CLINICAL INFORMATION

Today's Date _____

Patient Name: _____ Height: _____ Weight: _____lbs

Date of Birth: _____ VS: _____ Age: _____

Pain Description:

Where is your pain?

❑ Back ❑ Leg

❑ Neck ❑ Arm

❑ Other: _____

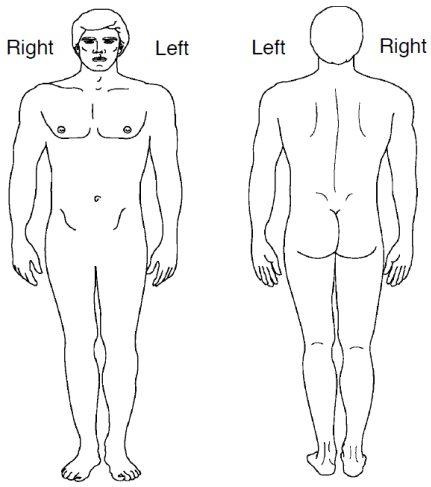
How long have you been in pain?

_____

Rank your average level of pain: _____

At its best: _____ At its worst: _____

0 ← 1 2 3 4 5 6 7 8 9 → 10



Please mark the areas where you feel pain

Check all that apply to describe your pain: ❑ Dull ❑ Sharp ❑ Burning ❑ Shooting

Is the area experiencing the pain weak? ❑ Yes ❑ No

Any of the following sensations: ❑ Numbness ❑ Tingling ❑ Burning

Any disturbances of: ❑ Bladder incontinence ❑ Bowel incontinence ❑ Sexual function

Is your pain the result of an injury or accident? ❑ Yes ❑ No

Do any of the following increase you pain? ❑ Coughing ❑ Sneezing ❑ Straining ❑ Sitting ❑ Lifting ❑ Stress ❑ Sleeping on back ❑ Sleeping on stomach ❑ Cold ❑ Walking ❑ Sex

How have you treated you pain? Medications: _____

Physical Therapy: _____

Injections: _____

Other: _____

Does your pain affect your sleep? ❑ Yes ❑ No How much do you sleep in a typical night? _____hours

Does your pain affect your mood and ability to enjoy life? ❑ Yes ❑ No

How would you describe your mood? ❑ Happy ❑ Sad ❑ Worried ❑ Depressed

List all of the physicians whom you have seen for this problem: _____

Have you missed work because of your pain? ❑ Yes ❑ No For how long? _____

Are you UNABLE to work because of your pain? ❑ Yes ❑ No For how long? _____

Are you receiving Worker's Compensation? ❑ Yes ❑ No

Allergies

Do you have allergies or reactions to medications? ❑ Yes ❑ No Are you allergic to X-ray dye? ❑ Yes ❑ No

List all allergies: _____

Medical History

High Blood Pressure	❑Yes	❑No	Heart Attack	❑Yes	❑No	Hepatitis: A B or C	❑Yes	❑No
Diabetes	❑Yes	❑No	Phlebitis/Blood Clots	❑Yes	❑No	Liver Problems	❑Yes	❑No
Bleeding Problems	❑Yes	❑No	Ulcers	❑Yes	❑No	Thyroid Problems	❑Yes	❑No
Asthma	❑Yes	❑No	Kidney Problems	❑Yes	❑No	HIV/AIDS	❑Yes	❑No
Other:						If female, are you pregnant?	❑Yes	❑No

Have you had two or more falls in the past year? ❑ Yes ❑ No
Have you received an influenza immunization? ❑ Yes ❑No If **yes**, when? _____
Have you received a pneumonia vaccination? ❑ Yes ❑No If **yes**, when? _____
Have you tried or currently taking NSAID's? ❑ Yes ❑No If **yes**, when? _____

Surgical History

List all past surgeries and dates: _____

Family History

Mark all appropriate diagnoses as they pertain to your ***biological parents only***.

