
Psoriasis
Dermatitis
Mole(s)
Other Skin Conditions

Neurological:
Vertigo (dizziness)
Epilepsy
Seizures
Tremors
Seizures
Headaches/ Migraine
Stroke
TIA

Psychiatric:
Bipolar Disorder
Depression
Suicidal Ideations
Suicide Attempts
Hallucinations, delusions
Anxiety

Endocrine:
Goiter
Hyperlipidemia
Hypothyroidism
Thyroid Disease
Thyroiditis
Type I Diabetes
Type 2 Diabetes

Hematology/Oncology:
Anemia
Cancer
Type: _____

Infectious:
MRSA
HIV
STD(s)
Tuberculosis (dz)

Auto Immune:
Rheumatoid Arthritis
Psoriatic Arthritis
Ankylosing Spondylitis
SLE/ Lupus
Other: _____

Past Surgical History (Please attach additional sheet if necessary)

Surgery	Surgeon/Location	Date/Year

Family History (Mark all appropriate diagnoses as they pertain to your biological parents only.)

Cancer: ☐ Mother ☐ Father Diabetes: ☐ Mother ☐ Father

Heart Disease: ☐ Mother ☐ Father Migraines: ☐ Mother ☐ Father

Other: _____

☐ Unknown ☐ No Health Concern/ No Family History

Social History

Tobacco Use:

☐ Current Tobacco User ☐ Former Tobacco User ☐ Never used Tobacco

☐ Vaping ☐ Hookah

Alcohol Use:

☐ Current Alcoholism ☐ History of Alcoholism ☐ Never Drinks Alcohol

☐ Social Alcohol Use ☐ Daily Alcohol Use (Drink/day: _____)

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

If yes, what? _____

Have you ever used or abused illicit drugs? ☐ Yes ☐ No

If yes, what? _____

Do you drink caffeine? ☐ Yes ☐ No (drink/day: _____)

Do you exercise regularly? ☐ Yes ☐ No (times/week: _____)

Medications (Please attach additional sheet if necessary)
Please list ALL of your current medications you are taking.

Are you currently taking any blood-thinner medications? ☐ Yes ☐ No

Medications	Dosage	Frequency	Prescribing Physician

Allergies ☐ No Known Allergies ☐ No Known Medication Allergies

List all allergies

Allergy	Reaction	Allergy	Reaction

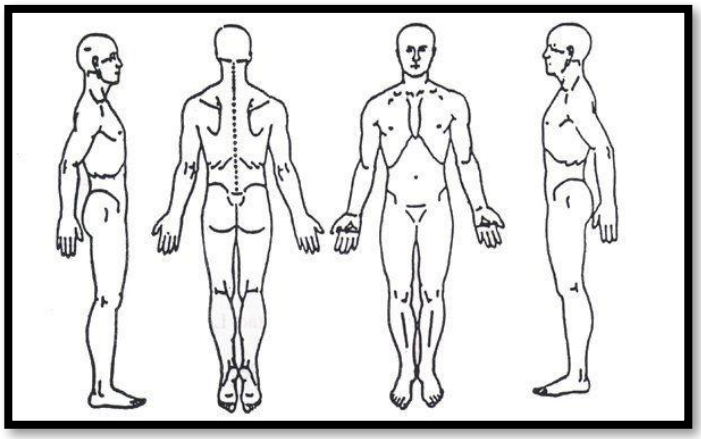
Patient Name: _____

Height: _____ft. _____in. Weight: _____ lbs.

Clinical Information

Where is your pain? ☐ Neck ☐ Back ☐ Arm ☐ Other: _____

Please mark below where the pain is:



Please describe your pain. Circle all that apply.

Stabbing	Stiffness	Soreness	Dull
Burning	Shooting	Throbbing	
Numbness	Tingling	Aching	
Weakness	Tightness	Sharp	

Loss of Bowels Loss of bladder control

Other, Please describe: _____

_____

Current Pain today on a scale of 0 to 10:

How long have you had this pain? _____

Is your pain the result of an injury or accident? ☐ Yes ☐ No Worker's Comp: ☐ Yes ☐ No

Do any of the following increase your pain? ☐ Coughing ☐ Sneezing

☐ Straining ☐ Sitting ☐ Lifting ☐ Stress ☐ Sleeping on back

☐ Sleeping on stomach ☐ Cold ☐ Walking ☐ Sex

What makes your pain better? _____

What makes your pain worse? _____

What treatments have you tried to help with your pain? _____

☐ Medications ☐ Physical Therapy ☐ Injections ☐ Chiropractic Care

☐ Acupuncture ☐ Massage ☐ Surgery ☐ Homeopathic

☐ Herbal Medications

Have you had any imaging studies (MRI, CT, X-rays?). If so, which physician and/or facility did you use?

