Northwest
Anesthesiology and
Pain Services, PA

Appointment Date: _____
Check-In Time: _____
Provider: _____
Location: _____

Dear Sir or Madam,

Welcome to Northwest Anesthesiology and Pain Services, PA Group. We thank you for choosing us to assist you with your pain management needs. Please note, North Houston Pain Center providers are physicians for Northwest Anesthesiology and Pain Services, PA.

Enclosed you will find several forms which we require you to complete prior to your first appointment. If any part of the form(s) is unclear or is not applicable to you, please leave it blank and be sure to ask us about it upon check in. Your provider will use your initial questionnaire as a guide at your first visit to direct your future care.

In order to maintain a high quality of care, clear communication between you and your provider is required. The enclosed forms are an important part of our communication therefore we do request that each form be completed *prior* to your initial appointment. Please be aware that incomplete forms *could* result in the delay of your appointment or *possibly* cause your appointment to be rescheduled. If you should have any questions, please contact your provider office.

We require that you bring a picture ID for identification, your insurance card(s), and a form of payment. We also request that you bring the bottles of **all** your current medications to your appointment. The enclosed medication list will also need to be completed by you, listing your current medication(s) and medications that you have taken in the last 6 months.

Please make sure you bring all pertinent MRI's, CT's, X-rays and any other imaging to your first visit (**this includes any and all CD's you may have**). You can obtain these records from the facility where the test was preformed. We can/will return the records to you after the visit.

We look forward to meeting you, and thank you again for choosing us for your pain management care.

Sincerely,

Northwest Anesthesiology and Pain Services, PA

NORTH HOUSTON PAIN CENTER, LLC

New Patient Intake Information

Date: _____

Name: _____

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

☐ Male ☐ Female **Marital Status:** ☐ Married ☐ Single

Employment: ☐ Employed ☐ Unemployed ☐ Divorced ☐ Widowed
☐ Retired ☐ Student ☐ Disabled ☐ 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: ( ) _____

Cardiology 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
Deaf

Nose/Sinuses:
Allergic Rhinitis
Sinus Infection

Mouth/Throat/Teeth:
Dentures

Cardiovascular:
Aneurysm
Angina
DVT
Dysrhythmia
High Blood Pressure
Murmur
Myocardial Infarction
Peripheral Vascular Disease
Other Heart Disease:(List Below)

_____

Respiratory:
Asthma
Bronchitis
COPD
Pleuritis
Pneumonia
Sleep Apnea

GI:
Cirrhosis
GERD/Reflux
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 <u>ALL</u> 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

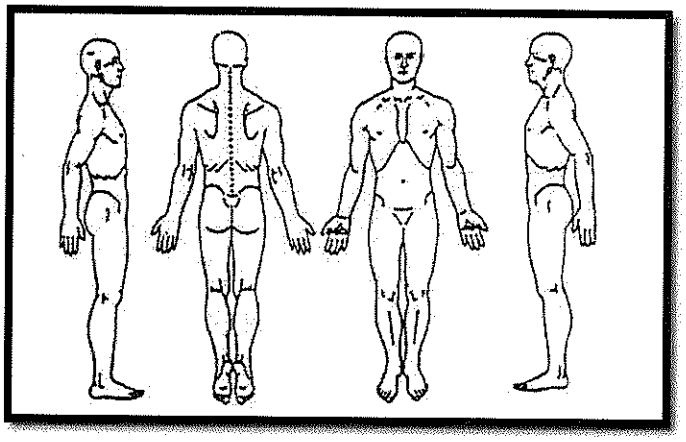
Patient Name: _____

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	

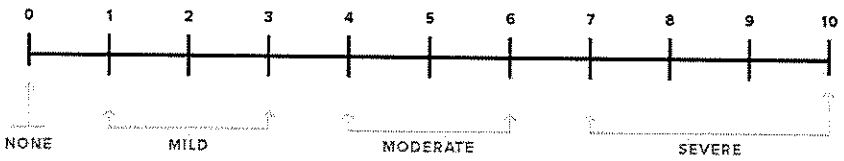
Loss of Bowels Loss of bladder control

Other, Please describe: _____

_____

Current Pain today on a scale of 0 to 10:

0-10 NUMERIC PAIN RATING SCALE



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 have these done? _____

Have you had any electro diagnostic studies- EMG/NCV? If so, which physician and/or facility did you have these done? _____

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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.

