Cy-Pain & Spine

☐**Dr. Baominh Vinh, MD.**
☐**Dr. Ian Lipski, MD.**
☐**Dr. Brian Bruel, MD.**

NEW PATIENT INFORMATION FORM

Last Name: _____ First Name: _____ MI: _____

Address: _____ City/State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Ethnicity/Race: _____

SSN: _____ Date of Birth: _____ Male ☐ Female ☐

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Referring Physician: _____ **Primary Care Physician:** _____

Marital Status: Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated ☐

Spouse's Name: _____ Date of Birth: _____

Spouse Employer: _____ Employer Phone: _____

_____ _____
Primary Insurance Carrier — Subscriber Name / DOB / SSN

_____ _____
Insurance ID # — Insurance Group #

_____ _____
Secondary Insurance Carrier — Subscriber Name / DOB / SSN

_____ _____
Insurance ID # — Insurance Group #

Note: We will bill your secondary insurance as a courtesy. If claims are not paid within 60 days the balance will be transferred to the patient responsibility.

Is your condition the result of a work related injury? _____ Date of Injury: _____
Is your condition the result of a MVA or any other accident?_____ Date of Injury:_____

My signature below indicates that I have been given the chance to read and review the following and understand and agree to their terms:

*Financial Policy, Consent for Treatment, and Release of Medical Information Form (see page 3)
*Notice of Privacy Practices at my discretion (located at front desk).

I agree that the above information is true and I authorize this information to be used to obtain financial reimbursement. Additionally, I authorize my attending physician to administer treatment and perform procedures as may be deemed necessary or advisable in my diagnosis. I further authorize the release of any medical information necessary to process my insurance claim and request payment of medical services to be assigned directly to my attending physician. In the event my insurance does not cover services rendered, I agree to be personally and fully responsible for payment. This authorization is to remain in full force unless I revoke the same in writing.

Patient's Signature: _____ Date: _____

Reviewed by: _____ Date: _____

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APPOINTMENT POLICY

The following outlines the rules of cancelling and/or not showing up for appointments without a 24 hour notice.

- If you are more than 15 minutes late to your appointment, you are subject to pay a $25 late fee and will be worked into the schedule. This is considered not showing up for your appointment. If you cannot pay the $25 late fee, you will be rescheduled. After 3 violations you could be subject to termination from the practice.

- There will be a fee accessed to your account should you not show up and/or cancel your new patient and/or follow up appointments of $50.00 per occurrence. After 3 violations you could be subject to termination from the practice.

- There will be a fee accessed to your account should you not show up and/or cancel your procedure of $50.00 per occurrence. After 3 violations you could be subject to termination from the practice.

These fees will be due immediately and are not eligible for payment arrangements. By signing this acknowledgement, you hereby agree that you have read the policy in full and agree to adhere to the policy.

_____
Patient Name

_____
Patient Signature

_____
Date

_____
Witness

9717 Jones Rd., Ste 108
Houston, TX
77065

1241 Campbell Rd.
Houston, TX 77055
(W) (713) 568-6095
(F) (713) 965-4091

9001 Forest Crossing Drive, Ste D
The Woodlands, TX
77381

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

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

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

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

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

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

EMAIL ADDRESS (Optional): _____

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

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

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name Cy-Pain & Spine PLLC
Address 9717 Jones Rd., Ste 108
City Houston State Texas Zip Code 77065
Phone (713)568-6095 **Fax** (713)965-4091

REASON FOR DISCLOSURE
(Choose only one option below)

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

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

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

Your initials are required to release the following information:

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

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

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

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

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

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

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

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

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

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

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

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

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

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

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

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

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

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

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

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

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

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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 (www.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 top 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 possibility as a result from taking these medication(s).

THE SPECIFIC MEDICATION(S)) THAT MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DISCRIBEDAND 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.

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.

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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, tolerance 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 in 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 of 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 the 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 pain 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.

_____ **Initial** **TEXAS MEDICAL BOARD - NOTICE CONCERNING COMPLAINTS:**
Complaints about physicians and other licensees and registrants of the Texas Medical Board, including physician assistants and acupuncturists, may be reported for investigation at the following address:

Texas Medical Board - Attention: Investigations
333 Guadalupe, Tower 3, Suite 610 P.O. Box 2018, MC-263
Austin, Texas 78768-2018

Assistance in filing a complaint is available by calling the following telephone number: **1-800-201-9353**

_____ **Initial** **TEXAS MEDICAL BOARD – AVISO SOBRE QUEJAS**

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Se pueden presentar quejas acerca de médicos, así también como de otras personas autorizadas y registradas por la Junta de Médicos del Estado de Texas (Texas Medical Board), incluyendo a ayudantes médicos y acupunturistas, para su investigación, en la siguiente dirección:

Texas Medical Board - Attention: Investigations
333 Guadalupe, Tower 3, Suite 610 P.O. Box 2018, MC-263
Austin, Texas 78768-2018

Se puede obtener ayuda para presentar una queja llamando al siguiente número telefónico: **1-800-201-9353**

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 laws, 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 mediation; 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 m y 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 an 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**

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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 psychiatric or 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.
- 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

_____
Physician Signature (or Appropriately Authorized Assistant)

_____

_____
Name and contact information of pharmacy

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Financial Policy, Consent for Treatment, Release of Medical Information

Thank you for trusting us with your health care.