Cancer ❑ Mother ❑ Father
Heart Disease ❑ Mother ❑ Father
Back/Neck Pain ❑ Mother ❑ Father
Diabetes ❑ Mother ❑ Father
Migraines ❑ Mother ❑ Father
Other: _____

❑ **I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY** ❑ **I AM ADOPTED (No Medical History Available)**

Social History

Alcohol Use: ❑ Current Alcoholism ❑ Daily Limited Alcohol Use ❑ History of Alcoholism
❑ Never Drinks Alcohol ❑ Social Alcohol Use

Tobacco Use: ❑ Current Tobacco User ❑ Former Tobacco User ❑ Never Used Tobacco

Have you ever abused narcotic or prescription medications? ❑ Yes ❑No (Which: _____)
Have you ever used any drugs that are illegal in Texas? ❑ Yes ❑No (Which: _____)

Current Medications

Are you taking a prescribed **blood-thinner** medication? ❑Yes ❑No

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

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency
1.			4.		
2.			5.		
3.			6.		

Preferred Pharmacy

Pharmacy Name: _____ Phone Number: _____
Street Address: _____ City/State/Zip: _____

Review of Systems

Respiratory			**Endocrine**			**Muscularskeletal**		
Shortness of breath	❑Yes	❑No	Diabetes	❑Yes	❑No	Swelling	❑Yes	❑No
Persistent cough	❑Yes	❑No	Absence of menstrual cycle	❑Yes	❑No	Stiffness	❑Yes	❑No
Cardiovascular			Decreased sex drive	❑Yes	❑No	Joint pain	❑Yes	❑No
Chest pains	❑Yes	❑No	**Neurological**			Bone pain:	❑Yes	❑No
High Blood Pressure	❑Yes	❑No	Headaches	❑Yes	❑No	Spasms	❑Yes	❑No
Lightheadedness	❑Yes	❑No	Memory changes	❑Yes	❑No	**Psych**		
			Numbness	❑Yes	❑No	Hallucinations	❑Yes	❑No
						History of Depression	❑Yes	❑No
						Suicidal/Homicidal Thoughts	❑Yes	❑No

SPINE & PAIN CENTER OF SAN ANTONIO

SOAPP® Version 1.0

Patient Name: _____ Date of Birth: _____

The following are some questions given to all patients at the Spine and Pain Center of San Antonio 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 **circle** your answer to 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 past 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.

INFORMED CONSENT AND PAIN MEDICINE AGREEMENT
AS REQUIRED BY THE TEXAS MEDICAL BOARD
REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9, CHAPTER 170
5th Edition: Developed by the Texas Pain Society, January 2021 (www.texaspain.org)

NAME OF PATIENT: _____
DATE OF BIRTH: _____

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 (medication) therapy to be used, so that you may make an informed decision whether or not to take the drug(s) 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. It is essential for the trust and confidence required for a proper patient-physician relationship and is intended to inform you of your physician's expectations that are necessary for patient compliance. For the purpose of this agreement the use of the word "physician" is defined to include not only your physician but also your physician's authorized associates, physician assistants, nurse practitioners, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat your condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician (name at bottom of agreement) to treat my condition of chronic pain, which is a state of pain that persists beyond the usual course of an acute disease or healing of an injury. 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 a part of the treatment of my chronic pain.

It has been explained to me that these medication(s) include opioid/narcotic drug(s). I have discussed with my Pain Medicine Physician the risks and benefits of the use of controlled substances for the treatment of chronic pain, including an explanation of the following: (a) diagnosis; (b) treatment plan; (c) anticipated therapeutic results, including realistic expectations for sustained pain relief, improved functioning and possibilities for lack of pain relief; (d) therapies in addition to or instead of drug therapy, including physical therapy or psychological techniques; (e) potential side effects and how to manage them; (f) adverse effects, including the potential for dependence, addiction, tolerance, and withdrawal; and (g) potential complications and impairment of judgment and motor skills. 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 accidental overdose, injury and death are also possibilities as a result of taking these medication(s).

I understand that concurrently consuming sedating substances like alcohol, or taking additional types of sedating controlled medications, such as benzodiazepines, along with opioids increases my chance for accidental overdose, injury, and death. If in the unusual situation it is medically indicated for me to receive multiple types of controlled substances, I understand that I will require close supervision of medical specialists to maximize my safety. I agree to follow their direction on the proper use of these medications. Deviation from using medications as directed is grounds for discontinuation of pain therapy.

THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT HAVE BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT (THIS IS SOMETIMES REFERRED TO AS "OFF-LABEL" PRESCRIBING). MY DOCTOR WILL EXPLAIN HIS TREATMENT PLAN(S) FOR ME AND DOCUMENT IT IN MY MEDICAL CHART.