_____

Have you had any electro diagnostic studies-EMG/NCV? If so, using which physician and/or facility?

NORTH HOUSTON PAIN CENTER, LLC

Patient Financial Policy

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept Cash, Check, Visa, MasterCard, Discover and American Express.

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment and/or deductible/co-insurance at the time of service. This office's policy is to collect fees due when you arrive for your appointment.

- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and submit the claim for you on an assigned basis. You will be responsible for your portion and also any payments your insurance may deny.

- In the event that your health plan determines a services to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

- We will bill your health plan for all services provided at North Houston Pain Center, LLC. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Minor Patients

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

Patient Signature: _____ Date: _____

Print Name: _____

NORTH HOUSTON PAIN CENTER, LLC

Fee Schedule

Item	Fee Schedule
Failure to **CANCEL** or **NO SHOW** to Your appointment within 24 hours of the scheduled time.	$50.00 per Clinic Appointment $150.00 per Procedure
Late Arrivals. Arrival to your appointment 15 minutes past your appointment time are subject to rescheduling based on schedule.	$50.00 per Clinic Appointment $150.00 per Procedure
Completion of disability forms. These fees are per occurrence/per form.	FMLA $50.00 Short-Term disability $30.00 Life Insurance $30.00 Other forms $30.00

Printed Name of the Patient: _____

Signature of Patient or Responsible Party if a Minor: _____ Date: _____

NORTH HOUSTON PAIN CENTER, LLC

Code of Conduct

In an effort to provide a safe and healthy environment for staff, visitors, patients and their families, North Houston Pain Center, LLC expects visitors, patients and accompanying family members to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff.

The following behaviors may result in North Houston Pain Center, LLC asking you seek treatment elsewhere.

Disrupting, rude, uncooperative or violent behavior to staff via in-person or telephone

This also applies to your family members and friends.

Physical assault, arson, or inflicting bodily harm, verbal threats to harm another individual, or destroying property.

Failure to pay for services rendered

Repeated cancellations, no shows, or continual late arrivals for any type of appointment

Intentionally damaging equipment or property

Violation of North Houston Pain Center, LLC controlled substance policy.

Refusal to adhere to the plan of care, including refusal of urine testing, as outlined by North Houston Pain Center, LLC

Making harassing, offensive or intimidating statements, or threats of violence through phone calls, letters, voicemail, email, or other form of written, verbal or electronic communication.

Racial or cultural slurs or other derogatory remarks associated with, but not limited to, race, language or sexuality.

The patient chooses to terminate the Physician-Patient relationship.

If you are subjected to any of these behaviors or witness inappropriate behavior, please report to any staff member. Violators are subject to removal from facility and/or discharge from the practice.

Printed Name: _____

Signature: _____ Date: _____

NORTH HOUSTON PAIN CENTER, LLC.

Prescription Refill Policy and Alcohol Policy

State law requires compliance and close monitoring for narcotic medications. If these are prescribed to you, you will be asked to sign an "Informed Consent and Pain Management Agreement"

Failure to comply, may result in termination from our practice.

Prescriptions will only be refilled during normal business hours and by appointment only. No prescriptions will be filled during weekends, holidays, or after hours. It is your responsibility to make sure you have a sufficient amount of medications.

Alcohol in combination with controlled substances can cause serious side effects and pre-dispose to serious, even life-threating situations for both the patient and others.

It is North Houston Pain Center, LLC's policy to not allow consumption of any alcohol, for patients undergoing chronic pain treatment with controlled substances. This is strictly enforced and applies for any type and amount of alcohol, including "Social Drinking".

If you test positive for ethanol or any metabolites on a urine drug screen, you will be required to have a consult with the physician to discuss these findings with you and this may cause you to be released from North Houston Pain Center, LLC

By signing this form, I acknowledge that I have read and understand the police's in place at North Houston Pain Center, LLC for Prescription Refills and Alcohol consumption.

Patient Name: _____

Signature: _____ Date: _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (_____)_____ **ALT. PHONE** (_____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____)_____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)). **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.

NORTH HOUSTON PAIN CENTER, LLC.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY AND MAINTAIN THIS NOTICE FOR YOUR RECORD.