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 policy in place at North Houston Pain Center, LLC for Prescription Refills and Alcohol consumption.

Patient Name: _____

Signature: _____ Date: _____

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: _____

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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: _____

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PAIN MANAGEMENT AGREEMENT:

I UNDERSTAND AND AGREE TO THE FOLLOWING:

That this pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called "narcotics, painkillers", and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand that there are federal and state 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: _____

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- 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: _____

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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 our 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: _____

NORTH HOUSTON PAIN CENTER, LLC

MEDICATIONS

PLEASE NOTE IF WE WRITE ANY MEDICATION(S) THAT ARE REJECTED BY YOUR INSURANCE COMPANY. WE WILL NO LONGER SUBMIT A "PRIOR AUTHORIZATION". IT WILL BE YOUR RESPONSIBILTY TO CONTACT YOUR INSURANCE COMPANY TO DETERMINE WHAT MEDICATION IS ON THEIR FORMULARY LIST.

By signing this form, I acknowledge that I have read and understand the above.

Signature Date

Printed Name

Northwest
Anesthesiology and
Pain Services, PA

Medication History Consent Form

Name:	DOB:	Date:

On behalf of Northwest Anesthesiology & Pain Services, PA my provider: _____ has educated me regarding medication that has been prescribed to me regarding the benefits and possible side effects of this medication, possible drug, and/or food interactions that may occur while taking this medication, and the possible effects of this medication if the person taking this medication becomes pregnant. I have also been informed of the reason or purpose for which this medication was prescribed.

I also provide consent to my prescriber to have access to my past prescription history.

Patient Signature: _____ Date: _____

- It is recommended that women who are or may become pregnant, or are breast-feeding, discuss this with their doctor **BEFORE** taking any medication.
- It is recommended that patients be educated on reporting all side effects they experience, including, but not limited to, which side effects to report **IMMEDIATELY** to a health care provider
- It is recommended that any provider prescribing medications to obtain a thorough patient history that should include (but not limited to):
    1. What medication including prescribed over-the-counter medications, the patient is or has been taking
    2. What food and drug allergies the patient has
    3. What medical conditions the patient has
- Patient (or guardian) has verbalized understanding of medication education

Northwest
Anesthesiology and
Pain Services, PA

CONSENT FOR PHOTOGRAPHY, VIDEO/AUDIO RECORDINGS AND/OR TO TELEVISE PATIENTS

(Images taken for the purposes of treatment, payment and/or health care operations)

Patient Name: _____
Last First M.I.

Date of Birth: _____

I consent to have my image taken by the staff of Northwest Anesthesiology & Pain Services, PA (NWAP) as described below:

I understand that my image, including photographs, digital images, video recordings, etc., will be recorded for the purpose of assisting in my care, documenting my treatment for payment reasons, and assisting in certain health care operations NWAP conducts including quality care initiatives.

For reasons other than treatment, payment, health care operations or education purposes as described above, I understand that NWAP will require me or my personal representative to sign a written authorization form in order to use or disclose my images.

I understand that NWAP will own these images, but I will be allowed to view them or obtain copies of them.

I certify this form has been fully explained to me. I have read it or have had it read to me, and I understand its contents. I agree to have my image taken by NWAP according to the conditions listed above.

_____ _____

Signature of the Patient or Personal Representative Date

Northwest Anesthesiology and Pain Service, PA
7010 Champion Plaza Dr, Suite 400
Houston, TX 77069
T (832) 698-5320
F (832) 698-5321

Northwest
Anesthesiology and
Pain Services, PA

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PHOTOGRAPHY, VIDEO/AUDIO RECORDINGS AND/OR TELEVISED SESSIONS OF PATIENTS

(Images to be used or disclosed for purposes other than treatment, payment and/or health care operations, such as, but limited to advertising or marketing)

Patient Name: _____
Last First M.I.

Date of Birth: _____

1. The following information can be used and/or disclosed: *(check all that apply and provide a description)*
   - ☐ Photographs _____
   - ☐ Video/Audio Recordings _____
   - ☐ Other: _____
2. I authorize Northwest Anesthesiology and Pain Service, PA (NWAP) to disclose the information (as described above) to:

Name:

_____

Address:

_____

City, State, Zip **Telephone Number:**

3. If this authorization is for any purpose other than the release of PHI for personal reasons, please state the purpose below:

_____

4. This authorization will expire on the 180th day of the signing or as otherwise specified below:

_____

5. I understand this authorization is voluntary and I may refuse to sign. NWAP may not withhold treatment based on the completion of this authorization.
6. The information to be used or disclosed pursuant to this authorization form may include information relating to: (1) Acquired immunodeficiency syndrome (AIDS) or (2) human immunodeficiency virus (HIV) infection, treatment for drug or alcohol abuse, or (3) mental or behavioral health or psychiatric care.

