TEXAS PARTNERS HEALTHCARE GROUP

A Patient's Mission Statement

Texas Partners Healthcare Group's goal is to relieve pain through an integrated and interventional pain management approach. This includes, but is not limited to, different types of injections, blocks, Regenerative Medicine and Stem cell therapies, physical therapy, chiropractic care, and surgical consultations. Our mission is to eliminate opioid use by addressing the underlying root of a patient's pain through surgical and interventional methods. We do not rely heavily on prescribing pain medications.

By signing this document, I agree to follow the providers treatment plan, and failure to do so could result in being discharged.

Patient Printed Name:_____

Patient Signature:_____

TEXAS PARTNERS HEALTHCARE GROUP

Disclosure of Physician Ownership and Financial Interest

State and Federal guidelines may require that physicians who may have an affiliation or ownership interest in or with the in and out of network facilities/services to which the physician prefers we must disclose this information. In the interest of providing our patients with complete information, we are providing the names of the out of network facilities where Texas Partners Healthcare Group may have an ownership interest/affiliation with Texas Partners in Hospital Consulting/East Anesthesia Associates/Preston Anesthesia Associates/West Anesthesia Associates/Southeast Anesthesia Associates/Southwest Anesthesia Associates/Northeast Anesthesia Associates/Northwest Anesthesia Associates/Texas Partners Healthcare Group at 3140 Legacy Dr. #310 Frisco, TX 75034 or 940 W. Stacy Rd. #110 Allen, TX 75013, Integrity Wellness Center at 920 S. Belt Line Rd. #250 Coppell, TX 75019, and McKinney Outpatient Surgical Center at 1505 Harroun Ave. Unit I, McKinney, TX 75069. During your course of treatment at Texas Partners Healthcare Group, you may be referred to one of these facilities for medical services. These in and out of network facilities or provider may bill the patient for services not covered by your benefit plan. You have the right to choose the facility where you receive medical treatment/services, including the right to choose a facility/service other than the ones listed above.

By signing below, I acknowledge receipt of the above disclosure information and have a right to a copy of this form.

Patient Printed Name: _____

Patient Signature: _____

TEXAS
PARTNERS
HEALTHCARE GROUP

Multiple Provider Care System

I have been informed and understand that Texas Partners Healthcare Group has multiple providers and I may be seen by another Doctor or a Nurse Practitioner on my following visits.

Patient Name: _____

Patient Signature: _____

TEXAS PARTNERS HEALTHCARE GROUP

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR COMMITMENT

When you receive services at Texas Partners Healthcare Group (TPHG), we will create a medical record, in order to provide you with quality care and comply with legal requirements. This record is the property of TPHG. We understand that the information in your medical record is personal and are committed to protecting it in accordance with state and federal law.

WHO WILL FOLLOW THESE PRACTICES

This notice is provided to you as required by the Health Insurance Portability and Accountability Act of 1996, and related privacy and security laws and regulations (collectively known as "HIPAA"). All of TPHG's health care professionals, and all members of our staff have agreed to follow the practices described in this notice in using, maintaining and disclosing information about you that is protected health information under HIPAA.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways we may use and disclose protected health information. Not every use and disclosure within a category is listed, but all of the ways we are permitted to use and disclose protected health information fall within one of these categories.

• **For Treatment.** Our physician's and other personnel involved in your care will have access to information about you in order to provide you with medical treatment and services. For example, our physicians need to know your health history in order to determine what procedure may be appropriate for your care. We may also disclose your protected health information to physicians and other health professionals providing care to you, such as your primary care physician, or a specialist treating you.

• **For Payment.** We may use and disclose protected health information about you in order to obtain payment for the services we provide to you. For example, we may provide information about your diagnosis and the procedure to be done to your insurance company or health plan in order to obtain pre-authorization for the procedure, if required, and to obtain payment for the services we provide to you.

• **For Health Care Operations.** We may use and disclose your protected health information for TPHG operations. For example, we may use and disclose such information for the purpose of evaluating the quality of the services you received, or the performance of the health care professionals involved in your care.

• **Appointment Reminders; Benefits and Services.** We may use your protected health information to provide appointment reminders, or to inform you about treatment alternatives, or other health-related benefits or services that may be of interest to you.

• **Research Studies.** We may use or disclose your protected health information for research purposes, when the research proposal and protocols established to ensure the privacy of your protected health information have been reviewed and approved by an institutional review board or privacy board.

• **Business Associates.** We may disclose protected health information to individuals and entities we engage to perform specific functions for TPHG, such as billing or transcription services. We require that our business associates implement appropriate safeguards for such information.

