# 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.
Chandler Mann, MD * Leonard Trahan, MD
24018 Hwy. 59 North
Kingwood, TX 77339
Phone: 281-446-4878
Fax: 281-446-4664

# NEW PATIENT PAIN ASSESSMENT FORM

Patient Name: ______________________________ DOB: ______________ Age: ______

**Welcome to our office. Our goal is to provide you with the best possible medical care in a timely manner. Please help us by completing this questionnaire:**

***MEDICAL HISTORY (check all that apply):***

_____AIDS
_____Attention Deficit
_____Anemia
_____Anxiety
_____Asthma
_____Bleeding Disorder
_____Cancer: ____________
_____Cholesterol – **High/Low**
_____Chronic Back Pain
_____Congestive Heart Failure
_____Coronary Artery Disease
_____Depression
_____Diabetes
_____Diverticulitis
_____Emphysema
_____GI Bleed
_____Gout
_____Heart Attack
_____Hepatitis – **A / B / C**
_____High Blood Pressure
_____HIV
_____**Hyper/Hypo** Thyroid
_____Irregular Heart Beat
_____ Irritable Bowel Syndrome
_____Kidney Failure
_____Liver Problems
_____Lupus
_____Migraines
_____Neurological Disorder
_____Poor Circulation
_____Pulmonary Embolism
_____Reflux
_____Rheumatoid Arthritis
_____Seizures
_____Sexual Dysfunction
_____Skin Rash/Ulcers/Lesions
_____Sleep Apnea
_____Stroke
_____Meningitis
_____**OTHER** ____________
_____**NONE**

***SURGICAL HISTORY***

1. Have you had spinal surgeries? □ CERVICAL (Neck) □ THORACIC (Mid-Back) □ LUMBAR (Low Back)
   If so, what type? ______________________________
2. Have you had Facet/Epidural Steroid Injections? □ CERVICAL(Neck) □ THORACIC(Mid-Back) □ LUMBAR
   If so, last injection date? ______________________________
3. Do you have a **STENT, PACEMAKER, PORT** or any other **implantable device?** □ Yes □ No
   If so, what type? ______________________________

***ALL OTHER SURGERIES (check all that apply):***

_____Abdominal Surgery
_____Amputation
_____AV Fistula Creation
_____AV Graft
_____Aortic Valve Replacement
_____Appendectomy
_____Beast Surgery
_____Bronchoscopy
_____CABG
_____Carotid Endarterectomy
_____Carpal Tunnel
_____Cataract Extraction
_____Cholecystectomy
_____Colon Resection
_____Craniotomy
_____Gastric Bypass
_____Hemorrhoidectomy
_____Hip Replacement
_____Knee Arthroscopy
_____Knee Replacement
_____Kyphoplasty
_____Lumpectomy
_____Mastectomy
_____Mitral Valve Replacement
_____Nephrectomy Native
_____Para Thyroidectomy
_____Pneumonectomy
_____Prostatectomy
_____PTCA
_____RA-F Bypass
_____Rotator Cuff Repair
_____TURP+
_____TAH w/ BSO
_____Hysterectomy
_____Tonsillectomy
_____Tunneled Dialysis Catheter
_____UPPP
_____Vertebroplasty
_____**OTHER:** ____________

Anesthesia Problems: □ Yes □ No
Surgical Complications: □ Yes □ No
Post-OP Complications: □ Yes □ No