PLEASE READ CAREFULLY

You and your insurance carrier are responsible for your bill.
Knowing your insurance benefits plan is your responsibility.

If you have medical insurance, we are grateful to assist you in receiving your maximum allowable benefits. In order to achieve these goals, we need your support and understanding of our financial policy.

- Insurance information must be presented and updated at the time of making your appointment, not at the time of service. Most insurance companies have requirements for authorization of services and/or referrals from the Primary Care Physician prior to the services. If you present for your appointment and you have not provided your correct insurance to ensure verification, authorization of services, and all required referrals, you will not be seen and your appointment will be rescheduled.

- _____(Initial) **Payment in Full for non-insurance services is expected at the time of service. Co-payments for services are <u>required</u> at the time of registration. Please be advised that we are contractually obligated by your insurance carrier to collect your co-payment at the time of service. If you arrive without the ability to pay for your services or your co-pay you will not be seen and your visit will be rescheduled.**

- If you have insurance, as a courtesy to you, we will file your primary and secondary insurance claim for services at no cost to you. However, we will not wait more than 45 days for the insurance to pay. After 45 days it is your responsibility to contact your insurance company and follow up on why your claim has not been paid. You must take the necessary action required to get your claim paid and communicate your actions to our office. Failure to assist our office in timely payment of your insurance claim will result in the total charges being transferred to patient liability. Any patient liability assigned to you by your insurance carrier will be billed to you. Once insurance has paid, payment in full of the patient assigned liability will be expected with the receipt of your statement. You will receive two billing statements regarding your balance. If we do not hear from you after these two statements, your account will be subject to our collection process unless prior arrangements are made with our financial office.

- _____(Initial)We are committed to providing the highest quality care for our patients and we charge what is usual and customary for our area. You are ultimately responsible for all clinic and surgery fees relating to your care. **You are responsible for payment regardless of your insurance company's arbitrary determination of usual and customary rates.** Your insurance policy is a contract between you and your insurance company. Any disagreement you have concerning the amount your insurance pays should be directed to your insurance company.

- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover or which they may consider medically unnecessary, and, in some instances, you will be responsible for these amounts. Your policy may also contain plan specific limitations that apply to referrals, referral dates and number of visits. We will make every effort to

ascertain your coverage for our services before treatment and will make you aware of our findings. However, this does not guarantee payment from your insurance carrier. The contract of coverage is between you and your insurance carrier and it is your responsibility to understand your coverage, coverage requirements and limitations due to the variations between policies. You will be expected to pay for the patient liability assigned to you by your insurance carrier.

- _____(Initial)For services that are not covered by insurance, the practice requires payment of 100% of the total **estimated charges** unless prior payment arrangements have been set up with our office.

- **Insured individuals electing to be self-pay**. The patient has the right to elect not to file their health insurance and elect to be a self-pay patient for services provided. The patient will be financially responsible for charges incurred and payment will be due at the time of service. After services have been rendered, the patient will not be able to file their health insurance for the services due to insurance claim submission requirements. We will not file insurance for any services where the patient elected to be self-pay. The patient's election to not file the services to their insurance company does not affect or reduce any out of pocket financial responsibility for future services as determined by their insurance plan.

- _____(Initial)**If you do not have insurance coverage for the service, are self-pay, or have insurance that we do not participate in or accept**, payment is expected at the time of service. We have established a discounted self-pay rate for our services. Prior financial arrangements must be made and approved before your visit if you cannot pay 100% at the time of service.

  No discount of assigned insurance patient liability (co-pay, deductibles, co-insurance) will be made to comply with federal insurance regulations and law.

  If financial arrangements have not been made and you arrive without the ability to pay for the services you will not be seen and your visit will be rescheduled.

- _____(Initial)Out of Network Insurance – Some insurance plans require you to pay different out-of-pocket amounts based on the provider and/or location where the service is performed. Deductibles, co-insurance and co- payments may also apply according to your insurance plan. By law, you are responsible for these amounts, as well as any non-covered services outlined in your health plan. It is your responsibility to inquire about any plan specific coverage limitations with your insurance company. You can choose to have the services performed as "Out of Network" or as self pay. You may also apply for financial hardship review if the "Out of Network" patient liability exceeds your ability to pay.

- Insurance information provided after the services have been provided will be billed or not billed at our discretion. Due to the Insurance contractual requirements for referrals, authorization of services and timely filing limitations insurance must be presented prior to services being provided. If we agree to bill your insurance you will be held liable for the charges if the insurance denies your claim as untimely because of late presentation of coverage or for lack of timely authorizations or referrals.