7. I understand that I may revoke this authorization at any time by notifying NWAP in writing to the following address: *7010 Champions Plaza Dr, Suite 400; Houston, TX 77069*, of my intent to revoke this authorization. I understand that such a revocation will not have any effect on any information already used or disclosed by NWAP before NWAP received my written notice of revocation.

8. If neither federal nor Texas privacy law apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Texas privacy laws.

_____ _____

Signature of the Patient or Personal Representative Date

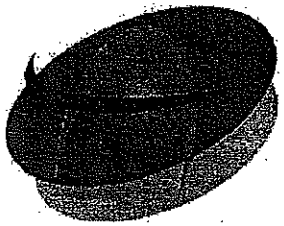
Northwest Anesthesiology and Pain Service, PA
7010 Champion Plaza Dr, Suite 400
Houston, TX 77069
T (832) 698-5320
F (832) 698-5321

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.



Northwest Anesthesiology and Pain Services, PA

Urine Toxicology Testing Protocol

- ***All*** visits which a controlled substance is indicated will require a Urine Drug ***Screen*** conducted and reviewed prior to prescribing.
- Urine Drug ***Confirmation*** will be conducted based on the results of the SOAPP-R Questionnaire, given on the initial visit and every 3 months after. The Confirmation will be reviewed with the patient at the next visit and guide the provider on future controlled substance prescriptions.
- Initial visit will have a Urine Drug Screen and Urine Drug Confirmation.
- Patients not taking opioids will be tested every 6 months, for quality assurance in treatment (including the initial visit).

SOAPP-R Results/Groups

Red

-Urine Confirmation
-Sent for confirmation on every visit
-Reviewed with patient at the following visit
-Documenting normal/abnormal results
-Conducted until SOAPP-R score re-categorizes patient into yellow or green groups

Yellow

-Urine Confirmation
-Sent for confirmation every 3 months
-Reviewed with patient at the following visit
-Documenting normal/abnormal results
-Conducted until SOAPP-R score re-categorizes patient into red or green groups

Green

-Urine Confirmation
-Sent for confirmation every 6 months
-Reviewed with the patient at the following visit
-Documenting the normal/abnormal results
-Conducted until SOAPP-R score re-categorizes patient into red or yellow groups

Patient Signature of Acceptance of protocols:_____ Date: _____

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?	O	O	O	O	O
2. How often have you felt a need for higher doses of medication to treat your pain?	O	O	O	O	O
3. How often have you felt impatient with your doctors?	O	O	O	O	O
4. How often have you felt that things are just too overwhelming that you can't handle them?	O	O	O	O	O
5. How often is there tension in the home?	O	O	O	O	O
6. How often have you counted pain pills to see how many are remaining?	O	O	O	O	O
7. How often have you been concerned that people will judge you for taking pain medication?	O	O	O	O	O
8. How often do you feel bored?	O	O	O	O	O
9. How often have you taken more pain medication than you were supposed to?	O	O	O	O	O
10. How often have you worried about being left alone?	O	O	O	O	O
11. How often have you felt a craving for medication?	O	O	O	O	O
12. How often have others expressed concern over your use of medication?	O	O	O	O	O

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The SOAPP®-R was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

PainEDU.org

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.

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The SOAPP®-R was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

PainEDU

Northwest
Anesthesiology and
Pain Services, PA

OFFICE AND FINANCIAL POLICIES

Initial:_____ **Insurance:** If a referral from your primary care physician is required for your visit, it is your responsibility to obtain it. As a courtesy, we will attempt to obtain it on your behalf, but failure to obtain the referral would require you to reschedule your appointment, unless you choose to be seen as a self-pay patient. If you confirmed your visit with our office and arrive with no referral, a rescheduling fee (also termed "No Show Fee") may be applied because your allocated time slot was confirmed with your acknowledgement of responsibility for obtaining a referral.

Initial:_____ **Forms Surcharge (at the discretion of your physician):**
Disabled Parking Applications, and Private Disability Insurance forms (No Charge).
$50.00: Family Medical Leave Act forms, Bad Check Fees, and Credit Card Deferment forms.
$150-300 (depending on complexity) for dictated letter describing medical care and limitations.