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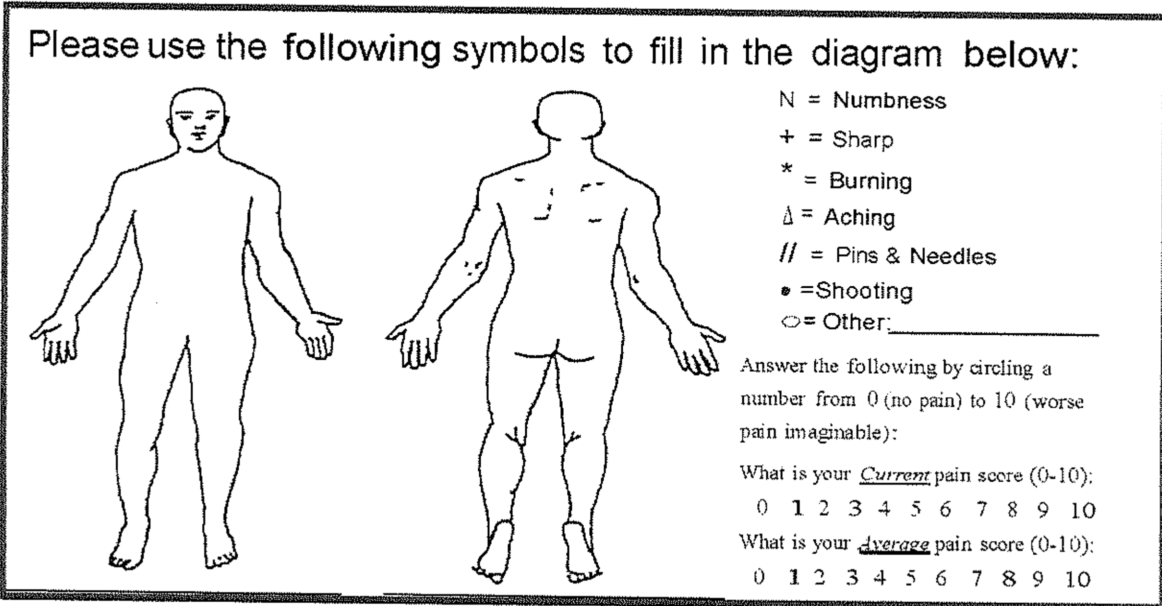
***FAMILY HISTORY (check all that apply):***

_____Alcoholism
_____Anemia
_____Angina
_____Arthritis
_____Anesthesia Complications
_____Anxiety
_____Asthma
_____Birth Defects
_____Blood Clots
_____Blood Transfusions
_____Bowel Disease
_____Cancer: ________________
_____Cholesterol **High/Low**
_____Depression
_____Diabetes
_____Growth Development
_____Headaches
_____Heart Disease
_____Hypertension
_____Liver Disease
_____Melanoma
_____Migraines
_____Osteoporosis
_____Psychiatric Care
_____Seizures
_____Severe Allergies
_____Stroke
_____Suicide Attempt
_____Thyroid Disease
_____Weight Disorder

***PAIN HISTORY:***

1. What is your chief complaint for todays visit? ____________________________________________
2. How did the problem begin?: □ WORK □ INJURY □ MOTOR VEHICLE ACCIDENT □ OTHER
   Brief explanation: ____________________________________________
3. How often do you have pain and how long does it last? ____________________________________________
4. Pain is worse WHEN I? ____________________________________________
5. Pain is better WHEN I? ____________________________________________
6. Difficulty sleeping? □ YES □ NO
7. Problems with daily activities (personal hygiene, house keeping, walking, grocery shopping, etc)? □ YES □ NO
8. On a scale of 0 to 10 (0=pain free and 10=very painful), pain level right now? __________
9. How would you describe your pain? □ Dull □ Aching □ Throbbing □ Sharp □ Burning
10. Please check below all that applies and write body part:
    □ Numbness - Where? ____________________________________________
    □ Tingling - Where? ____________________________________________
    □ Weakness - Where? ____________________________________________
    □ Coldness - Where? ____________________________________________
    □ Muscle Spasms/Cramps - Where? ____________________________________________
    □ Changes on Skin Color - Where? ____________________________________________

CURRENT PAIN DETAILS



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***PAIN TREATMENT HISTORY:***