- Patients who request payment arrangements and/or financial hardship adjustments are required to supply financial documentation to support their request. Financial documentation will include income and expenses as outlined on our financial assistance application. Failure to supply the required documentation will result in normal collection activity being adhered to.

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☐**Dr. Ian Lipski, MD.**
☐**Dr. Brian Bruel, MD.**

- In the event your account/s must be turned over for outside collections, you will be billed and are responsible for all fees involved in the collection process. Returned checks are subject to a handling fee of $30.00.

  In the event you have an account with a credit balance, we reserve the right to transfer credits to any other outstanding account balances prior to issuing a refund.

- Patients with a history of presenting for their appointment without the ability to pay their co-pay, short notice (less than 24 hours) cancelling of appointment or not showing up for their appointments will be subject to be reviewed for dismissal from our practice.

- There is a charge of $25.00 per page to complete FMLA paperwork, forms for disability claims, accident or injury claims, attorney verification of medical condition or any other non-medical services reimbursement paperwork. Payment must be made at the time the forms are complete. Some third party forms requests must be paid for prior to the forms being completed.

We realize that temporary financial problems do occur. If such problems do arise, we encourage you to contact us promptly for assistance. If you have any questions about the above information, or any uncertainty regarding your insurance coverage, PLEASE do not hesitate to ask us.

<u>Authorization:</u> I hereby authorize my attending physician to administer treatment, diagnostic testing and perform procedures as may be deemed necessary or advisable in my diagnosis. I further authorize the release of any medical information necessary to process my insurance claim and request payment of medical services to be assigned directly to my attending physician In the event my insurance makes payment directly to me for services I will immediately endorse and assign the payment to my attending physician If my insurance does not cover services rendered, I agree to be personally and fully responsible for payment. I give my attending physician permission to appeal any denials by my insurance for services rendered on my behalf. I will assist my attending physician with follow up of timely payment, requests for information and appeals to my insurance as necessary to ensure full and timely payment for services received.

I have read the Financial Policy, Consent for Treatment, Release of Medical Information, policy and understand and agree to its terms. This authorization is to remain in full force unless I revoke the same in writing.

(Patient/Responsible Party) Signature	(Patient/Responsible Party) Printed Name
(Date)	(Date)

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☐Dr. Ian Lipski, MD.
☐Dr. Brian Bruel, MD.

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

Patient Name: _____For Physicians: Baominh Vinh, MD/Thuan Dao, MD/Ian Lipski, MD/Brian Bruel, MD

Patient Plan In-Network:_____Diagnosis:_____

Treatment: _____

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

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

Compliance & Disclosure under Texas Occupations Code –Section 102.006

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

Facility with affiliation &remuneration:
Steeplechase NW Houston Medical Center, Woodlands Way Medical Center, North West Houston Medical Center, Complete Surgery Houston Northwest, Surgical Center of Woodlands.
Any other physicians or Providers contracted by or affiliated with these providers/entities.
Any other Physician Owned Entity that may have been referred to by these providers/entities.

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

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

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

_____ _____ _____

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

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☐**Dr. Baominh Vinh, MD.**
☐**Dr. Ian Lipski, MD.**
☐**Dr. Brian Bruel, MD.**

Member Advance Notice Form for the Involvement of a Non-Participating Provider

Your physician or other health care professional has decided to involve a non-participating physician, facility or other provider in your care. In order to assist you in making informed decisions regarding your health care, we ask that you sign this form to indicate you have had a discussion with your physician or other health care professional about your option to utilize a participating provider and you have agreed to receive services from a non-participating provider despite potential increased out-of-pocket costs associated with that decision.

Please note that if you have out-of-network benefits under the terms of your benefit plan, you may utilize those benefits to receive services from a non-participating provider. However, it is important you understand that you may have higher out-of-pocket costs when using a non-participating provider based on your benefit plan. Please also note that if you do not have out-of-network benefits under the terms of your benefit plan and you receive services from a nonparticipating provider, you may be responsible for the entire cost of the services. If you have questions or would like to find a participating provider that can perform the services you require, please ask your physician or other health care professional to arrange for the use of a participating provider. You can confirm the participation status of providers by contacting your insurance plan at the telephone number on the back of your health plan ID card. You may also log on to most insurance websites to search the online provider directory for a participating provider in your area.

To be completed by the member's physician or other health care professional:

Member Name: _____**Member ID #:**_____

Physician Name and Tax ID#: Baominh Vinh MD (TIN# 473637120),
Physician Name and Tax ID#: Ian Lipski MD (TIN# 473637120),
Physician Name and Tax ID#: Brian Bruel MD (TIN# 473637120),

Non-Participating Physician/Facility Name: *Steeplechase NW Houston Medical Center, Woodlands Way Medical Center, North West Houston Medical Center, Complete Surgery Houston Northwest, Surgical Center of Woodlands.*

Type of Service Non-Participating Provider to Render: Pain Management Injection/Services, SCS/DCS Trials
Reason Involving Non-Participating Provider: Proximity, provider reputation, patient convenience, care quality

To be completed by the member or the member's legal guardian:

I am aware that the physician, facility or other health care provider listed above will be involved in my care on the date of service listed above and I understand that this health care provider is not a participating provider in my insurance network. I was provided and declined the opportunity to select a participating provider to provide the health care services indicated above and am voluntarily choosing to obtain services from a non-participating provider. I am aware that I may be responsible for any additional costs resulting from my use of a non-participating provider, if provided in my benefit plan. I understand that non-participating providers are generally prohibited from waiving member cost share amounts such as copayments, deductibles, coinsurance.