North Houston Pain Center, LLC. is required by law to provide you with this Notice so that you will understand how we may use or share your information from your Designated Record Set. The Designated Record Set includes financial and health information referred to in this Notice as "Protected Health Information" ("PHI") or simply "health information." We are required to adhere to the terms outlined in this Notice. If you have any questions about this Notice, please contact North Houston Pain Center, LLC. Attn: Privacy Officer

UNDERSTANDING YOUR HEALTH RECORD AND INFORMATION

Each time you are seen at North Houston Pain Center, LLC a record of your stay is made containing health and financial information. Typically, this record contains information about your condition, the treatment we provide and payment for the treatment. We may use and/or disclose this information to:

- plan you care and treatment
- communicate with other health professionals involved in your care
- document the care you receive
- educate health professionals
- provide information for medical research
- provide information to public health officials
- evaluate and improve the care we provide
- obtain payment for the care we provide

Understanding what is in your record and how your health information is used helps you to:

- ensure it is accurate
- better understand who may access your health information
- make more informed decisions when authorizing disclosure to others

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

The following categories describe the ways that we use and disclose health information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall into one of the categories.

For Treatment. We may use or disclose health information about you to provide you with medical treatment. We may disclose health information about you to doctors, nurses, therapists or other North Houston Pain Center, LLC personnel who are involved in taking care of you at North Houston Pain Center, LLC. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can plan you meals. Different departments of North Houston Pain Center, LLC also may share health information about you in order to coordinate your care and provide you medication, lab work and x-rays. We may also disclose health information about you to people outside North Houston Pain Center, LLC who may be involved in your medical care after you leave North Houston Pain Center, LLC. This may include family members, or visiting nurses to provide care in your home.

- **For Payment.** We may use and disclose health information about you so that the treatment and services you receive at North Houston Pain Center, LLC. may be billed to you, an insurance company or a third-party. For example, in order to be paid, we may need to share information with your health plan about services provided to you. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

- **For Health Care Operation.** We may use and disclose health information about you for our day-to-day health care operations. This is necessary to ensure that all patients receive quality care. For example, we may use health information for quality assessment and improvement activities and for developing and evaluating clinical protocols. We may also combine health information about many patients to help determine what additional services should offer, what services should be discontinued, and whether certain new treatments are effective. Health information about you may be used by our office for business development and planning, cost management analysis, insurance claims management, risk management activities, and in developing and testing information systems and programs. We may also use and disclose information for professional review, performance evaluation, and for training programs. Other aspects of health care operations that may require use and disclosure of your health information include accreditation, certification, licensing and credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and compliance programs. Your health information may be used and disclosed for the business management and general activities of North Houston Pain Center, LLC including resolution of internal grievances, customer service and due diligence in connection with a sale or transfer of North Houston Pain Center, LLC. In limited circumstances, we may disclose your health information to another entity subject to HIPAA for its own health care operations. We may remove information that identifies you so that the health information may be used to study health care and health care delivery without learning the identities of patients. We may disclose your age, birth date and general information about you in the North Houston Pain Center, LLC newsletter, on activities calendars, and to entities in the community that wish to acknowledge your birthday or commemorate your achievements on special occasions. If you are receiving therapy services, we may post your photograph and general information about your progress.

OTHER ALLOWABLE USES OF YOUR HEALTH INFORMATION

- **Business Associates.** There are some services provided at North Houston Pain Center, LLC through contracts with business associates. Examples include medical directors, outside attorneys and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

- **Providers.** Many services provided to you, as part of care at North Houston Pain Center. LLC are offered by participants in one of our organized healthcare arrangements. These participants include a variety of providers such as physicians (e.g., MD, DO, Podiatrist, Dentist, Optometrist), therapists (e.g., Physical therapist, Occupational therapist, Speech therapist), portable radiology units, clinical labs caregivers, pharmacies, psychologists, LCSWs, and suppliers (e.g., prosthetic, orthotics).

- **Treatment Alternatives.** We may use and disclose health information to tell you about possible treatment options or alternatives that may be of interest to you.

- **Health-Related Benefits and Services and Reminders.** We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

- **Individuals Involved in Your Care or Payment for Your Care.** Unless you object, we may disclose health information about you to a friend or family member who is involved in your care. We may also give health information to someone who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

- **As Required By Law.** We will disclose health information about you when required to do so by federal, state or local law.

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about you to prevent a serious threat to your health and safety or the health and safety of the public or another person. We would do this only to help prevent the threat.

- **Organ and Tissue Donation.** If you are an organ donor, we may disclose health information to organizations that handle organ procurement to facilitate donation and transplantation.

- **Military and Veterans.** If you are a member of the armed forces, we may disclose health information about you as required by military authorities. We may also disclose health information about foreign military personnel to the appropriate foreign military authority.

- **Research.** Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with patients' need for privacy of their health information. Before we use or disclose health information for research, the project will have been approved through this research approval process. We may, however, disclose health information about you to people preparing to conduct a research project so long as the health information they review does not leave North Houston Pain Center, LLC.