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 (urine, blood, saliva or any other testing indicated and deemed necessary by my physician at any time) 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 or absence of authorized substances may result in my being discharged from my Pain Medicine Physician's care.

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 will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction times might still be slowed. Such activities include but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself.

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 functional 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 may 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.

For female patients only:

- To the best of my knowledge **I am NOT pregnant.**
- If I am not pregnant, I will take appropriate precautions to avoid pregnancy during my course of treatment. I accept that it is **my responsibility** to inform my physician immediately if I become pregnant.
- **If I am pregnant or am uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY**.

I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) 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, or baby.

PAIN MEDICINE AGREEMENT:

I UNDERSTAND AND AGREE TO THE FOLLOWING:

That this pain medicine agreement relates to my use of any and all medication(s) called dangerous drugs and/or controlled substances (i.e., opioids, also called narcotics or painkillers, and other prescription medications) for chronic pain prescribed by my physician. I understand that there are many strict 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.**

The term "Pain Medicine Physician" below means your primary Pain Medicine Physician or your physician who is managing your pain, or that physician's Physician Assistant or Nurse Practitioner, or another physician covering for your primary Pain Medicine Physician.

My Pain Medicine Physician may at any time choose to discontinue 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.

- I am aware that all controlled substance prescriptions are now being monitored by the Texas State Board of Pharmacy and that information must be accessed by my Pain Medicine Physician every time a prescription is written, and by my pharmacist every time before my prescription is dispensed.
- I will not consume alcohol or use any illegal substances (such as marijuana, heroin, cocaine, methamphetamines, etc.) while being prescribed dangerous and controlled substances for the treatment of chronic pain.
- I agree to submit to laboratory tests for drug levels upon request, including 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 alcohol or illegal substance(s), 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.
- 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.

My Pain Medicine Physician may limit the number and frequency of prescription refills.

- I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money. **If either are lost or stolen, they may not be replaced. But if my medications were stolen and I provide my Pain Medicine Physician with a copy of the police report, my Pain Medicine Physician after carefully reviewing my situation, may issue an early refill.**
- My Pain Medicine Physician will manage all of my chronic pain symptoms. **Only my Pain Medicine Physician may prescribe Dangerous Drugs and Controlled Substances for the treatment of chronic pain**. I will receive controlled substance medication(s) **only from ONE Pain Medicine Physician,** unless it is for an emergency **or** the medication(s) that is being prescribed by another physician is approved by my Pain Medicine Physician. Information that I have been receiving medication(s) prescribed by other physicians that has not been approved by my Pain Medicine Physician may lead to a discontinuation of medication(s) and treatment. All other health related issues must be managed by my primary care physician and my other specialists.
- I agree that I **will inform any physician** who may treat me for any other medical problem(s) that I am enrolled in a pain medicine program and have signed this Pain Medicine Agreement.
- I hereby give my Pain Medicine Physician **permission to** discuss all diagnostic and treatment details with my other physician(s) and my pharmacist(s) regarding my use of medications prescribed by my other physician(s). I give my Pain Medicine Physician permission to obtain any and all medical records necessary to diagnose and treat my painful conditions.
- I will use the medication(s) **exactly as directed by my Pain Medicine Physician**. **Any unauthorized increase** in the dose of medication(s) may cause the discontinuation of my pain treatment(s).
- If anyone other than my Pain Medicine Physician prescribes me medication(s) to treat acute, post-surgical or chronic pain, then I will **disclose** this information to my Pain Medicine Physician at or before my next date of service, which must include, at a minimum, the name and contact information for the person who issued the prescription, the date of the prescription, the name and quantity of the drug prescribed, and the pharmacy that dispensed the medication.
- I will alert my physician if I receive a prescription for Naloxone or any opioid antagonist which are designed to reverse the effects of an accidental or intentional overdose of pain medication.
- All medication(s) must be obtained at **one pharmacy designated by me**, with exception for those circumstances for which I have no control or responsibility, that prevent me from obtaining prescribed medications at my designated pharmacy. Should the need arise to change pharmacies, my Pain Medicine Physician must be informed at or before my next date of service regarding the circumstances and the identity of the pharmacy. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my Pain Medicine Physician to release my medical records to my pharmacist as needed.
- My progress will be periodically reviewed and, if the medication(s) are not improving my function and quality of life, the **medication(s) may be discontinued**.
- I must **keep all follow-up appointments** as recommended by my Pain Medicine Physician or my treatment may be discontinued.
- I agree **not to** share, sell or otherwise permit others, including my family and friends, to have access to my medications.
- I will **not use any cannabidiol (CBD) products unless one of my physicians has prescribed me Epidiolex, and I will immediately provide you with that physician's name and lab work so that I can make sure it is not causing problems with my current medications. I understand that the use of over-the-counter CBD products increases my risk of failing a urine drug test because of the presence of illegal substances present in many over-the-counter CBD products.**
- I understand that using benzodiazepines can increase my risk of intoxication or death. These medications may be determined to be unallowed in conjunction with my pain medications. Any benzodiazepine use must be documented to be necessary based on a qualifying diagnosis from a mental health provider or other physician, and this rationale must also be deemed to not introduce excessive risk by your pain physician.
- I understand that using soma can increase my risk of intoxication or death. These medications may be