_____

Signature of Memberor Legal Guardian **Printed Name of Member**

_____

Date **Telephone Number**

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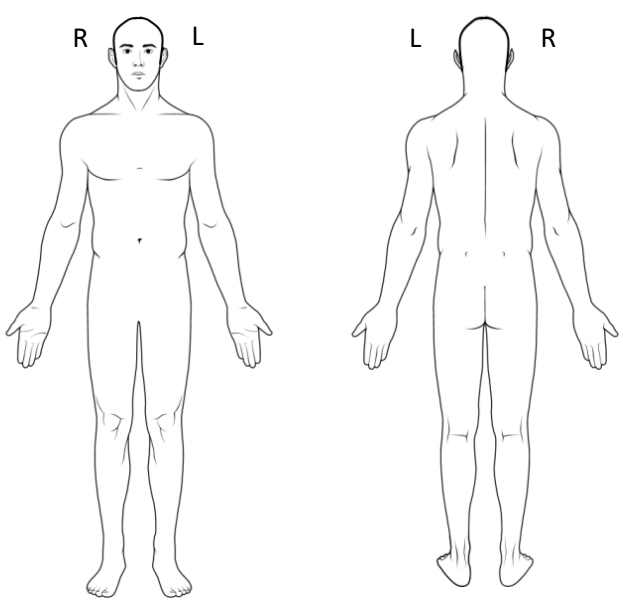
Patient Name:_____ DOB: _____ Today's Date: _____

Reason for Visit: _____



PAIN SCALE 10

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

FOR OFFICE USE ONLY

BP_____ P _____ □ RX □ PV

WT _____ Last U/A_____ + / -

Last Procedure _____

MACRA

C/M _____ TOB + / - DEP + / -

ALC + / - P/A + / - BMI + / -

HBP + / -

MA INT_____

Was your last visit here for a procedure or injection? ☐YES ☐NO % Improvement: ____

Any new developments in your health since your last office visit? ☐YES ☐NO

If YES, please list: _____

Any new medications started since your last visit? ☐YES ☐NO

If YES, please list: _____

Any problems with your current medications? ☐YES ☐NO

If YES, please list: _____

List Medication(s) Requested to be Refilled: _____

Have you designated a Power of Attorney or DNR? yes/no

The pain is currently located in the _____. The pain that is worse is in the _____. It is described as _____and has affected daily chores, socializing with friends, recreation, and physical exercise. The pain is better with _____ and worse with _____

Please answer ***YES*** or ***NO*** to the following questions. If ***YES*** to one of the following complete questionnaire on back. If ***NO*** to both skip questionnaire and continue to next questions.

Over the past 2 weeks, how often have you been bothered by any of these problems?

1. Little interest or pleasure in doing things _____
2. Feeling down, depressed or hopeless _____

Turn Page Over

.

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1) Little interest or pleasure in doing things	○	○	○	○
2) Feeling down, depressed, or hopeless	○	○	○	○
3) Trouble falling or staying asleep, or sleeping too much	○	○	○	○
4) Feeling tired or having little energy	○	○	○	○
5) Poor appetite or overeating	○	○	○	○
6) Feeling bad about yourself or that you are a failure, or have let yourself or your family down	○	○	○	○
7) Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
8) Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	○	○	○	○
9) Thoughts that you would be better off dead or of hurting yourself in some way	○	○	○	○

Do you have a bowel movement every day or every other day?

How have your bowels changed since starting you pain medications?

Please list any over the counter medications/remedies you are currently taking for constipation:

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☐**Dr. Baominh Vinh, MD.**
☐**Dr. Ian Lipski, MD.**
☐**Dr. Brian Bruel, MD.**

Patient Name: _____ Date: _____

MEDICATIONS:

Please indicate which (if any) of the following **BLOOD THINNERS** you are taking?

☐Aggrenox ☐ Aspirin ☐Coumadin ☐Effient ☐Eliquis ☐Lovenox

☐Plavix ☐Pletal ☐Pradaxa ☐Ticlid ☐Xarelto ☐Warfarin

Other: _____

Please list ALL medications you are currently taking. Attach an additional sheet, if required.