- **Workers' Compensation.** We may disclose health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- **Reporting.** Federal and state laws may require or permit North Houston Pain Center, LLC to disclose certain health information related to the following:

    - *Public Health Risks*. We may disclose health information about you for public health purposes, including:
        - ➢ Prevention or control of disease, injury or disability
        - ➢ Reporting births and deaths;
        - ➢ Reporting child abuse or neglect:
        - ➢ Reporting reactions to medications or problems with products;
        - ➢ Notifying people of recalls of products;
        - ➢ Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease;
        - ➢ Notifying the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

    - *Health Oversight Activities.* We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activites are necessary fot the government to monitor the health care system, government programs, and compliance with civil rights laws.

    - *Judicial and Administrative Proceedings:* If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

    - *Reporting Abuse, Neglect or Domestic Violence:* Notifying the appropriate government agency if we believe a patient has been the victim of abuse, neglect or domestic violence.

- **Law Enforcement.** We may disclose health information when requested by a law enforcement official:
    - In response to a court order, subpoena, warrant, summons or similar process;
    - To identify or locate a suspect, fugitive, material witness, or missing person;
    - About you, the victim of a crime if, under certain limited circumstances, we are unable to obtain your agreement;
    - About a death we believe may be the result of criminal conduct;
    - About criminal conduct at North Houston Pain Center, LLC; and
    - In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

- **Coroners, Medical Examiners and Funeral Directors.** We may disclose medical information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also disclose medical information to funeral directors as necessary to carry out their duties.

- **National Security and Intelligence Activities.** We may disclose health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **Correctional Institution:** Should you be an inmate of a correctional institution, we may disclose to the institution or its agents health information necessary for your health and safety of others.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

Although your health record is the property of North Houston Pain Center, LLC, the information belongs to you. You have the following rights regarding your health information:

- **Right to Inspect and Copy.** With some exceptions, you have the right to review and copy your health information.
  You must submit your request in writing to North Houston Pain Center, LLC Attn: Privacy Officer. We may charge a fee for the costs of copying, mailing or other supplies associated with your request.
- **Right to Amend.** If you feel that health information in your record is incorrect or incomplete, you may ask us to amend the information. You have this right for as long as the information is kept by or the North Houston Pain, LLC.

You must submit your request in writing to North Houston Pain Center, LLC Attn: Privacy Officer. In addition, you must provide a reason for your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information kept by or for the North Houston Pain Center, LLC; or
- Is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures". This is a list of certain disclosures we made of your health information, other than those made for purposes such as treatment, payment, or health care operations.

You must submit your request in writing to North Houston Pain Center, LLC. Attn: Privacy Officer. Your request must state a time period which may not be longer than six years from the date the request is submitted and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you. For example, you may request that we limit the health information we disclose to someone who is involved in your care or the payments for your care. You could ask that we not use or disclose information about a surgery you had to a family member or friend.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

You must submit your request in writing to North Houston Pain Center, LLC Attn: Privacy Officer. In your request, you must tell us (1)what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

- **Right to Request Alternate Communications.** You have the right to request that we communicate with you about medical matters in a confidential manner or at a specific location. For example, you may ask that we only contact you via mail to a post office box.
  You must submit your request in writing to North Houston Pain Center, LLC Attn: Privacy Officer. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.
- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice of Privacy Practices even if you have agreed to receive the Notice electronically. You may ask us to give you a copy of this Notice at any time.

- *You may obtain a copy of this Notice at our website, www.Northhoustoncenter.com*

- *You may obtain a paper copy Notice, contact North Houston Pain Center, LLC Attn: Privacy Officer.*

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in the North Houston Pain Center, LLC and on the website. The Notice will specify the effective date on the first page, in the top right- hand corner. In addition, if material changes are made to this Notice, the Notice will contain an effective date for the revisions and copies can be obtained by contacting the North Houston Pain Center, LLC administrator.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with North Houston Pain Center, LLC or with the Secretary of the Department of Health and Human Services. To file a complaint with North Houston Pain Center, LLC, contact North Houston Pain Center, LLC Attn: Privacy Officer. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

NORTH HOUSTON PAIN CENTER, LLC.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth: _____

Address: _____

I have been given a copy of North Houston Pain Center, LLC *Notice* of Privacy Practices *("Notice"),* which describes how my health information is used and shared. I understand that North Houston Pain Center, LLC has the right to change this *Notice* at any time. I may obtain a current copy by contacting North Houston Pain Center, LLC's Privacy Official.