1. First medical care date for current problem? ______
2. Please list the names of all doctors you have seen for **this** condition:
   - Doctor ______ Specialty______ Phone ______
   - Doctor ______ Specialty______ Phone ______
   - Doctor ______ Specialty______ Phone ______
   - Doctor ______ Specialty______ Phone ______
   - Doctor ______ Specialty______ Phone ______
3. What studies were done?
   □ EMG Physician: ______ Most recent date ______
   □ MRI Most recent date ______
   □ CT scan/Myelogram Most recent date ______
   □ X-RAY Most recent date ______
   □ DEXA SCAN Most recent date ______
4. Treatments performed:
   □ Physical Therapy (circle) US, Ten Unit, Massage, Core Strengthening
   □ Exercise Program Relief? ______
   □ Chiropractic Manipulation How long? ______
   □ Injections IN office ______ OutPatient Procedure ______
   □ Psychotherapy/Counseling Results ______
5. **Allergies** to medication? □ No □ Yes - Please List: ______
6. Allergies other than medications? □ No □ Yes - Please List: ______
7. Please list all of the medications including any over the counter medications, diet supplements, blood thinning medications (Asa, Ecotrin), all herbal (Mai huang, St John's wart), and NSAIDS (Motrin, Ibuprofen, Aleve) medications:

**PLEASE LIST ALL INFORMATION REQUESTED**

| Medication | Doseage | Frequency | Prescribing Physician |
|---|---|---|---|
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- Please be advised, if you have any heart conditions or if you are on Plavix, Coumadin,etc, we will require a written approval from your prescribing physician for discontinuation of these medications prior to scheduling any procedures.
- Please be advised, if you are a diabetic, your blood sugar may increase following steroid injections. Please also note that you need to monitor your blood sugar closely following procedures, and may need assistance at home for 24 hours after injections. Contact your prescribing physcian prior to your procedure for specific instructions.

8. Height ______ Weight ______
9. Have you been **prescribed or use any type of OXYGEN** in the past 12 months? If so, explain usage: ______
10. Have you ever seen a psychologist or psychiatrist? □ Yes □ No

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11. Do you smoke? □ Yes □ No How may cigarettes per day? ________
12. If you are a former smoker, when did you quit? ________
13. Do you drink alcohol? □ Yes □ No
14. Do you use recreational drugs? □ Yes □ No
15. Have you ever had a problem with substance abuse? □ Yes □ No
16. Are you currently working? □ Yes □ No If not, why? ________
17. Please, briefly describe your job duties: ________

Patient Name: ________ DOB: ________

***REVIEW OF SYSTEMS (check all that applyto you NOW)***

| GENERAL | EYES | EARS, NOSE, THROAT | CARDIOVASCULAR | RESPIRATORY |
|---|---|---|---|---|
| □ fever<br>□ chills<br>□ sweats<br>□ anorexia<br>□ fatigue / weakness<br>□ malaise (discomfort)<br>□ weight loss<br>□ weight gain<br>□ sleep disorder | □ blurring<br>□ diplopia (double vision)<br>□ irritation<br>□ discharge<br>□ vision loss<br>□ eye pain<br>□ photophobia | □ earache<br>□ ear discharge<br>□ tinnitus<br>□ decreased hearing<br>□ nasal congestion<br>□ nosebleeds<br>□ sore throat<br>□ hoarseness | □ chest pains<br>□ palpitations<br>□ syncope (fainting)<br>□ dyspnea on exertion (difficulty breathing)<br>□ orthopnea (difficulty breathing lying flat)<br>□ PND (Paroxysmal Nocturnal Dyspnoea)<br>□ peripheral edema | □ cough<br>□ dyspnea (difficulty breathing)<br>□ excessive sputum<br>□ hemoptysis (coughing up blood)<br>□ wheezing<br>□ pleurisy |

