COMPREHENSIVE PAIN MANAGEMENT, P.A.

Patient Information (Please Print) Today's Date ___/___/___

Name _____ Sex ____ Age ____ Birthdate _____

(Last) (First) (Middle)

Mailing Address _____

(Street) (City) (State) (Zip)

Physical Address _____

(Street) (City) (State) (Zip)

Primary Phone _____ Secondary Phone _____ S.S. # _____

Work Phone _____ Employer _____

Employer Address _____

(Street) (City) (State) (Zip)

Person we may release information to:

Name _____ Sex ____ Age ____ Birthdate _____

(Last) (First) (Middle)

Home Address _____

(Street) (City) (State) (Zip)

Home Phone _____ Work Phone _____ S.S. # _____

Emergency Contact: _____

(Name) (Address) (Phone)

Referring Physician name: _____

List Names of All Physicians Who Care For You:

_____

_____

PHARMACY NAME YOU USE:

_____

Consent to Release Medical Information

I, _____, do hereby consent to and authorize
(Patient, legal guardian or representative)

_____, to disclose to ***Comprehensive Pain Management, P.A.***
(Full name and address of health care provider or institution)

(at 5734 Spohn Drive, Suite A, Corpus Christi, Texas 78414; Ph 361-882-4452; Fax 361-882-5414)

information from the medical record of _____
(Patient's Full Name) (Date of Birth)

check the appropriate box below:

- ☐ Identity, diagnosis, prognosis, and treatment.
- ☐ Other:_____
(Specify Information Requested)

A copy of this authorization is as valid as the original.

SIGNATURE_____ DATE_____

Relationship to Patient_____

Authorization for Release of Information

I hereby authorize ***Comprehensive Pain Management, P.A.*** to release my health care information including but not limited to testing, diagnosis, and/or treatment for chemical dependency, mental health/psychiatric disorders, and HIV, ARC, and AIDS, if any as requested by my insurance company or Worker's Compensation carrier, and to my employer, rehab nurse, if this is a work-related injury, and to any hospital or physician I may be referred to by this office.

I hereby authorize any health care provider to release information as requested by ***Comprehensive Pain Management, P.A.***

A copy of this authorization is as valid as the original.

SIGNATURE_____ DATE_____

Relationship to Patient_____

Financial Policy

Thank you for choosing Comprehensive Pain Management, P.A. as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your account is considered a part of your treatment. The following is a statement of our financial policy which we ask that you read, agree to, and sign prior to treatment(s).

- All patients must complete the "Patient Information" form before seeing the doctor.
- Your share of the cost of our services is due at the time of service.

INSURANCE: Our physician is a provider for most major insurers including HMO's and PPO's. HMO insurers may require authorization from your primary doctor, prior to seeing a specialist. ***You must get that insurance authorization prior to your appointment with us to receive maximum benefits.*** We also accept assignments for Medicare. Texas Workers' Compensation is gladly accepted when properly verified in advance of the appointment.

COPAYS: **Your co-pays and deductibles are due at time of service.**

OFFICE VISITS: Your coinsurance portion of the fee is due at time of service.

OFFICE PROCEDURES: Many of the patients referred to Comprehensive Pain Management require some type of pain procedure treatment(s). If procedure is indicated, we will pre-certify your procedure with your insurance carrier. We will also verify your insurance benefits, and get deductible and out-of-pocket status. From this information we can estimate the patient portion of the physician's fees. The patient portion of the procedure fee is collected at time of service.

OUTPATIENT PROCEDURES: We will verify your insurance benefits, and get deductible and out-of-pocket status. From this information we can estimate the patient portion of the physician's fees. The patient portion of the procedure fee is *due at time procedure is scheduled* (unless prior arrangements are made with our accounts manager).

USUAL & CUSTOMARY CHARGES: Our practice is committed to providing the best treatment possible to our patients. We charge what we believe to be the usual and customary fees for our area. You are responsible for paying the bill in full, regardless of your insurance company's interpretation of usual and customary rates.

SELF-PAY PATIENTS: Payment in full is due for all office services and procedures at time of service.

THREE MISSED APPOINTMENTS MAY RESULT IN DISCHARGE FROM OUR CLINIC. PLEASE NOTIFY US 24 HOURS IN ADVANCE TO RESCHEDULE OR CANCEL YOUR APPOINTMENT.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read, understand, and agree to the above stated financial policy.