Initial:_____ **Check In and Financial Policy:** Please bring your insurance card and photo ID. You are required to notify our office when your insurance policy changes. Please be prepared to pay any co-payments or co-insurances or past due balances, which we will notify you through our online portal or communication with the billing company. In the event that your plan determines a service to be "not covered", you will be responsible for the entire charge.

Initial:_____ **No Shows, Late Cancellations, Procedural Cancellation and Late Arrivals:** We ask that you give us a courtesy call 24 hours in advance if you must cancel your office appointment. We will attempt to confirm your visit 24-48 hours prior to the visit. *No-showing for a confirmed appointment/procedure or canceling within the 24 hour period will result in a **$50 charge** to your account.* Arriving 15 mins past your arrival time may require a rescheduling of your appointment, so as not to inconvenience other patients. Over 30 mins late will automatically cancel your appointment for rescheduling. All late fees are subject to provider discretion.

Initial:_____ **Refill Requests:** Please allow 48 hours to process all prescription refill requests. Therefore, schedule a medication refill visit >48 hours to completion of prescribed controlled substances. Prescription refill requests will not be accepted after hours or on weekends. No exceptions.

Initial:_____ **Minors:** Guardian(s) accompanying patients that are minors are responsible for any financial responsibilities as well as providing current insurance information for the minor.

Initial:_____ **Medical Records:** Please note that Northwest Anesthesiology and Pain Services, PA has an active contract with HealthMark Group to fulfill all medical record requests. All urgent requests/copies of your medical records can be made available upon request at a normal **charge of $25.00** *for the first 20 pages and $0.50 per page thereafter.* A medical records release must be completed and submitted to request a copy of your records.

Initial:_____ **Office Based Procedures:** Office based procedure visits are not early medication refill visits and may require a copay. The medication refill visit will need to be scheduled on a separate visit date.

I have read, understand and agree to the above office and financial policies. I agree to be bound by its terms. I hereby attest that I have provided current and accurate demographic and insurance information. In addition, I authorize release of information necessary for insurance filing and precertification by signing this statement. I am herein authorizing payment of medical benefits to my provider when an assigned claim is filed.

Patient Name: _____ DOB: _____

Patient's Signature: _____ Date: _____

Northwest Anesthesiology and Pain Services, PA
7010 Champions Plaza Dr, Suite 400
Houston, TX 77069
T (832) 698-5320
F (832) 698-5321

Northwest
Anesthesiology and
Pain Services, PA

Billing Disputes and Health Insurance Coverage

Notice to All Patients:

Your insurance contract is an agreement between you and your insurance carrier. Your health insurance policy spells out your specific benefits and varies greatly from patient to patient. Payment decisions are made by your health insurer and are based on your specific benefits and may not be consistent with the medical recommendations of your Physician. We must always provide care that is consistent with your individual medical needs and consistent with the standard of care. In that regard we will recommend procedures and diagnostic testing consistent with the standard of care. You will receive a bill for all services performed by our physicians and our in-house toxicology laboratory. Our bills are consistent with usual and customary charges in the geographic area where the services are provided.

If a dispute arises between you and your health carrier, we will assist you in any disputes that may arise between you and your insurance carrier, but ultimately the dispute resolution is your responsibility. Our office complies with contractually regulated billing policies and procedures of your insurance carrier.

When you sign in and consent to care you understand that you may be responsible for payment of non-covered services. Should you have a balance due for which you are responsible, payment will be due once we receive notice from your insurer of your obligation.

Please read your Explanation of Benefits CAREFULLY.

If you have any questions regarding your billing statement, please contact our billing office by phone at 832-698-5320

_____ _____

Patient Printed Name Date

_____ _____

Patient Signature DOB

Northwest
Anesthesiology and
Pain Services, PA

Legal Assignment of Benefits and Designation of Authorized Representative

Patient Name: _____

DOB: _____

Social SecurityNumber: _____

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider group, as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand and agree that I am legally responsible for any and all actual total charges expressly authorized by me regardless of any applicable insurance or benefit payments. I hereby authorize the above-named provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement, or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named provider group, to the full extent permissible under the laws, including but not limited to, ERISA §502(a)(1)(B) and §502(a)(3), under any applicable employee group health plan(s), insurance policies or public policies, any benefit claim, liability or tort claim, chose in action, appropriate equitable relief, surcharge remedy or other right I may have to such group health plans, health insurance issuers or other insurer(s), with respect to any and all medical expenses legally incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the laws to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

Patient Signature Date

Northwest Anesthesiology and Pain Services, PA
7010 Champions Plaza Drive, Suite 400
Houston, TX 77069
T (832) 698-5320
F (832) 698-5321

Northwest
Anesthesiology and
Pain Services, PA

Code of Conduct

We are glad that you have chosen Northwest Anesthesiology and Pain Service, PA as your new pain management group. Our providers strive to improve your quality of life through medication management and interventional pain therapies.