determined to be unallowed in conjunction with my pain medications. Use of soma must be documented to be necessary based on a qualifying diagnosis from a mental health provider or other physician, and this rationale must also be deemed to not introduce excessive risk by your pain physician.

- There may be other medications such as ambien that can cause sedation which may require authorization by your pain physician.
- I agree to be seen in **in-person office visits** because in Texas it is illegal to use Telehealth for the treatment of chronic pain with controlled substances.
- If it appears to my Pain Medicine Physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then **my Pain Medicine Physician may try alternative medication(s) or may taper me off all medication(s**). I will not hold my Pain Medicine Physician liable for problems caused by the discontinuance of medication(s).
- I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, interventional pain medicine (e.g. steroid injections, nerve ablations, implants to relieve pain, etc.) 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 medicine program** recommended by my Pain Medicine Physician to achieve increased function and improved quality of life.
- I understand many prescription medications for chronic pain produce serious side effects including drowsiness, dizziness, and confusion. Alcohol will enhance all of these side effects and I will discontinue it before starting these medications.

<u>I certify and agree to the following:</u>

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** to me 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.**

5) I understand that I may be asked to bring all my medicine for a random pill count. **Early refill request, misuse or abuse of medication will lead to dismissal from practice. Lost or stolen medication will NOT be refilled. <u>**DO NOT ASK FOR EARLY REFILLS**</u>**

6) If I become a patient in this clinic and receive controlled substances to control my pain, this Pain Medicine Agreement supersedes any other pain management agreement that I may have signed in the past.

Patient Signature

Date

_____

Physician Signature *(or Appropriately Authorized Assistant)*

Patient Financial Agreement

You are financially responsible for the medical services you receive at Spine and Pain Center of San Antonio (the "Practice"). Please review our policies below, initial each section and sign at the end to indicate your agreement to these terms.

APPOINTMENTS

1. **Copayments and Deductibles**. Copayments and deductibles for clinic visits are due at the time of service, in accordance with your insurance carrier's plan.
2. **Self-Pay.** If you do not have health insurance, or if your health insurance will not pay for services rendered by the Practice, or if you notify us not to contact or bill your insurance company, you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule. Payment is due in full at the time of service.
3. **Missed Appointments and Late Arrivals.** Patient cancellations that occur within 24 hours of appointment time, late arrivals (more than 15 minutes) and no-show events are subject to a fee of $25.00 for office visits and $75.00 for procedures.

INSURANCE PAYMENTS

4. **Financial Responsibility.** Your insurance policy is a contract **between you and your insurance carrier.** You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurance carrier will be your responsibility, except as limited by the Practice's specific network agreement with your insurance carrier, if such an agreement is in place.
5. **Coverage Changes and Timely Submission.** If there are any changes in your insurance, it is your responsibility to inform us and provide the detailed changes of your insurance. We request that you inform us at least 24 hours prior to your appointment. If the Practice is unable to process your claim within this period due to your providing incorrect insurance information or not responding to insurance carrier inquiries, you will be responsible for all charges.