Medication Name, Dose, Frequency

For Office Use Only:

VITALS:

B/P:_____ **Pulse:** _____ **Height:** _____ **Weight:** _____

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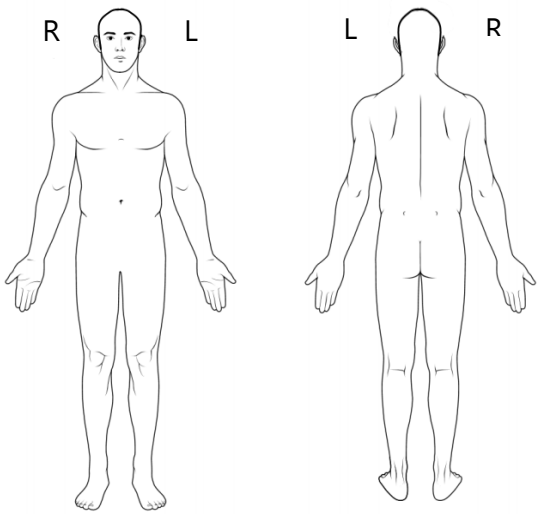
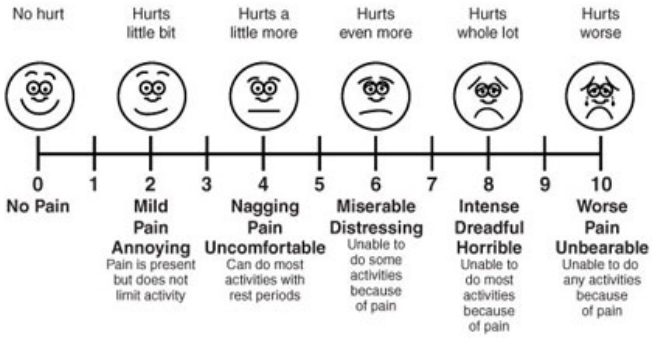
☐**Dr. Ian Lipski, MD.**
☐**Dr. Brian Bruel, MD.**

Patient Name: _____DOB: _____ Today's Date: _____
PCP: _____Were you referred by another physician?_____

If not, how did you hear about us?_____



Mark on the diagram above where your pain is located.



Please use the diagram above to specify your areas of pain

What number on the scale **(0-10)…**
…best describes your pain **right now**? _____
…best describes your **worst pain**?_____
…best describes your **least pain?** _____

PAIN DESCRIPTION

Where is your WORST area of pain located? _____

Does your pain radiate? ` yes/no ` so, where to? _____

Do you have any additional areas of pain? yes/no If so, where?_____

The Pain began?_____ (DAYS / WEEKS / MONTHS / YEARS)

How did it begin: GRADUALLY / SUDDENLY

Since your pain began, has it (DECREASED / INCREASED / REMAINED THE SAME)

Is this from a prior injury? yes/no What is the date of injury ___/___/_____ Motor vehicle accident / work related / sports / slip or fall motor vehicle accident

***Describe your pain…Circle all that apply*:**

☐Aching ☐Cramping ☐Hot/Burning ☐Tiring/Exhausting ☐Dull ☐Shock-like ☐Shooting ☐Spasms ☐Squeezing ☐Throbbing ☐Numbness

☐Swelling ☐Stabbing/Sharp ☐Clicking/Locking ☐Popping ☐Pain at rest/Pain at Night ☐Pain with Activities ☐Soreness

Tingling/Pins & Needles OTHER:_____

What word best describes your frequency of pain? (CONSTANT / INTERMITTENT)

When is your pain at its worse? (MORNING / DAY / EVENINGS / MIDDLE OF NIGHT)

Circle all of the following activities that are adversely/negatively affected by pain:

☐Enjoyment of Life ☐Ability to work Normally ☐Worsened sleep ☐General Activity ☐Recreational Activities ☐Worsened mood ☐Walking

☐Relationships with People ☐Ability to walk normally

In the past three months have you developed any of the following…Circle all that apply:

☐Bladder problems ☐Bladder incontinence ☐Bowel incontinence ☐Chills ☐Difficulty walking ☐Fevers ☐Nausea ☐Vomiting

☐Numbness/Tingling – Where? _____ ☐Weakness – Where? _____

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☐Dr. Brian Bruel, MD.

***The Pain is Improved By…*Circle all that apply:**

☐Acupuncture ☐Biofeedback ☐Chiropractic ☐Massage ☐Physical Therapy ☐Psychological Therapy ☐TENS Unit ☐Joint Injections
☐Epidural Steroid Injections ☐Podiatrist Treatment ☐Ice ☐Heat ☐Rest ☐Elevation ☐Muscle Relaxers ☐Assistive Device
☐Immobilization ☐NSAIDS ☐Steroid Injections ☐Home Exercises ☐Hypnosis ☐Trigger Point Injections ☐Medical Branch Blocks
☐Nerve Blocks ☐Radiofrequency Ablation ☐Spinal Cord Stimulator ☐Spine Surgery ☐Vertebroplasty/Kyphoplasty

***Symptoms worsen when…Circle all that apply*:**

☐Weight bearing☐Standing ☐Driving ☐Squatting ☐Kneeling ☐Sitting ☐Bending ☐Climbing ☐Twisting☐Lying Supine ☐Moving ☐Walking
☐Engaging in activities ☐Lifting ☐OTHER:_____

PREVIOUS STUDIES

Diagnostic Test/Imaging

☐ MRI of the _____ Date/Location: _____
☐ X-RAY of the _____ Date/Location: _____
☐ CT SCAN of the _____ Date/Location: _____
☐ EMG/NCV of the _____ Date/Location: _____
☐ ULTRASOUND of the _____ Date/Location: _____
☐ OTHER: _____
☐ I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS.