| GASTROINTESTINAL | GENITOURINARY | MUSCULOSKELETAL | DERM / SKIN | NEUROLOGICAL |
|---|---|---|---|---|
| □ nausea<br>□ vomiting<br>□ diarrhea<br>□ constipation<br>□ change in bowel habits<br>□ abdominal pain<br>□ melena (black, tarry stools)<br>□ hematochezia (vomiting of blood)<br>□ jaundice<br>□ gas / bloating<br>□ indigestion / heartburn<br>□ dysphagia (difficulty swallowing)<br>□ odynophagia (painful swallowing) | □ dysuria (painful urinating)<br>□ hematuria (blood in urine)<br>□ discharge<br>□ urinary frequency<br>□ urinary hesitancy<br>□ nocturia (excessive urination at night)<br>□ incontinence<br>□ genital sores<br>□ decreased libido<br>□ erectile dysfunction | □ back pain<br>□ neck pain<br>□ joint pain<br>□ joint swelling<br>□ muscle cramps<br>□ muscle weakness<br>□ stiffness<br>□ arthritis<br>□ sciatica<br>□ restless legs<br>□ leg pain at night<br>□ leg pain with exertion | □ rash<br>□ itching<br>□ dryness<br>□ suspicious lesions | □ paralysis<br>□ paresthesias (burning or prickling in hands, arms, legs, feet, etc)<br>□ seizures<br>□ tremors<br>□ vertigo<br>□ transient blindness<br>□ frequent falls<br>□ frequent headaches<br>□ difficulty walking |

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| PSYCHOLOGICAL | ENDOCRINE | HEMATOLOGICAL/LYMPHATIC | ALLERGY / IMMUN |
|---|---|---|---|
| □ depression<br>□ anxiety<br>□ memory loss<br>□ suicidal ideation<br>□ hallucinations<br>□ paranoia<br>□ phobia<br>□ confusion | □ cold intolerance<br>□ heat intolerance<br>□ polydipsia (excessive thirst)<br>□ polyphagia (excessive hunger)<br>□ polyuria (excessive amount of urine production)<br>□ unusual weight change | □ abnormal bruising<br>□ bleeding<br>□ enlarged lymph nodes | □ urticarial (hives)<br>□ allergic rash<br>□ hay fever<br>□ recurrent infections |

Northwest Anesthesiology and Pain Services, PA

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# 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, North Houston Pain Center, a provider for 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 Services, PA

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## 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
- ☐ Transferring Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other ______________

I hereby authorize ______________________________, to **RELEASE MY HEALTH INFORMATION TO:**

NORTH HOUSTON PAIN CENTER, LLC
(Person or Organization)
24018 HWY. 59 N.
(Street Address or PO Box)
KINGWOOD, TX 77339
(City, State, Zip)
(281) 446-4878
(Telephone Number)
(281) 446-4664
(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
- ☐ Last 6 Months Records of Active Treatment
- ☐ Office Visits (From__________to___________)
- ☐ Imaging Reports
- ☐ Lab Results
- ☐ Operative Reports
- ☐ Psychological Records **SEE BELOW**
- ☐ Physician Orders
- ☐ Other (specify) ______________________

**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 North Houston Pain Center 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.*

Patient Name: ______________________________ Date: ____/_____/______

***Please answer each question as honestly as possible by putting the corresponding number in the box to the right (ie, if "Seldom" write "1", if "Sometimes" write "2", etc). There are no right or wrong answers.***

| SCORE | COLOR | Initials of Reviewer |
|---|---|---|
| | | |

| SOAPP®-R | **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 your 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? | | | | | |
| 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? | | | | | |
| Has any relative had a problem with: **(Please circle Y/N for each item below)**<br>Alcohol: Y/N Addiction: Y/N Mental Illness: Y/N | | | | | |

| ***Green = less than 9*** | ***Yellow = 10-21*** | ***Red = 22 and over*** |
|---|---|---|

