ADVANCED PAIN
INSTITUTE OF TEXAS

PERSONAL INFORMATION (Please Print)			
Today's Date:	Last Name:	First Name:	M.I.
Date of Birth:	Address:	City:	State:
Home Phone:		Zip Code:	SS#
Work Phone: Ext:		Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed	
Cell or Alternate Phone:	Email:		
Employer:	Occupation:		

INSURANCE INFORMATION: (Please provide current card to front office)	
Primary Insurance Name: ID: Group #: Insurance Phone Number:	Secondary Insurance Name: ID: Group #: Insurance Phone Number:
Work Comp Case: ◯ Yes ◯ No If yes, Work Comp Case Worker's Name: Phone:	
Are you involved in a lawsuit: ◯ Yes ◯ No	If Yes, please explain: Attorney's Name: Attorney's Phone Number:

EMERGENCY CONTACT INFORMATION:		
Emergency Contact Name:	Relationship:	Phone:

Patient Signature _____ Date_____

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NEW PATIENT HISTORY

Name:_____ Age:_____ Height:_____ Weight:_____

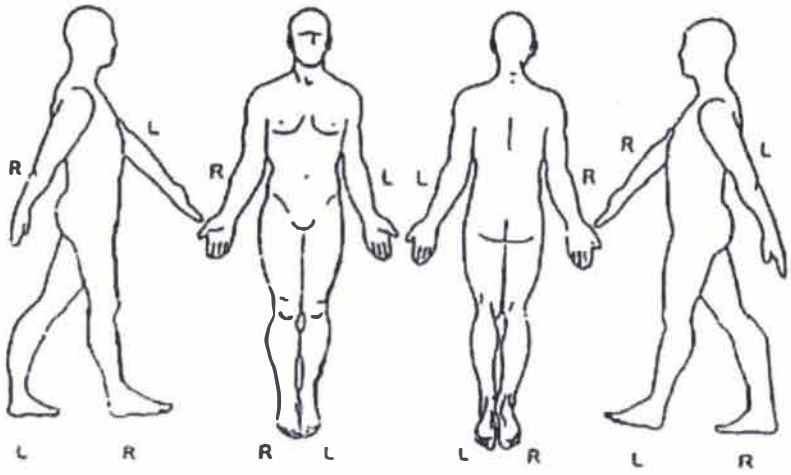
Referring Physician_____Primary Care Physician_____

Chief Complaint: _____

When did your pain begin? _____

How did your pain begin? _____

Please mark the location(s) of your pain:



Rate your pain on a scale of 0-10 (0=No Pain, 10= Worst Pain Possible)

Least Pain: _____ Worst Pain: _____ Current Pain: _____

Describe your pain (mark all that apply):

☐Constant ☐Intermittent ☐Sharp ☐Dull ☐Pain ☐Ache ☐Throbbing ☐Burning ☐Shooting ☐Other

What makes your pain worse? (mark all that apply):

☐Walking ☐Standing ☐Sitting ☐Coughing ☐Sneezing ☐Bending ☐Lifting ☐Other:_____

What makes your pain better? (mark all that apply):

☐Heat ☐Ice ☐Lying Down ☐Rest ☐Walking ☐Medication ☐Bending ☐Stretching ☐Other:_____

Do you have other symptoms? (mark all that apply):

☐Tingling ☐Numbness ☐Weakness ☐Cramping ☐Incontinence (bowel or Bladder) ☐Other:_____

Does your pain affect your (mark all that apply):

☐Sleep ☐Physical Activity ☐Appetite ☐Concentration ☐Mood ☐Relationships ☐Other:_____

Previous Treatments:

Treatment	Yes/No	Was the treatment helpful?
Physical Therapy		
Chiropractic Care		
Massage Therapy		
TENS Unit		
Biofeedback		
Psychological Therapy		
Medications (List all tried)		
Injections (What types?)		
Surgery (What types?)		

Past Medical History (list any conditions you have)

Past Surgical History (Please list all prior surgical procedures)

Surgery	Date	Surgery	Date

Family History

Do you have any significant medical problems in your family? ◯ No ◯ Yes

*if yes, please describe:

Social History

Do you smoke or use other forms of tobacco? ◯ No ◯ Yes, # of packs/week _____

Do you drink alcohol? ◯ No ◯ Yes, # of drinks/week _____

Do you have a history of illicit drug use? ◯ No ◯ Yes, in the past. ◯ Yes, currently.