BENEFITS AND AUTHORIZATION

6. **Insurance Plan Participation.** It is your responsibility to contact your insurance carrier to verify that your assigned provider participates in your plan. Be aware, our participation can change at any time and you are responsible to contact your insurance carrier to ensure we are contracted with your insurance plan. Your insurance carrier's plan may have out-of-network charges that have higher deductibles and copayments, which you will be responsible for.
7. **Referrals.** Referral and prior authorization requirements vary among insurance carriers and plans. If your insurance carrier requires a referral for you to be seen by the Practice, **it is your responsibility to obtain this referral prior to your appointment.** Pursuant to HIPAA, your referring health care provider, and the Practice, are expressly permitted to disclose your Protected Health Information (PHI) to each other and other healthcare providers and facilities for your treatment. As a matter of course, the practice will inform your referring physician of your patient care plan and progress either by using any secure electronic transmission machine or by an employee of the Practice.
8. **Prior Authorization and Non-Covered Services.** The Practice may provide services that your insurance carrier's plan excludes or requires prior authorization. The Practice as a courtesy to our patients, will make a good-faith effort to determine if services we provide are covered by your insurance carrier's plan, and, if so, determine if prior authorization for treatment is required. If determined that a prior authorization is required, we will attempt to obtain such authorization on your behalf. If we are unable to obtain prior authorization, we will either reschedule the procedure or offer a self-pay option. Ultimately, it is your responsibility to ensure that services provided to you are covered benefits and authorized by your insurance carrier.
9. **Out-of-Network Payments and Direct Insurer Payments.** You are personally responsible for all charges. If the Practice is not part of your insurance carrier's network (out-of-network) or your insurance carrier pays you directly, you are obligated to forward the payment or payment proceeds to the Practice immediately.

ACCOUNT BALANCES AND PAYMENTS

10. **Reassignment of Balances.** If your insurance carrier does not pay for services within a reasonable time, we may transfer the balance to your sole responsibility. Please follow up with your insurance carrier to resolve non-payment issues. **Balances are due within 30 days of receiving an initial statement.**
11. **Collection of Unpaid Accounts.** If your account is turned for collection to a collection agency, you will be responsible for the collection agency fees.
12. **Returned Checks.** You will be charged $30 per incident for returned checks (including any Bank Fees).
13. **Refunds.** Refunds for overpayment are processed only after full insurance reimbursement of all medical services has been received. Please submit a written refund request.Send requests to: Spine and Pain Center of San Antonio, Attn: Billing Department, 3903 Wiseman Blvd. Ste 311, San Antonio, TX 78251
14. **Statements.** Charges shown by statement are agreed to be correct and reasonable unless protested in writing within 30 days of the receipt.

ADDITIONAL FEES

15. **Medical Records Requests**. The HIPAA Privacy Rule and state law allows you to receive a copy of your personal medical and billing records, and allows the Practice to require individuals to complete and sign an Authorization for Disclosure and Release of Medical Records Form or go to https://requestmanager.healthmark-group.com/register.
16. **Other Forms.** Depending upon the circumstances, we charge a fee for completing certain forms.
17. **Acknowledgment of Notice of Privacy Practice & Public Fee Schedule**. I have received and reviewed a copy of the Practice's Notice of Privacy Practice and Public Fee Schedule.

I have read and understand the Financial Policy of the Practice and I agree to abide by its terms. I hereby assign all of my medical and surgical insurance benefits and authorize my insurance carrier(s) to issue payment directly to Spine and Pain Center of San Antonio. I understand that I am financially responsible for all services I receive from the Practice. This financial agreement is binding upon me and my estate, executors and/or administrators, if applicable.

Printed Name: _____ Date of birth: _____

Signed: _____ Date: _____

Release of Medical Records Request

SPINE & PAIN CENTER OF SAN ANTONIO

To: _____ **Attention:** Medical Records

Fax: _____ **Date:** _____

Re: Request for Medical Records **Pages:** 1

I hereby request and authorize you to release copies of all medical records concerning treatment including:

□ Last 3 office notes □ Medication list/log □ Other:

□ Initial evaluation □ Radiology report(s)

Patient Information

Last Name: _____ First Name: _____ MI:_____

Date of Birth: _____ SS#: _____

Delivery Instructions

Please fax the records to the following Spine and Pain Center of San Antonio office:

Provider: □ Sergio Alvarado, MD

Contact: _____ Phone: _____ Fax: _____

Comments: _____

❑ Please RUSH (patient is at our office) ❑ Send by: _____ ❑ 2nd Request

Release Statement

I authorize Spine and Pain Center of San Antonio to transmit and receive any records via fax or other electronic means.