• **Family and Friends; Disaster Relief.** We may disclose your protected health information to a family member or friend who is involved in your care, or to someone who helps pay for your care. We may also disclose protected health information to entities authorized to assist in disaster relief efforts. Except in certain limited situations, such as an emergency or when you are unable to communicate, we will first give you an opportunity to object to such disclosures.

• **Threat to Health or Safety.** We may use and disclose protected health information about you when necessary to prevent a serious threat to your health or safety, or to the health or safety of the public or another individual.

• **Workers' Compensation.** We may release protected health information as required by laws relating to workers' compensation or similar programs.

• **Public Health Activities.** We may disclose protected health information for public health activities, such as preventing or controlling disease, injury or disability; reporting reactions to medications or problems with products; notifying a person who may be at risk for contracting or spreading a disease; or reporting workplace injury or illness.

• **Domestic Violence, Abuse of Neglect.** We may disclose protected health information in notifying a government authority of suspected domestic violence, abuse or neglect, when required or authorized by law.

• **Health Oversight Activities.** We may disclose protected health information to a health oversight agency for activities authorized by law. These activities might include, for example, audits, investigations and inspections conducted to monitor the health care system and government programs.

• **Lawsuits and Disputes.** If you are involved in a lawsuit or other dispute or legal action, we may disclose your protected health information in response to a court or administrative order and, under some circumstances, in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute.

• **Law Enforcement.** Under certain circumstances we may release protected health information to assist law enforcement officials in their law enforcement duties.

• **Coroners, Medical Examiners, Procurement Organizations and Funeral Directors.** We may release protected health information to a coroner or medical examiner as necessary to identify a deceased person, or determine the cause of death, to organizations involved in procurement, banking or transplantation of organs or tissues, and to funeral directors as necessary to fulfillment of their duties.

• **Specialized Government Functions.** We may release protected health information for certain specialized government functions. For example:

• **Military Personnel.** If you are a member of the armed forces, we may release protected health information as required by military authorities.

• **Inmates.** In the case of an inmate of a correctional facility, or someone under custody of a law enforcement official, we may release protected health information to the facility or the law enforcement official, as necessary (1) to provide the inmate with health care; (2) to protect the health and safety of the inmate or others; or (3) for the safety and security of the correctional facility or law enforcement official.

• **National Security and Intelligence Activities; Security Clearances.** We may disclose your protected health information to authorized federal officials for purposes of intelligence, counterintelligence, security clearances, and other national security activities, as authorized by law.

• **As Required by Law.** We will disclose protected health information about you when required to do so by federal, state or local law.

USES OR DISCLOSURES THAT REQUIRE YOUR WRITTEN AUTHORIZATION

We are required to obtain your written authorization for the following uses or disclosures of your Protected Health Information, unless otherwise permitted or required by law:

- Most uses and disclosures of psychotherapy notes and/or mental health information;
- Uses and disclosures of HIV status;
- Uses and disclosures related to alcohol and substance abuse;
- Use and disclosures for marketing purposes such as providing your protected health information to a pharmaceutical company or placing you on a mailing list;
- Uses and disclosures that constitute a sale of your protected health information; or
- A request by you to provide your health information to an attorney for use in a civil litigation claim.

You have the right to revoke a written authorization at any time as long as your revocation is provided in writing to our Privacy Officer at the office address at the end of this notice. If you revoke your written authorization, we will no longer use or disclose

your protected health information for the purposes identified in the authorization. You understand that we are unable to retrieve any disclosures, which we may have made pursuant to your authorization prior to its revocation.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights regarding the protected health information we maintain about you.

• **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. To inspect or copy medical information that may be used in making decisions about your care, submit a request in writing to our Privacy Officer. If you request a copy of the information, we may charge a fee to cover our costs associated with the request. In very limited circumstances, we may deny a request to inspect and copy medical information. In most but not all circumstances, if you are denied access to medical information, you may be able to request that the denial be reviewed. In that case, a licensed health care professional other than the individual who denied your request will be chosen by TPHG to review your request and the denial.

• **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend our information. A request to amend your medical information must be submitted to our Privacy Officer in writing, with a reason supporting your request. We may deny your request if it is not in writing or does not include a reason supporting your request. In addition, we may deny a request if you ask us to amend information that was not created by us, unless the person or entity that created the information is no longer available to make the amendment, or is not part of the information you would be permitted to inspect or copy, or is accurate and complete. If we deny your request for an amendment, we will notify you of the reason for the denial. You may then submit a statement of disagreement, or ask that your request become part of your medical record. These documents, and any rebuttal we prepare, will become part of your medical record.