*If yes, which drugs and when did you last use them?:_____

Have you had any recent infections? ◯ No ◯ Yes

Are you taking Antibiotics? ◯ No ◯ Yes, antibiotic:_____

Allergies

Are you allergic to anything? (Medications, contrast dye, food, or latex) ☐ No ☐ Yes*

*If yes, please describe:_____

Are you allergic to Iodine or Shellfish? ☐ No ☐ Yes*

*If yes, please describe your reaction:_____

Medication (Please list all current medications and how often you take them)

Medication	Dose	Frequency	Medication	Dose	Frequency

Blood Thinners

☐ Eliquis (Apixaban) ☐ Plavix (Clopidogrel bisulfate) ☐ Effient (Prasugrel) ☐ Brilinta (Ticagrelor)

☐ Warfarin (Coumadin) ☐ Heparin (Lovenox) ☐ Xarelto (Rivaroxaban) ☐ Aspirin Dose:_____ mg

☐ Other:_____

Prescriber:_____ PH: _____

Electronic Devices (provide office a copy of card)

☐ Spinal Cord Stimulator ☐ Pacemaker ☐ Other_____

Review of Symptoms (mark all that apply)

Constitutional
☐ Recent fevers
☐ Unexplained weight loss
☐ Unexplained weight gain
☐ Fatigue
☐ Decrease of appetite
☐ Increase of appetite

Neurological
☐ Headaches
☐ Dizziness
☐ Tremors
☐ Poor balance
☐ Loss of consciousness
☐ Memory loss

HEENT
☐ Change in vision
☐ Difficulty hearing
☐ Nasal congestion
☐ Sputum color changes
☐ Trouble swallowing

Psychiatric
☐ Anxiety
☐ Difficulty sleeping
☐ Depression
☐ Suicidal thoughts
☐ Suicidal attempts

Gastrointestinal
☐ Constipation
☐ Nausea/vomiting
☐ Diarrhea
☐ Frequent heartburn
☐ Blood in stool

Cardiovascular
☐ Chest pain
☐ Irregular heartbeat
☐ Palpitations

Musculoskeletal
☐ Muscle pain
☐ Muscle spasms
☐ Joint pain
☐ Joint stiffness

Skin
☐ Rashes
☐ Itching
☐ Sores

Respiratory
☐ Shortness of breath
☐ Wheezing
☐ Coughing

Genitourinary
☐ Difficulty urinating
☐ Pain with urination
☐ Frequent urination
☐ Sexual dysfunction

Hematology/Lymph
☐ Easy bruising/bleeding

Patient Signature: _____ Date:_____

SOAPP® Version 1.0 - SF

Name: _____ Date: _____

The following are some questions given to all patients at the Pain Management Center 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 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.

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OPIOID CONTRACT

Opioid (narcotic) treatment for chronic pain is used to reduce pain and improve what you are able to do each day. Along with opioid treatment, other medical care may be prescribed to help improve your ability to do daily activities. This may include exercise, use of non-narcotic analgesics, physical therapy, psychological counseling or other therapies or treatment. Vocational counseling may be provided to assist in your return to work effort.

I, _____, understand that compliance with the following guidelines is important in continuing pain treatment with the physicians of Advanced Pain Institute of Texas.

1. I understand that I have the following responsibilities:
    A. I will take medications only at the dose and frequency prescribed.
    B. I will not increase or change medications without the approval of this doctor.
    C. I will actively participate in return to work efforts and in any program designed to improve function (including social, physical, psychological, and daily or work activities).
    D. I will not request opioids or any other pain medications from physicians other than from this doctor.
    E. I will inform this doctor of all other medications that i am taking.
    F. I will obtain all medications from one pharmacy, when possible known to this doctor with full consent to talk with the pharmacist given by signing this contract.
    G. This office may discuss your case with your insurance company, pharmacy, and law enforcement when necessary.
    H. I will protect my prescriptions and medications. I will keep all medications from children. I will not share, divert, or sell my medications.
    I. I agree to participate in psychiatric or psychological assessments, if necessary.
    J. If i have an addiction problem, I will not use illegal or street drugs or alcohol. This doctor may ask me to follow through with a program to address this issue. Such programs may include the following: 12-step program and securing a good sponsor, individual counseling, inpatient or outpatient treatment, other: _____
2. I understand that in the event of an emergency, and to the extent possible, this doctor should be contacted and the problem will be discussed with the emergency room or other treating physician. I am responsible for signing a consent to request record transfer to this doctor. Opioid medications may not be prescribed by the emergency room or other physician without this doctor's notification.
3. I understand that I will consent to random drug screening. A drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking.
4. I will keep my scheduled appointments and/or cancel my appointment a minimum of 24 hours prior to the appointment.
5. I understand that this doctor may stop prescribing opioids or change the treatment plan if:
    A. I do not show any improvement in pain from opioids or my physical activity is not improved.
    B. My behavior is inconsistent with the responsibilities outline in #1 above.
    C. I give, sell, or misuse the opioid medications.
    D. I develop rapid tolerance or loss of improvement from the treatment.
    E. I obtain opioids from other than this doctor.
    F. I refuse to cooperate when asked to get a drug screen.
    G. If an addiction problem is identified as a result of prescribed treatment or any other addictive substance.
    H. If i am unable to keep follow-up appointments.