Pain Treatment History

☐ Chiropractic ☐ Physical Therapy ☐ Psychological Therapy ☐ Podiatrist Treatment
☐ Discogram – Cervical / Thoracic / Lumbar
☐ Epidural Steroid Injection – Cervical / Thoracic / Lumbar
☐ Joint Injection – Joint(s) _____
☐ Medical Branch Blocks/Facet Injections – Cervical / Thoracic / Lumbar
☐ Nerve Blocks – Area/Nerve(s) _____
☐ Radiofrequency Ablation – Cervical / Thoracic / Lumbar
☐ Spinal Column Stimulator – Trial / Permanent Implant
☐ Spine Surgery
☐ Trigger Point Injections – Where? _____
☐ Vertebroplasty / Kyphoplasty – Level(s) _____
☐ Others: _____
☐ I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS

Medications you have tried for your pain: ***Write on back of page for more***

MEDICATION NAME	WHO PRESCRIBED/OTC	DATES USED	Effective/Not Effective

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ANESTHESIA HISTORY

Have you ever had anesthesia (sedation for a surgical procedure)? yes/no
If so, have you ever had any adverse reaction to anesthesia? yes/no

Which type of anesthesia did you react adversely to? Please circle all that apply.

☐LOCAL ANESTHESIA ☐EPIDURAL ☐GENERAL ANESTHESIA ☐IV SEDATION

PAST MEDICAL HISTORY

Please circle all that apply:

MUSCULOSKELETAL
☐Amputation ☐Rheumatoid Arthritis
☐Carpal Tunnel Syndrome ☐Bursitis
☐Fibromyalgia ☐Tennis Elbow Lupus
☐Chronic Low Back Pain ☐Osteoporosis
☐Chronic Joint Pain ☐Phantom Limb Pain
☐Chronic Neck Pain ☐Osteoarthritis
☐Vertebral Compression Fracture

HEAD/EYES/NOSE/THROAT
☐Headaches ☐Head Injury
☐Thyroid Disease ☐Migraines
☐Glaucoma

GENERAL
☐Cancer
☐Diabetes
☐HIV/AIDS

LIVER
☐Hepatitis A
☐Hepatitis B
☐Hepatitis C

GENITOURINARY/NEPHROLOGY
☐Bladder Infection ☐Dialysis
☐Kidney Infection ☐Kidney Stone
☐ ☐Urinary Incontinence

RESPIRATORY ☐Mitral Valve Prolapse
☐Bronchitis ☐Pneumonia ☐Asthma
☐Exposure to Mold ☐Emphysema/COPD
☐Tuberculosis

CARDIOVASCULAR/HEMATOLOGIC
☐Anemia ☐High Cholesterol ☐Stroke
☐Bleeding Disorder ☐High Blood Pressure
☐Heart Attack ☐Paralysis
☐Coronary Artery Disease ☐Murmur
☐Phlebitis ☐Pacemaker/Defibrillator
☐Poor Circulation

NEUROPSYCHOLOGICAL
☐Alcohol Abuse ☐Alzheimer Disease
☐Epilepsy ☐Multiple Sclerosis
☐Peripheral Neuropathy
☐Schizophrenia ☐Seizures ☐Bipolar
☐Prescription Drug Abuse ☐Depression

GASTROINTESTIONAL
☐Bowel Incontinence ☐Constipation
☐Acid reflux ☐Gastrointestinal Bleeding

Over the past 2 weeks, how often have you been bothered by the following problems?

(0) Not at all (1) Several days (2) More than half the days (3) Nearly every day

1. Little interest or pleasure in doing things? _____
2. Feeling down, depressed or hopeless? _____

ALLERGIES

Medication Name:	Reaction:	Allergy or Side Effect:

Write on back of page for more

PAST SURGICAL HISTORY

Surgery	Date	Performed by Who:

Write on back of page for more

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☐Dr. Ian Lipski, MD.
☐Dr. Brian Bruel, MD.

FAMILY HISTORY

Circle all appropriate diagnosis as they pertain to your biological mother & father ONLY

☐ Please ***check*** if you have no significant family medical history. Were you adopted? yes/no

MOTHER / FATHER	Alcohol Problems	MOTHER / FATHER	Headache
MOTHER / FATHER	Gambling Problems	MOTHER / FATHER	Heart Disease
MOTHER / FATHER	Diabetes	MOTHER / FATHER	Liver Disease
MOTHER / FATHER	Drug Problems	MOTHER / FATHER	High Blood Pressure
MOTHER / FATHER	Kidney Disease	MOTHER / FATHER	Smoking
MOTHER / FATHER	Rheumatoid Arthritis	MOTHER / FATHER	Cancer
MOTHER / FATHER	Stroke		

SOCIAL HISTORY

Are you capable of becoming pregnant? yes/no

If so, are you currently pregnant? yes/no

What is your occupation? _____

Are you currently working? yes/no

Circle all that apply below.