***Please include any additional information you wish about the above answers. Thank you.***

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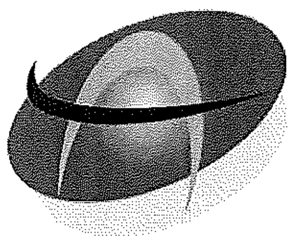
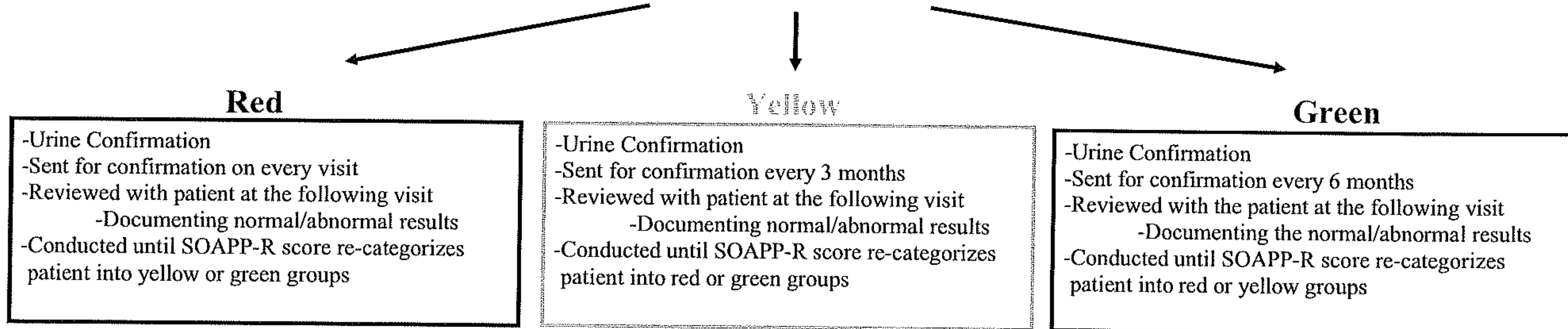


# Northwest Anesthesiology and Pain Services, PA

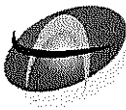
## Urine Toxicology Testing Protocol

- ***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**




Patient Signature of Acceptance of protocols:______________________________ Date: ____________



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# Code of Conduct

We are glad that you have chosen North Houston Pain Center as your new pain management provider. 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:

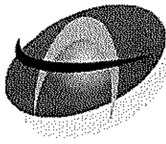
- ✓ Disruptive, uncooperative, or disrespectful behavior towards our staff either in-person or via telephone conversation ( Please Note: this will include relatives and non-relatives of the patient)
- ✓ Repeated No Shows, Cancellations, and Late arrivals. Patients are required to provide notification 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 North Houston Pain Center, 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, PA and North Houston Pain Center. 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

# Medication History Consent Form

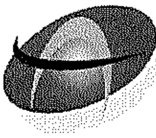
| Name: | DOB: | Date: |
|---|---|---|

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




## Legal Assignment of Benefits and Designation of Authorized Representative

Patient Name: ______________________________

DOB: ________________

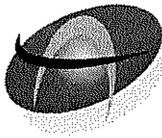
Social SecurityNumber: ________________________

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

# 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.

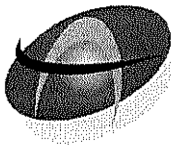
Initial:_____ **Medical Records**: Please note that Northwest Anesthesiology and Pain Services, PA has an active contract with HealthMark Group to fulfill all medical record requests. All urgent requests/copies of your medical records can be made available upon request at a normal **charge of $25.00** *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: ______________




**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

**North Houston Pain Center, LLC.**
Chandler Mann, MD * Leonard Trahan, MD
24018 Hwy. 59 North
Kingwood, TX 77339
Phone: 281-446-4878
Fax: 281-446-4664

## 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 North Houston Pain Center, a provider for 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

# 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: (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: ______________________________

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