Listed below are reasons our group may consider as grounds for patient termination from the practice. This are inclusive, but not limited to the following:

- ✓ Disruptive, uncooperative, or disrespectful behavior towards our staff either in-person or via telephone conversation (Please Note: this will include relatives and non-relatives of the patient)
- ✓ Repeated No Shows, Cancellations, and Late arrivals. Patients are required to provide notification to office staff 24-hours prior to the scheduled appointment of any reason they are not able to keep the original appointment date or time.
- ✓ Refusing to adhere to your provider's plan of care
- ✓ Violating your medication and controlled substances agreement.
- ✓ Failure to pay for services rendered. (Please Note: for any questions regarding outstanding balances, call the billing department at 832-698-5320 for assistance.)
- ✓ You, the patient, terminates the relationship with a provider of Northwest Anesthesiology and Pain Services, PA.

Message Regarding Social Media Reviews/Postings:

You have the right to publish reviews via social media (Facebook, Yelp, Google, etc...) regarding your experience with Northwest Anesthesiology and Pain Services. However, if a negative review is published before allowing us to rectify or resolve the situation, you grant us permission to review and/or request the negative comment to be removed from the site.

Violation of these policies may be considered for patient termination at your provider's discretion.

Printed Name: _____ Date: _____

Signature: _____

Northwest Anesthesiology and Pain Services,
PA 7010 Champions Plaza Drive, Suite 400
Houston, TX 77069
T (832) 698-5320
F (832) 698-5321

Northwest
Anesthesiology and
Pain Services, PA

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
Medical Records Release/Request Form

Patient Name: _____
(Last, First, Middle Initial) (Previous Name)

Address: _____
(Street or PO Box) (City/State) (Zip)

Date of Birth:_____ **Telephone:**_____ **Social Security#** xxx-xx-_____

Reason of Record Request:

□ Continuation of Care	□ Billing or Claims	□ Disability Determination	□ Other
□ Transferring Care	□ Insurance	□ School	_____
□ Personal Use	□ Legal Purposes	□ Employment	

I hereby authorize **Northwest Anesthesiology and Pain Services, PA** to **RELEASE MY HEALTH INFORMATION TO:**

_____
(Person or Organization)
_____
(Street Address or PO Box)
_____
(City, State, Zip)
_____ _____
(Telephone Number) (Fax Number)

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want released/disclosed. If all health information is to be released/disclosed, then check ONLY the first box.

□ Complete Medical Record - ALL	□ Operative Reports
□ Last 6 Months Records of Active Treatment	□ Psychological Records **SEE BELOW**
□ Office Visits (From_____to_____)	□ Physician Orders
□ Imaging Reports	□ Other (specify) _____
□ Lab Results	

YOUR INITIALS ARE REQUIRED TO RELEASE THE FOLLOWING:
_____ I do____(OR) do not____consent to release information relating to psychiatric or psychological testing or treatment, biofeedback training, alcohol/drug abuse and/or HIV testing/results, or such disclosure shall be limited to the following specific types of information: _____.

EFFECTIVE TIME PERIOD: This authorization expires within (6) months from the date signed. If you wish to have the authorization expire before (6) months, please indicate the date of expiration:_____.
RIGHT TO REVOKE: I understand that I can withdrawal my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named as the RECEIPENT of the medical records and to Houston Pain Specialists I understand that prior actions taken in reliance on the 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. It is further understood that the information is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization or person. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____ _____
(Signature of Patient or Legal Representative*) (Date)
**Legal Representative must submit copies of a legal document supporting assignment of this authority.*

Northwest Anesthesiology and Pain Services, PA 7010 Champions Plaza Drive, Suite 400 Houston, Texas 77069

Ph: (832) 698-5320 Fax: (832) 698-5321

Northwest
Anesthesiology and
Pain Services, PA

HIPAA DISCLOSURE:
PATIENT CONTACT & VERBAL RELEASE OF INFO CONSENTS

Patient Name (*print*): _____ DOB: _____

A) RELEASE OF PATIENT INFORMATION CONSENT
Consent to Verbally Release

I hereby give consent to release my personal health information either verbally or in writing to my family, friends, or others for purposes of obtaining treatment and/or for payment of medical services.