ALCOHOL USE
- ☐Current Alcoholism
- ☐History of Alcoholism
- ☐Social Alcohol Use
- ☐Never Drinks Alcohol
- ☐Daily limited Alcohol Use

TOBACCO USE
- ☐Current tobacco user
- ☐Former tobacco user
- ☐Never used tobacco
- ☐Chewing Tobacco
- ☐E-Cigarette/Vape

ILLICIT DRUG USE
- ☐Denies any illicit drug use
- ☐Currently using illicit drugs

Please list all illicit drugs: _____

Have you formerly used illicit drugs? yes/no If so, please list which. _____

Have you ever abused narcotic or prescription medications? yes/no

Are you recovering from drugs, alcohol, or any addiction? yes/no

REVIEW OF SYSTEMS

Circle the following symptoms that you currently suffer from.
Note: Diagnosed conditions/diseases should be noted under past medical history section.

CONSTITUTIONAL
☐Weakness ☐Weight gain
☐Fatigue ☐Weight loss
☐Night Sweats

EYES
☐Recent vision changes
☐Eye glasses/contacts

EARS/NOSE/THROAT
☐Dental Problems ☐Ringing in ears
☐Earaches ☐Sinus Problems
☐Nosebleeds Recurrent sore throat

GASTROINTESTINAL
☐Acid Reflux ☐Abdominal cramps
☐Constipation ☐Diarrhea
☐Vomiting ☐Dark & tarry stools
☐Coffee ground appearance in vomit

CARDIOVASCULAR
☐Chest Pain ☐Blood clots
☐Murmur ☐Irregular Heartbeat
☐Rapid Heartbeat ☐Palpitations
☐Swollen Extremities ☐Fainting

RESPIRATORY
☐Cough ☐Wheezing
☐Shortness of breath on exertion/effort
☐Shortness of breath at rest

PSYCHIATRIC
☐Depressed mood ☐Stress
☐Anxiety ☐Suicidal thoughts

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GENITOURINARY/NEPHROLOGY

☐Blood in urine ☐Low frequency/volume
☐Painful urination ☐Incontinence
☐Erectile dysfunction ☐Decreased urine
☐Flank pain

INTEGUMENTARY/SKIN

☐Change in skin color ☐Pruritus
☐Dry skin Rashes

MUSCULOSKELETAL

☐Joint swelling ☐Joint pain
☐Muscle spasms ☐Back pain
☐Neck pain ☐Pelvic pain
☐Joint Stiffness

ENDOCRINE

☐Heat intolerant ☐Cold intolerant
☐Hair changes ☐Excessive thirst

NEUROLOGICAL

☐Dizziness ☐Seizures
☐Headaches ☐Memory loss
☐Numbness/tingling ☐Difficulty with speech
☐Incoordination

HEMATOLOGIC/LYMPHATIC

☐Easy bruising ☐Easy bleeding
☐Slow healing wounds
☐Lymphadenopathy

ALLERGIC/IMMUNOLOGIC

☐Recurrent infections
☐Hives
☐Swelling
☐Itching eye/nose

PATIENT CARE TEAM

DOCTOR	NAME	PHONE	FAX
PCP/Family Care			
Cardiologist			
Neurologist			
Orthopedic Surgeon			
Imaging Center			

Do you have a Medical Power of Attorney or DNR? yes/no

Name: -

_____

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❑Dr. Baominh Vinh, MD.
❑Dr. Ian Lipski, MD.
❑Dr. Brian Bruel, MD.

Patient Name: _____ Date: _____

Modified Oswestry Pain Questionnaire

This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by marking in each section **one circle** that most applies to you. We realize that you may feel that more than one statement may relate to you, but please **just mark the circle that most closely describes your problem**.

Section 1 – Pain Intensity

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is severe.
- The pain is severe and does not vary much.

Section 2 – Personal Care

- I do not have to change my way of washing or dressing to avoid pain.
- I do not normally change my way of washing or dressing even though it causes me pain.
- Washing and dressing increase the pain, but I manage not to change my way of doing it.
- Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Because of the pain I am unable to do some washing and dressing without help.
- Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting (skip if you have not attempted lifting since the onset of your low back pain)

- I can lift heavy weights without extra low back pain.
- I can lift heavy weights but it causes extra pain.
- Pain prevents me lifting heavy weights off the floor.
- Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- I can only lift light weights at the most.

Section 4 - Walking

- I have no pain walking.
- I have some pain on walking, but I can still walk my required to normal distances.
- Pain prevents me from walking long distances.
- Pain prevents me from walking even short distances.
- Pain prevents me from walking at all.