Patient Signature: _____ Date: _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Texas law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

Patient Name: _____ Date of Birth: _____ Email (Optional): _____
Address: _____ City: _____ State:_____ Zip Code:_____
Phone: (_____)_____

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

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

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

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

REASON FOR DISCLOSURE
(Choose only one option below)

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

_____

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

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

Your initials are required to release the following information:

_____Drug, Alcohol, or Substance Abuse Records
_____Mental Health Records (excluding psychotherapy notes)
_____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):_____

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 Patient **DATE**

Printed Name: _____

Oswestry Disability Index (ODI)

Patient Name: _____

Date: _____

1. Pain Intensity

☐ I have no pain at the moment	+0
☐ The pain is very mild at the moment	+1
☐ The pain is moderate at the moment	+2
☐ The pain is fairly severe at the moment	+3
☐ The pain is very severe at the moment	+4
☐ The pain is the worst imaginable at the moment	+5

2. Personal Care (Washing, Dressing, etc.)

☐ I can look after myself normally without causing extra pain	+0
☐ I can look after myself normally but it causes extra pain	+1
☐ It is painful to look after myself and I am slow and careful	+2
☐ I need some help but can manage most of my personal care	+3
☐ I need help every day in most aspects of self-care	+4
☐ I do not get dressed, I wash with difficulty and stay in bed	+5

3. Lifting

☐ I can lift heavy weights without extra pain	+0
☐ I can lift heavy weights but it gives extra pain	+1
☐ Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example on a table	+2
☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned	+3
☐ I can only lift very light weights	+4
☐ I cannot lift or carry anything at all	+5

4. Walking

☐ Pain does not prevent me walking any distance	+0
☐ Pain prevents me from walking more than 1 mile	+1
☐ Pain prevents me from walking more than ½ mile	+2
☐ Pain prevents me from walking more than 100 yards	+3
☐ I can only walk using a stick or crutches	+4
☐ I am in bed most of the time	+5

5. Sitting

☐ I can sit in any chair as long as I like	+0
☐ I can only sit in my favorite chair as long as I ike	+1
☐ Pain prevents me sitting more than 1 hour	+2
☐ Pain prevents me from sitting more than 30 minutes	+3
☐ Pain prevents me from sitting more than 10 minutes	+4
☐ Pain prevents me from sitting at all	+5

6. Standing

☐ I can stand as long as I want without extra pain	+0
☐ I can stand as long as I want but it gives me extra pain	+1
☐ Pain prevents from standing for more than 1 hour	+2
☐ Pain prevents me from standing for more than 30 minutes	+3
☐ Pain prevents me from standing for more than 10 minutes	+4
☐ Pain prevents me from standing at all	+5

7. Sleeping

☐ My sleep is never disturbed by pain	+0
☐ My sleep is occasionally disturbed by pain	+1
☐ Because of pain I have less than 6 hours sleep	+2
☐ Because of pain I have less than 4 hours sleep	+3
☐ Because of pain I have less than 2 hours sleep	+4
☐ Pain prevents me from sleeping at all	+5

8. Sex life (if applicable)

☐ My sex life is normal and causes no extra pain	+0
☐ My sex life is normal but causes some extra pain	+1
☐ My sex life is nearly normal but is very painful	+2
☐ My sex life is severely restricted by pain	+3
☐ My sex life is nearly absent because of pain	+4
☐ Pain prevents any sex life at all	+5

Oswestry Disability Index (ODI)

9. Social Life

☐ My social life is normal and gives me no extra pain	+0
☐ My social life is normal but increases the degree of pain	+1
☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, for example sport	+2
☐ Pain has restricted my social life and I do not go out as often	+3
☐ Pain has restricted my social life to my home	+4
☐ I have no social life because of pain	+5

10. Travelling

☐ I can travel anywhere without pain	+0
☐ I can travel anywhere but it gives me extra pain	+1
☐ Pain is bad but I manage journeys over two hours	+2
☐ Pain restricts me to journeys of less than 1 hour	+3
☐ Pain restricts me to short necessary journeys under 30 minutes	+4
☐ Pain prevents me from travelling except to receive treatment	+5

Scoring Instructions:

Raw Score: Summation of Points Ray Score: _____ Points

Percentage Score: $\frac{\text{Raw Score}}{\text{\# Completed Questions} * 5}$

Percentage Score: _____ %