• **Right to an Accounting of Disclosures.** You have the right to request a list of the instances in which we have disclosed your protected health information. Your request must be in writing, directed to our Privacy Officer, and must state a time period not longer than six years. The first list you request within a twelve month period will be free of charge. We may charge you the costs of providing any additional lists within the same twelve month period. The list will not include disclosures for treatment, payment or Center operations, disclosures to family members or friends involved in your care, or disclosures that you have authorized in writing,

• **Right to Request Restrictions.** You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment or operations. You also have the right to request a limitation on the protected health information we disclose to someone involved in your care or the payment for your care, such as a family member or friend. You must make your request in writing, directed to our Privacy Officer. Your request must tell us (1) what information you want to limit; (2) whether you want to limit our use or disclosure, or both; and (3) to whom you want the limits to apply. We are not required to agree to your request. If we do agree we will comply with your request unless the information is needed to provide emergency treatment to you.

• **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical information in a certain way, or at a specific location. For example, you can request that we contact you at work. Your request for confidential communications must be made in writing, directed to our Privacy Officer. You need not specify a reason for your request. We will accommodate reasonable requests, when possible.

• **Right to Restrict Disclosure to a Health Plan for Out-of-Pocket-Payments.** You have the right to request that we not disclose to your health plan or other insurer protected health information with respect to an item or service for which you pay out-of- pocket in full. You must make your request in writing, and we are required to honor it.

• **Right to Paper Copy of this Notice.** You have a right to a paper copy of this notice at any time.

OUR RESPONSIBILITIES REGARDING YOUR PROTECTED HEALTH INFORMATION

We are required to (1) keep protected health information that identifies you private; (2) give you this notice of our legal duties and privacy practices with respect to protected health information; (3) follow the terms of the notice that is currently in effect; and (4) notify you of a breach of your secured protected health information, in accordance with applicable requirements of HIPAA.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the changed notice effective for protected health information we already have about you as well as any information we receive in the future. We will post a copy of our current notice in our office, and on our website (www.txphealthcare.com) and give you a copy upon request.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer at the address below. In addition, you may file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

Contact our Privacy Officer at:

Texas Partners Healthcare Group, PA

3140 Legacy Dr. #300 Frisco, TX 75034

Phone: 972-435-4002 Fax: 972-435-4105

Patient Name:

_____

Signature of Patient or Legal Guardian:

_____

TEXAS PARTNERS HEALTHCARE GROUP

Office Policies and Procedures

Appointments, Cancellations, and "No-Shows"

Please try to arrive a few minutes early for your appointment to allow time for sign-in. We understand that unexpected circumstances occur. However, patients who arrive more than 15 minutes late for their appointment are subject to being rescheduled. If you must cancel your appointment for any reason we must be notified 24 hours in advance. This allows for our patients on the waiting list to get the care they deserve. Appointment slots are very important. If we are not given proper notice you will be subject to a $50 fee at your next appointment. If your appointment was missed due to an emergency please provide those records in order to waive the "no-show" fee. If we are not given proper notice of missing a procedure you will be subject to a $75 fee at your next appointment.

Early Appointment Requests

We do our best to accommodate patients needing earlier appointments than allowed. In this instance we will approve only on a case by case basis and request remaining medication be brought in to your appointment to confirm opioid compliance. If you are leaving town we will require flight itinerary for an early refill which will be allowed only once. If you prefer to schedule your appointment through the internet please send us message through your patient portal account so we may ensure it is in fact time for a refill of medication. Otherwise we would love to hear your voice through our office telephone number!

Opioid Compliance

As a pain management specialist controlled substances may be commonly prescribed. In the instance you have received a controlled substance prescription, please understand we monitor compliance very closely. We do not write for more than thirty days of medication at a time and in turn, will not fill these prescriptions early. **We do not consider running out of medication, to be an emergency.** You are responsible for taking your medication in the manner in which it was prescribed. If you run out of medication before your next appointment, you may not be issued more medication, unless at the discretion of the physician or physician assistant. No refills or medication changes will be given after hours, on weekends or holidays. Narcotics will not be refilled unless you are seen in the office monthly and comply with the pain management therapy program. Please remember that **it is your responsibility** to monitor you medication usage and to plan for your follow-up visit if you need a refill. We suggest you do not wait until you are out of medication to call and check on your appointment slot or make an appointment. We do also collect urine samples on a random basis. Once you have checked in you will not be able to leave the premises without this collection. Please refer to our opioid contract given when we established a new patient relationship for all rules and regulations. **You may be subject to discharge if you do not comply. Please request a copy if needed for reference.**

Telephone Communication

We are happy to address your questions or concerns via telephone whenever possible. However, treating you by phone without a proper face-to-face evaluation has many potential pitfalls and will be avoided. **Clearly, your health deserves better treatment.** Please do not ask us to call in medications without an office visit. In addition, most providers are advised not to give "complex information" or discuss "emotionally charged issues" via telephone. For those issues that can be resolved via telephone however, we strive to address them by the conclusion of each business day. However, unexpected circumstances do occasionally occur so please allow one business day for answers to telephone inquiries.