Section 5 - Sitting

- Sitting does not cause me any pain.
- I can sit as long as I need provided I have my choice of sitting surfaces.
- Pain prevents me from sitting more than 1 hour.
- Pain prevents me from sitting more than ½ hour.
- Pain prevents me from sitting more than 10 minutes.
- Pain prevents me from sitting at all.

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☐Dr. Brian Bruel, MD.

Section 6 - Standing

- I can stand as long as I want without pain.
- I have some pain while standing, but it does not increase with time.
- I cannot stand for longer than 1 hour without increasing pain.
- I cannot stand for longer than ½ hour without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain immediately.

Section 7 - Sleeping

- I have no pain while in bed.
- I have pain in bed, but it does not prevent me from sleeping well.
- Because of pain I sleep only ¾ of normal time.
- Because of pain I sleep only ½ of normal time.
- Because of pain I sleep only ¼ of normal time.
- Pain prevents me from sleeping at all.

Section 8 – Social Life

- My social life is normal and gives me no pain.
- My social life is normal, but increases the degree of pain.
- Pain prevents me from participating in more energetic activities e.g. sports, dancing.
- Pain prevents me from going out very often.
- Pain has restricted my social life to my home.
- I hardly have any social life because of pain.

Section 9 - Traveling

- I get no pain while traveling
- I get some pain while traveling, but none of my usual forms of travel make it any worse.
- I get some pain while traveling, but it does not compel me to seek alternative forms of travel.
- I get extra pain while traveling that requires me to seek alternative forms of travel.
- Pain restricts all forms of travel.
- Pain prevents all forms of travel except that done lying down.

Section 10 – Employment / Homemaking

- My normal job/homemaking duties do not cause pain.
- My normal job/homemaking duties cause me extra pain, but I can still perform all that is required of me.
- I can perform most of my job/homemaking duties, but pain prevents me from performing more physically
- stressful activities e.g. lifting, vacuuming, etc.
- Pain prevents me from doing anything but light duties.
- Pain prevents me from doing even light duties.
- Pain prevents me from performing any job or homemaking chores.

SCORE _____

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TOTAL: _____

Name: _____ **Date:** _____

The following are some questions given to all patients 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.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1.	How often do you have mood swings?	0 1 2 3 4
2.	How often do you smoke a cigarette within an hour after you wake up?	0 1 2 3 4
3.	How often have you taken medication other than the way that it was prescribed?	0 1 2 3 4
4.	How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the last five years?	0 1 2 3 4
5.	How often in your lifetime, have you had legal problems or been arrested?	0 1 2 3 4

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

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TOTAL: _____

COMM

Please answer each question as honestly as possible. Keep in mind that we are only asking about the past 30 days. There are no right or wrong answers. If you are unsure about how to answer the question, please give the best answer you can.

Please answer the questions using the following scale:	**Never**	**Seldom**	**Sometimes**	**Often**	**Very Often**
	0	**1**	**2**	**3**	**4**
1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?	☐	☐	☐	☐	☐
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments)	☐	☐	☐	☐	☐
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e., another doctor, the Emergency Room, friends, street sources)	☐	☐	☐	☐	☐
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?	☐	☐	☐	☐	☐
5. In the past 30 days, how often have you seriously thought about hurting yourself?	☐	☐	☐	☐	☐
6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?	☐	☐	☐	☐	☐
7. In the past 30 days, how often have you been in an argument?	☐	☐	☐	☐	☐
8. In the past 30 days, how often have you had trouble controlling your anger (e.g., road rage, screaming, etc.)?	☐	☐	☐	☐	☐
9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?	☐	☐	☐	☐	☐
10. In the past 30 days, how often have you been worried about how you're handling your medications?	☐	☐	☐	☐	☐
11. In the past 30 days, how often have others been worried about how you're handling your medications?	☐	☐	☐	☐	☐
12. In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?	☐	☐	☐	☐	☐
13. In the past 30 days, how often have you gotten angry with people?	☐	☐	☐	☐	☐
14. In the past 30 days, how often have you had to take more of your medication than prescribed?	☐	☐	☐	☐	☐
15. In the past 30 days, how often have you borrowed pain medication from someone else?	☐	☐	☐	☐	☐
16. In the past 30 days, how often have you used your pain medicine for symptoms other than for pain (e.g., to help you sleep, improve your mood, or relieve stress)?	☐	☐	☐	☐	☐
17. In the past 30 days, how often have you had to visit the Emergency Room?	☐	☐	☐	☐	☐

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AUTHORIZATION TO DISCUSS OR DISCLOSE HEALTH INFORMATION

I authorize *(check at least one of the above)* the provider(s) above to discuss and/or disclose my health information with the following person/persons below:

1. _____
2. _____
3. _____
4. _____
5. _____

I understand that this information may include any and all treatment plans, medication issues, history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service / psychiatric care and evaluations; treatment for alcohol and/or drug abuse; or similar conditions.

The following information should not be released: _____

Patient's Name: _____

SSN# _____ DOB: _____

Patient's Signature: _____ Date: _____

Witness: _____ Date: _____

This form is valid for one year from the patient signature date.