X_____ _____

Signature of Patient or Responsible Party Date

ASSIGNMENT OF BENEFITS

In considering the amount of medical expenses to be incurred, I the undersigned, have insurance and/or employee health care benefits coverage and hereby assign and convey directly to Comprehensive Pain Management, P.A. all medical benefits and/or insurance reimbursements, if any, otherwise payable to me for services rendered from such facility. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the facility to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer, and my attorney to release to such facility any and all plan documents, insurance policy and/or settlement information upon written request from such facility in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to Comprehensive Pain Management, P.A. to the full extent permissible under the law and under any applicable insurance policies and/or employee health care benefits coverage with respect to medical expenses incurred as a result of the medical services I received from the above named facility and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such facility in any attempts by such facility to pursue such claims or rights against my insurers and/or employee health care plan in my name but only at such facility's expenses.

This lifetime assignment will remain in effect from first day of service until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

SIGNATURE: _____ DATE_____

Relationship to Patient: _____

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this facility's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

SIGNATURE_____DATE_____

Relationship to patient: _____

RECONOCIMIENTO DE REVISA DE NOTICIA DE PRACTICAS PRIVADAS

Yo he revisado la Noticia de Practicas Privadas de su oficina que me explica como podra ser usada ydivulgada mi informacion medica. Yo entiendo mis derechos a recibir una copia de este documento.

FIRMA _____ FECHA_____

Relationship to Patient_____

PATIENT INITIAL INTAKE FORM

Patient's Name_____DOB_____Today's Date_____
First Middle Last

Primary Physician_____Referring Physician_____

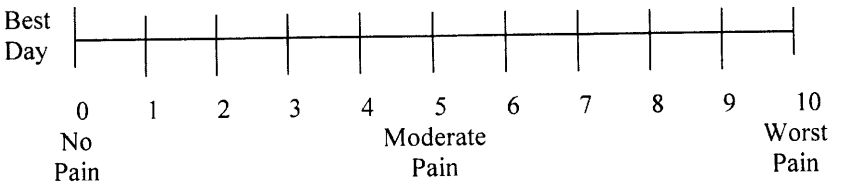
Current Medications:

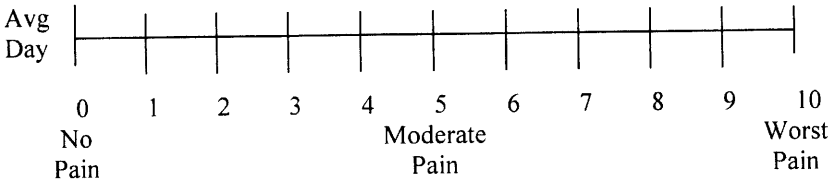
Medication	Dose	Frequency	Date Started	Prescribing Physician

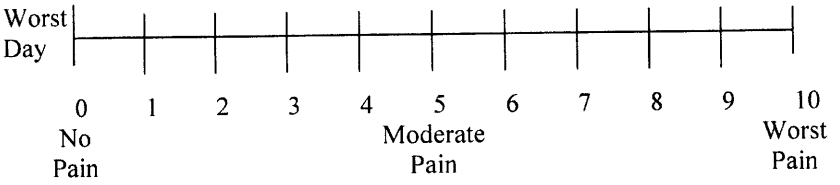
Past Medications:

Medication	Dose	Frequency	Date Stopped	Prescribing Physician

Rate your pain using the scale below on you're:







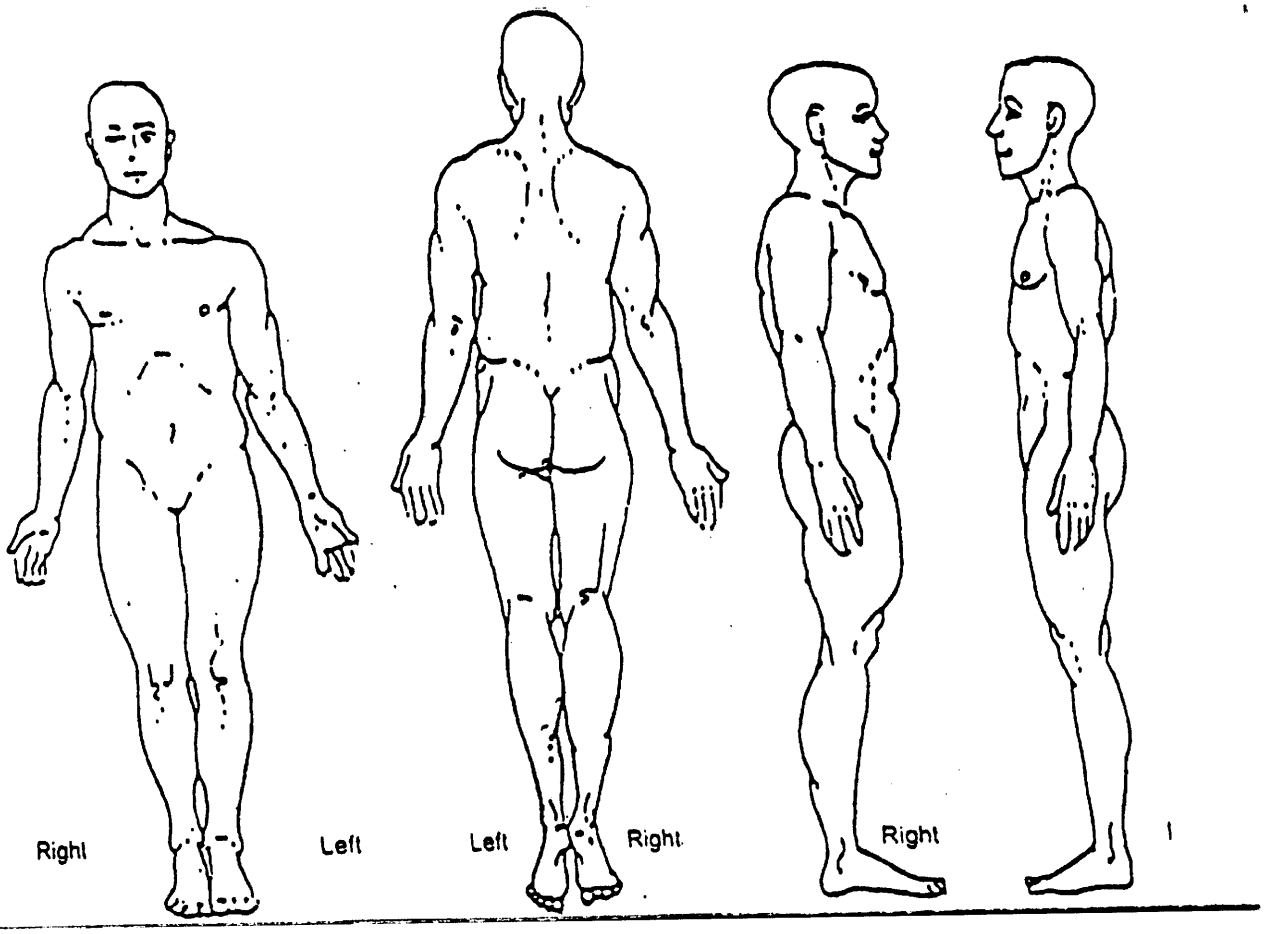
PAIN TREATMENT DESCRIPTION

Have you tried any of the following for your pain?

Treatment Description	Circle correct answer		Was it helpful?	
Pain clinic	Yes	No	Yes	No
Anti-Inflammatories	Yes	No	Yes	No
Anti-Depressant	Yes	No	Yes	No
Muscle Relaxants	Yes	No	Yes	No
Narcotics/Opioids	Yes	No	Yes	No
Benzo	Yes	No	Yes	No
Epidural Steroids	Yes	No	Yes	No
Biofeedback or Relaxation	Yes	No	Yes	No
TENS Unit (Transcutaneous Nerve Stimulator)	Yes	No	Yes	No
Physical Therapy	Yes	No	Yes	No
Home Exercises	Yes	No	Yes	No
Acupuncture	Yes	No	Yes	No

Mark the areas on this body where you feel the described sensations (use symbols from menu):

Numbness	----------
Pins & Needles	000000
Burning	XXXXX
Aching	*****
Stabbing	//////////



For Females only:

Are you currently pregnant or attempting pregnancy? ☐ Yes ☐ No

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The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

Name: DOB: Date:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○

Pain E...

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Name: DOB: Date:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

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