YOUR SAFETY RISKS WHILE WORKING UNDER THE INFLUENCE OF OPIOIDS:

You should be aware of potential side effects of opioids, such as decreased reaction time, clouded judgment, drowsiness and tolerance. Also, you should know about the possible danger associated with the use of opioids while operating heavy equipment or driving. We do not recommend driving or using heavy equipment or machinery while under the influence of opioid medications.

SIDE EFFECTS OF OPIOIDS:

- Confusion or other change in thinking abilities
- Problems with coordination or balance that may make it unsafe to operate dangerous equipment or motor vehicles
- Breathing too slowly - overdose can stop your breathing and lead to death
- Nausea
- Sleepiness or drowsiness
- Vomiting
- Constipation
- Aggravation of depression
- Dry mouth

THESE SIDE EFFECTS MAY BE MADE WORSE IF YOU MIX OPIOIDS WITH OTHER DRUGS, INCLUDING ALCOHOL.

RISKS:

- Physical dependence. This means that abrupt stopping of the drug may lead to withdrawal symptoms characterized by one or more of the following:
    A. Runny nose
    B. Difficulty sleeping for several days
    C. Diarrhea/Abdominal cramping
    D. Sweating
    E. 'Goosebumps'
    F. Rapid heart rate
    G. Nervousness
- Psychological dependence. This means it is possible that stopping the drug will cause you to miss or crave it.
- Tolerance. This means you may need more and more drugs to get the same effect.
- Addiction. A small percentage of patients may develop addiction problems based on genetic or other factors.
- Problems with pregnancy. If you are pregnant or contemplating pregnancy, discuss with your physician.

RECOMMENDATIONS TO MANAGE YOUR MEDICATIONS:

- Keep a diary of the pain medications you are taking, the medications dose, time of day you are taking them, their effectiveness and any side effects that you may be having.
- Use of medication boxes that you can purchase at your pharmacy that is already divided into the days of the week and times of the day so it is easier to remember when to take your medications.

I have read this document, understand it, and have had all my questions answered satisfactorily. I consent that the use of opioids may be used to help control my pain, and that my treatment with opioids will be carried out as described above.

_____ _____

Patient Signature / Printed Name **Date**

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INSTITUTE OF TEXAS

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received the Notice of Privacy Practices from Advanced Pain Institute of Texas.

X_____ Date:_____

Signature of Patient / Legal Guardian / Authorized Person

In accordance with the Telephone Consumer Protection Act of 1991, Advanced Pain Institute my contact me in the manner below: ◯ Both Automated Voicemail and Text Messages

I wish to be contacted by the following manner (check all that apply):

Home: Phone (_____) _____
◯ OK to leave message with detailed info
◯ Leave message with call back number only

Work: Phone (_____) _____
◯ OK to leave message with detailed info
◯ Leave message with call back number only

Cell: ~~Phone~~ (_____) _____
◯ OK to leave message with detailed info
◯ Leave message with call back number only

Email:_____

Designation of Certain Relatives, Close Friends and Other Caregivers

I agree that Advanced Pain Institute of Texas may disclose certain of my health information to a family member, close personal friend, or other caregiver because such person is involved with my health care or payment relating to such. In that case, Advanced Pain Institute of Texas will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to such. I designate the following persons listed below as persons involved in my health care or payment relating to such. For the purpose of Advanced Pain Institute of Texas making the limited disclosures described above. (I understand that I am not required to list anyone and that I may change this list at any time in writing).

Print Name of each designated person below:	Date of Birth

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INSTITUTE OF TEXAS

Practice Policies

Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to your treatment and being successful. Please understand that payment on your bill is considered a part of your treatment. The following statement of our Financial Policy, which we require you to read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the doctor.

- We accept cash, checks, MasterCard and Visa.
- We offer an extended payment with prior approval.
- Your co-payment is due at the time of service.