In that regard, Northwest Anesthesiology and Pain Services, PA, has my permission to release my confidential personal health information to the following family members, friends, or other individuals who are involved in my care:

Name	**Relationship to Patient**
_____	_____
_____	_____
_____	_____

I understand that I have the right to revoke this authorization, at any time by providing written notice to this office. The revocation will take place on the date of the written notice and cannot be applied to prior disclosures.

A) AUTHORIZATION TO COMMUNICATE/LEAVE MESSAGES

From time to time it may be necessary for representatives of Northwest Anesthesiology and Pain Services, PA to leave messages for patients on their home or cellular phone. The purpose of these messages may be to return patient calls, remind patients that they have an appointment, to notify patients that the medical staff would like to discuss lab or procedure results, or to ask a patient to call one of the clinics of Northwest Anesthesiology and Pain Services, PA regarding an issue or concern. At no time will a representative of Northwest Anesthesiology and Pain Services, PA discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with your household members, your answering machine and/or on your voicemail. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Initial: _____ Consent to leave message with HOUSEHOLD MEMBERS (at phone numbers you have provided in record)

Initial: _____ Consent to leave message on HOME ANSWERING MACHINE (to phone numbers you have provided in record)

Initial: _____ Consent to leave message on VOICEMAIL and/or TEXT MESSAGING/SMS (to phone numbers you have provided in record)

_____ _____
Patient Signature Date

Northwest Anesthesiology and Pain Service, PA
7010 Champion Plaza Dr, Suite 400
Houston, TX 77069
T (832) 698-5320
F (832) 698-5321

Northwest
Anesthesiology and
Pain Services, PA

MEDICAL RELEASE FORM

We would appreciate your cooperation as our mutual patient is scheduled to see a provider of Northwest Anesthesiology and Pain Services, PA (NWAP). We are requesting the following records for this appointment:

- ○ Last 2 office notes from primary care physician Dr._____.
  - ○ PH: _____ FAX: _____

- ○ Last 2 office notes from referring physician Dr._____.
  - ○ PH: _____ FAX: _____

- ○ Last 2 months of office notes from previous Pain Management doctor(s) seen in the last 2 years. Dr(s)._____.
  - ○ PH: _____ FAX: _____

- ○ *Release/Transfer of Care* Letter from the previous Pain Management Doctor for NWAP to take over medication/controlled substance management for Pain Management. If NWAP is handling Interventional Pain only, then a letter is not required.

- ○ Imaging reports from the last 2 years to include, if available, x-rays, MRI, CT or Myelogram. (This may be brought in on CD/Films but must be accompanied by *REPORT*)

I, _____ (DOB:_____), AUTHORIZE you to release the medical record information request above to Northwest Anesthesiology and Pain Services, PA. I understand that I may revoke this authorization at any time except to the extent that action has already been taken to comply with it.

_____ _____

Patient Signature Date

Northwest Anesthesiology and Pain Services, PA
7010 Champions Plaza Dr, Suite 400
Houston, TX 77069
T (832) 698-5320
F (832) 698-5321

NOTICE OF PRIVACY PRACTICES

(Effective: June 18, 2019)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

PLEASE REVIEW IT CAREFULLY.

Northwest Anesthesiology and Pain Services, PA

Our Responsibilities.

- We are required by law to maintain the privacy of your health care information (Protected Health Information – PHI) and to educate our personnel concerning privacy and confidentiality.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your health information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your health information except as described in this notice or if you tell us in writing that we can. You may change your mind at any time by sending us written notice. If you revoke your authorization, we will no longer use or disclose your PHI for the reasons covered by your written authorization.
- If your health information is electronically disclosed and your written authorization is required, a separate authorization will be needed for each request.
- This notice applies to all health care records created by and received at Northwest Anesthesiology and Pain Services, PA (NWA) and tells you about the ways in which we may use and disclose your PHI. This notice also describes your rights and certain obligations we have regarding the use and disclosure of your PHI.
- This notice applies to NWAP employees, contractors, students, volunteers and anyone doing business with NWAP.
- We do not create or manage a hospital directory.