My signature below acknowledges that I have been provided with a copy of the Notice of

Privacy Practices:

Signature of Patient or

Personal Representative: _____ **Date:** _____

Print Name: _____

Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

For North Houston Pain Center, LLC Use Only: Complete this section if you are unable to obtain a signature.

1. If the patient or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not singed for any other reason:

_____

_____

2. Describe the steps taken to obtain the patient's (or personal representative's) signature on the *Acknowledgement:*

_____

_____

Completed by: _____

Signature of North Houston Pain Center, LLC's

Representative: _____ Date: _____

Print Name _____

The following are some questions given to all

patients at North Houston Pain Center, LLC

who are on or being considered for opioids for their pain.

Please answer each question as honestly as possible. This information is for our records and will remain confidential.

Your answers alone will not determine your treatment.

Thank you.

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?					

PainEDU.org
IMPROVING PAIN TREATMENT THROUGH EDUCATION

Name:_____ **Date:**_____

	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.

NORTH HOUSTON PAIN CENTER, LLC.

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, April 2008 (ww.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 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 possibly as a result 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.

PATIENT INITIALS: _____

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, intolerance 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 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 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 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 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.

PATIENT INITIALS: _____

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 law, 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 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 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.

PATIENT INITIALS: _____

- 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: _____

Print Name: _____

Physician Signature: _____

(or Appropriately Authorized Assistant)

Name and contact information for pharmacy:

_____

_____

PATIENT INITIALS: _____

NORTH HOUSTON PAIN CENTER, LLC

PHYSICIAN OWNERSHIP DISCLOSURE FORM

Dr. Mann and Dr. Trahan has an investment in:

Memorial Hermann Surgical Hospital- Kingwood
300 Kingwood Medical Drive
Kingwood, TX. 77339

Although we are on staff at several local hospitals, we prefer to utilize the above institution for multiple reasons including:

- Patient convenience
- Same day pre-assessment
- Better fluoroscopy
- Quicker turnaround times
- Ease of scheduling

This information is being provided to you to help you make an informed decision about your health care. You have the right to choose your health care provider. You have the option of obtaining health care ordered by your physician at a different facility other than Memorial Hermann Surgical- Kingwood. You will not be treated differently by your physician or Memorial Hermann Surgical Hospital- Kingwood if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

If you have any questions concerning this notice, please feel free to contact:

Tamara Tippey at (281)446-4878.

By signing below you acknowledge that should you be referred to Memorial Hermann Surgical Hospital- Kingwood, your signature below evidences your informed decision to decline the option to have your health care provided at another health care facility.

Signature of Patient: _____ Date: _____

Printed Name of Patient: _____

NORTH HOUSTON PAIN CENTER, LLC.

Many patients undergoing pain injections procedures request anesthesia in order to be comfortable during the procedure. Please note that any anesthesia fees will be billed separate from the facility charge, by USAP.

By signing this form, you have read and understand the above.

Signature: _____ Date: _____

Print Name: _____

NORTH HOUSTON PAIN CENTER, LLC.

MEDICATION POLICY

Our philosophy and policy on prescribing medications are influenced by Dr. Mann and Dr. Trahan's fifteen plus years of experience in taking care of pain patients; as well as, dictated professional and government guidelines. It is our opinion that the responsibilities for obtaining and taking pain medications are solely and ultimately are that of the responsibilities of the patients wanting and receiving pain medications.

1. If a patient desires a pain medication, the request must come from Face to Face discussion with the patient and doctor. There will be no medications prescribed without a face to face discussion of the type of medication, the direction of use, the side effects, the length of usage, and the purpose of the medication use in the overall treatment plan. No medication will be given or called in without this face to face discussion.
2. It will be up to the discretion of the Doctor as to the appropriateness of Narcotic's Contract or Agreement to be signed and abided by. If an Agreement is decided on, it is the patient's responsibility to know and abide by the contract.
3. If you are a chronic patient attempting to transfer care to out clinic, it is our policy that NO pain medications will be written until prior pain clinic records are received, screening tested are performed, and a Narcotic Agreement is signed.
4. It is the responsibility of the patient to know when their medications will need to be refilled, and give the clinic a 7 day window to discuss the refill with the doctor. It will be the discretion of the doctor as to the need to see you prior to the prescription being filled. If your prescription runs out, it will not be the policy of the clinic to fill it emergently.
5. It is our opinion that only one physician should prescribe certain medications. It is your responsibility to inform the doctors and clinic as to what doctor is prescribing which pain medications.
6. Patients on chronic opioid medications must be evaluated with a face to face discussion every month, or based on the doctors' discretion.

Patient Signature: _____ Date: _____

Print Name: _____