Regarding Insurance

Whether your insurance pays or not, you are responsible for the appropriate balance. We do require your co-payment or co-insurance (10%, 20%, etc.) to be paid at the time or service. Please be aware of the requirements of your plan. We cannot bill your insurance unless you bring all of your insurance information. Your insurance policy is a contract between you and your insurance company; we may or may not be an "IN NETWORK" provider. It is your responsibility to verify whether we are an "IN NETWORK" provider. Please be aware that some, perhaps all of the services provided may be non-covered services and not considered reasonable and customary under the Medicare Program and/or other medical insurance. Patients who wish to submit claims themselves must pay in full at the time of service, unless other arrangements are made.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our specialty. You are responsible for the appropriate contracted or billed charges regardless of any insurance company's arbitrary determination of usual and customary rates. Once your balance becomes patient responsibility, the account must be paid in full within three (3) months, to keep your account out of collections. If your account must be turned over to a collection agency, you will be held responsible for the full amount and any legal and court fees. Our nurse practitioner/physicians' assistant may see you independently, but Advanced Pain Institute of Texas endorses all of his/her clinical decisions. Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

Physician Disclosure of Financial Interest

Thank you for the opportunity to provide your pain management needs. We are committed to ensuring your complete satisfaction. The purpose of the disclosure notice is to inform you that we, the physicians at Advanced Pain Institute of Texas, have financial interests in the following facilities in North Texas:

1. Sonax Anesthesia
2. Sonax Neuromonitoring

Your physician may also have a financial interest in the professional component of intraoperative monitoring that is provided during selected surgical procedures, as well as in companies that provide implants for certain surgical procedures. You have the right by law to choose the provider of your health care services as well as the option of utilizing an alternate medical facility, monitoring or implant company. You will not be treated differently by your physician if you choose to obtain health care services at another facility, or to utilize another monitoring or implant company, if applicable. We welcome you as a patient and value our relationship with you. If you have any questions concerning this notice, please feel free to ask your physician.

Patient Appointment Policy

Welcome to our practice and thank you for choosing us! We appreciate your confidence and goodwill. Please note our cancellation, late, and no show policies:

- Patients must give at least 24 hours cancellation notice; please call 972-866-4246.
- Patients who are 15 (or more) minutes late may have to be rescheduled.
- Patients who do not show to appointments or show up late 3 or more times may be discharged.

Please keep this as a copy for your records.

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Physician / Financial Policy Acknowledgement

By signing this Disclosure of Physicians Ownership, you acknowledge that you have read and understand the foregoing notices and hereby understand that your physician has financial interest in the listed facilities and other above stated services.

I have read the Financial and Practice Policies. I understand and agree to adhere to the Financial Policies..

X_____ Date:_____

Signature of Patient or Responsible Party

_____

Printed Name of Patient or Responsible Party

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No Show Policy

Advanced Pain Institute is committed to providing access and appointment availability to all of our patients in a manner that fits your needs and availability. In order to maintain this access, we currently strive to confirm appointments with everyone who has scheduled an appointment more than 24 hours in advance of that date and time.

If you will not be able to make your scheduled appointment, please contact the office within 24 hours to cancel or reschedule your appointment.

Patients may incur a $50 no show fee to anyone who fails to keep their regularly scheduled appointment or fails to reschedule within 24 hours. This fee will be assessed to the patient, is not reimbursable by your insurance carrier and will be due upon receipt. Patients with multiple no shows for appointments may be dismissed from the practice.

I hereby acknowledge and accept the above policy.

_____ _____

Patient Signature Date

Late Arrival Policy

Our providers do their best to keep appointments on schedule. If you arrive later than your scheduled appointment time, we will make every effort to honor your appointment as a "work in" as the schedule allows upon arrival. There may be times when this will not be possible and you will have to reschedule.

If you are running late, please contact the office as soon as you become aware that you will not be on time. Out of respect for patients who have arrived on time for their appointment, you may be asked to reschedule your appointment if you arrive more than 15 minutes late.

I hereby acknowledge and accept the above policy.

_____ _____

Patient Signature Date

ADVANCED PAIN
INSTITUTE OF TEXAS

AUTHORIZATION TO RELEASE MEDICAL RECORDS

NAME:_____ DATE OF BIRTH_____

SOCIAL SECURITY NUMBER:_____

TO:_____
(Physician, Facility/Hospital, Attorney, Insurance Company, Self)

_____
(Address)

_____
(Phone and Fax)

FROM:_____
(Physician, Facility/Hospital, Attorney, Insurance Company, Self)

_____
(Address)

_____
(Phone and Fax)

Information to be released:

☐Office Notes ☐Imaging Reports ☐Discharge Summary
☐Procedure Notes ☐Labs ☐Other _____

Reason for disclosure:

☐Continuity of Care ☐Legal ☐Insurance
☐Social Security/Disability ☐Work/School ☐Other_____

This authorization expires 1 year from signature date.

_____
(Signature) (Date)

_____
(Witness) (Date)

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apitexas.com