Our Uses and Disclosure. Except as listed below, we will not use or disclose your health information without your written authorization.

1. **Typical Use and Disclosure of Your Health Information.** We usually use or share your information for treatment, payment and healthcare operations as defined in this Notice. NWAP shares information with its Affiliated Organizations which includes, but is not limited to, Advanced Revenue Management GP, LLC. This group of Affiliated Organizations may use and disclose your health information to provide treatment, payment, or health care operations for the Affiliated Organizations which include activities such as patient care, financial services, insurance, quality improvement, education and risk management.

- **Treatment.** We can use your health information and share it with other professionals who are treating you. For example, your physician may ask a pharmacist or referring physician about your current medications and/or care in order to treat you.
- **Payment.** We can use and share your health information to bill and get payment from health plans or other entities. For example, we give information about you to your health insurance plan so it will pay for your services.
- **Health Care Operations.** We can use and share your health information to run our practice, improve your care, train future health care professionals and contact you when necessary. For example, we use health information about you to manage your treatment and provide quality healthcare services.

We may disclose your health information to our business associates who provide services to us to help us carry out our treatment, payment or health care operations. For example, we may disclose your information to a consultant who is helping us improve patient care.

2. **Other Cases We Use and Disclose Your Health Information.** We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

- **Help with Public Health and Safety Issues.** We can share your health information for certain situations such as:

  √ Preventing disease
  √ Helping with product recalls
  √ Reporting adverse reactions to medications
  √ Reporting births or deaths or suspected abuse, neglect or domestic violence
  √ Preventing or reducing a serious threat to anyone's health. This includes notifying a person who may have been exposed to, or be at risk for, contracting or spreading a disease or condition to protect the public health.

- **Conducting Research.** We can use or share your information for health research subject to a special approval process that balances your need for privacy with the proposed research. This special approval process is not required when we

allow researchers preparing a research project to look at information about patients with specific medical needs so long as the information does not leave NWAP.

- **Comply with the Law.** We will share your information if state or federal laws require it, including with the Department of Health and Human Services if it wants to verify that we are complying with federal laws.
- **Respond to Organ and Tissue Donation Requests.** We can share your health information with organ procurement organizations.
- **Medical Examiners or Funeral Directors.** We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- **Workers' Compensation, Law Enforcement, and Other Government Requests.** We can use or share your health information:

√ For workers' compensation or similar programs that provide benefits for work-related injuries or illness.

√ For law enforcement purposes.

√ If you are a member of the armed forces, as required by military command authorities.

√ With health oversight agencies for activities authorized by law.

√ For special government functions such as intelligence, counterintelligence, and other national security activities authorized by law and presidential and foreign dignitary protective services.

- **Inmates.** We may release health information of inmates to the correctional institution or official under specific circumstances for care and safety purposes.
- **Health Oversight Activities.** We may disclose your health information to a health oversight agency for audits, investigations, inspections and licensure and other activities necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Respond to Lawsuits and Legal Actions.** We can share your health information in response to a court or administrative order, or in response to a subpoena or discovery request.

3. **Special Protections for Certain Information.** We will not disclose or provide any information about any substance abuse treatment, genetic information, HIV/AIDs status or mental health treatment unless you provide specific written authorization or we are otherwise required by law to disclose or provide the information.

Your Choices

1. **Your Right and Choice to Tell Us To.** We can share your information as described below. Please tell us if you have a preference on how we share your information in these situations.

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Provide you with appointment reminders

If you are not able to tell us your preference, for example, you are unconscious we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

2. **Other Limited Situations**

- **Treatment Alternative.** We may use and disclose your information to give you information about treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits, educational programs, or services that may be of interest to you.

3. **Cases Where We Never Share Your Information Unless You Give Us Written Authorization**

- Marketing purposes
- Sale of your health information

Your Rights. When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- **Get an Electronic or Paper Copy of Your Medical Record.**

√ You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. We may deny your request in certain limited circumstances; in such cases, we will notify you in writing and you may request that the denial be reviewed. Ask us how to do this.
√ We will provide a copy or a summary of your health information within 15 days of your request, provided all conditions related to release of records are met. We may charge a reasonable fee.

Ask Us to Amend Your Medical Record.

√ You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how.
√ If we agree with the request, we will make the correction and give it to those who need it and those you ask us to give it to. If we say "no" to your request we will tell you why in writing within 60 days.

Request Confidential Communications.

√ You can ask us to contact you in a specific way, such as calling your home or office phone, or sending mail to a different address. We will say "yes" to all reasonable requests.

Ask Us to Limit What We Share or Use

√ You can ask us not to use or share certain health information for treatment, payment or our operations. We can say "no" to your request. If we do agree, we will comply unless the information is needed to provide emergency treatment.

√ If you pay us for a service or health care item out of pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a List of Those With Whom We Have Shared Your Information

√ You can ask for a list (accounting) of the times we have shared your health information for six (6) years prior to the date you ask for it. This list will include whom we shared it with and why.
√ The first list you request within a twelve (12) month period is free, but we will charge a reasonable, cost- based fee if you ask for another list within twelve (12) months. You may choose to cancel your request before any costs are incurred.

Get a Copy of This Privacy Notice. You can ask for a copy of this Notice at any time, even if you have agreed to receive the notice electronically.

Choose Someone to Act for You.

√ If you have given someone medical power of attorney or if someone is your legal guardian with authority under state law, that person can exercise your rights and make choices about your health information when you are not capable of doing so.
√ We will make sure the person has this authority and can act for you before we take any action.

File a Complaint if You Feel Your Rights are Violated. You can file a complaint if you feel we have violated your privacy rights by contacting:

Northwest Anesthesiology and Pain Services, PA
Office of General Counsel
311 Holderrieth Blvd.
Tomball, Texas 77375
privacycompliance@nwapservices.com

Office for Civil Rights, U.S. Department of Health & Human Services

200 Independence Avenue, S.W.,
Washington, D.C. 20201
1.877.696.6775
or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/

We will not retaliate against you for filing a complaint.

Changes to the Terms of this Notice. We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request in our offices.

Thank you for choosing Northwest Anesthesiology and Pain, Services, PA

Non-Discrimination Statement. NWAP complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that Northwest Anesthesiology and Pain Services, PA, provided me with a written copy of their Notice of Privacy Practices. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

Print Patient Name _____ Patient DOB _____

Patient Signature _____ Date Signed _____

Northwest
Anesthesiology and
Pain Services, PA

PHYSICIAN OWNERSHIP, LAB NOTICE AND FINANCIAL DISCLOSURES

Patient Name: _____ DOB: _____

PATIENT DISCLOSURE:

To All New Patients:

During the course of your medical treatment with Northwest Anesthesiology and Pain Services, PA (hereinafter NWAP), Physicians of NWAP may refer you to a hospital, ambulatory surgery center, diagnostic facility, laboratory and/or implant a medical device in which they may have a pecuniary interest in the company that owns the aforementioned.

As a patient of NWAP you have a right to be treated by physicians and at facilities of your choosing. If you elect to be treated at facilities other than those to which you have been referred, this will in no way affect the quality of your healthcare. However, your treating physician may or may not be credentialed at the facilities of your choosing and thus require you to obtain a new treating physician.

As a patient of NWAP you have the right to request and you agree that you will request that NWAP refer you to different physician, hospital, ambulatory surgery center and/or diagnostic facility if you are unhappy with the initial referral.

You will receive a bill for all services performed by our physicians and our company's toxicology laboratory. Our bills are consistent with usual and customary charges in the geographic area where the services are provided and vary based on varying elements such as diagnosis addressed, type of testing required, complexity of decision making and associated work associated to the visit. Your insurance contract is an arrangement between you and your insurance carrier. When disputes occur between you and the insurance carrier, we will assist you in those disputes, but ultimately the dispute resolution is your responsibility. Our office complies with contractually regulated billing policies and procedures of your carrier, when applicable.

Patients are responsible for full payment of charges incurred during each appointment. Our staff collects payment based on the patient's insurance coverage and benefits. **All financial responsibility amounts quoted to patient are estimates and responsibility may change once insurance has processed and paid the patient's claim.**

If you assign the benefits from any insurance or third party to Northwest Anesthesiology and Pain Service, PA for medical services provided to you. NWAP has the right to decline or accept assignment of such benefits. If these benefits are not assigned to NWAP, you, the patient, agrees to forward to NWAP, upon receipt, any insurance or third-party payments received for services rendered to you.

_____ _____

Patient Signature Signature Date

Northwest Anesthesiology and Pain Service, PA
7010 Champion Plaza Dr, Suite 400
Houston, TX 77069
T (832) 698-5320
F (832) 698-5321