E-Mail Marketing Campaigns

As medicine is changing, we are able to continually evolve and update our treatment options for our patients. Occasionally, we will send out a non-targeted e-mail marketing campaign explaining our latest treatment options and how they may be able to help with some common pain management conditions. By signing this document, you automatically opt-in to receiving these e-mails. If do not wish to receive these e-mails or wish to opt-out, you may click "unsubscribe" at the bottom of any emails sent to you.

FMLA/Disability Form Requests

We may fill out FMLA on a **case by case basis**. There is a fee associated with this of $75. However, we do not fill out disability form requests. In the event that you do require disability, you will need to have these forms completed by your primary care physician or appropriate surgeon whom you would be referred to. If we do choose to fill out FMLA paperwork, you must come in for an office visit with your provider.

Billing/Financial Hardships

We make every effort to explain all insurance plan benefits at the time of establishing a doctor-patient relationship. However, **it is your responsibility** to understand your insurance benefits and costs you may be responsible for. Payment is due at the time of service. Please see our front desk for any additional insurance questions you may have.

Insurance

If your insurance requires a referral to see a specialty clinic, the patient is responsible for obtaining such referrals through their insurance or Primary Care Physician. This responsibility does not fall on the clinic or clinic staff. Failure to obtain an appropriate referral or documentation may result in a delay in appointments. We must have the referral in our system prior to an upcoming appointment, when applicable. Clinic staff will do their best to inform patients in a timely manner that a new referral is required.

I have read and understand the Office Policies and Procedures provided by Texas Partners Healthcare Group and have also received a copy for my own records. I hereby authorize TPHG to prescribe and provide treatment under the circumstances given.

Name of Patient:_____ Signature of Patient or Legal Guardian: _____

TEXAS PARTNERS HEALTHCARE GROUP

Financial Policy

During the course of treatment by Texas Partners Healthcare Group, charges will be accumulated and routinely filed with the responsible parties reported form of payment. Please read the below categories to understand our policy for each.

Insurance Policy Holders:
Charges not covered by your insurance company such as patient co-pays, deductibles, and co-insurance will be your responsibility and are due at the time of service. If your insurance company requires a "referral" from your primary care physician, you will need to contact PCP for the referral. Treatment provided by this office without the required referral will serve as your consent for treatments not covered by insurance and will be payable at the time of service. Any claim not paid for your insurance within 60 days from the date filed, will become account holder responsibility and payable upon billing. Keep in mind, at times your insurance may not pay for the services discussed with your provider. Your insurance only pays for covered items and services when its rules are met, for example obtaining appropriate referrals from your primary care physician. The fact that your insurance may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. **Note: Our company waives responsibility for unknowingly treating any Medicare policy holding patient if you do not disclose this information before services are rendered.**

Our office will only accept secondary insurance policies that have verified benefits and coverage limit before time of service. In some cases, your responsibility may become due with a refund if payment is received from your secondary carrier.

Letter of Protection and Personal Injury Protection:
You understand you will be charged for all services received by TXPHG and the bill is your responsibility. You have authorized an attorney to protect all medical debt accumulated with any settlement received. You will also sign a release of payment directly to provider if your carrier opts to mail payment to patient first. If for any reason, attorney representation is discontinued the account holder becomes immediately responsible for all charges incurred.

Private Pay:
Patients in hardship choosing to pay out of pocket may be offered fair rates to receive as much affordable care as possible. Payment is due in full at time of services.

Payment Plans:
Contact your receptionist to learn more about services that allow payment plan set up.

Consent to Treatment

I have the right to refuse any procedure or treatment. I have the right to discuss all medical treatments with my provider.

Authorization to Release Medical Information

I hereby authorize Texas Partners Healthcare Group to provide medical records as requested by my verbally or electronically reported carrier for any charges of services covered by the terms of my policy. I agree to cooperate, aid and assist the facility on procuring all possible insurance benefits including initiation and fulfillment of all policy provisions such insurance companies may require for payment.

I have carefully read and understand to all of the above information which includes TXPHG's Financial Policy, Consent to Treatment, and Medical Release. I hereby authorize Texas Partners Healthcare Group to prescribe and provide treatment under all the above terms and conditions.

Name of Patient: _____ Signature of Patient or Legal Guardian: _____

TEXAS PARTNERS HEALTHCARE GROUP

Informed Consent and Agreement for Opioid Therapy of Pain

Pain relief is an important goal for your care. Opioid medications may be a helpful part of chronic pain treatment for some people; however, misuse of opioid medications may result in serious harm to patients prescribed them and, when the medications are diverted, to the public at large. As opioid use for pain management has increased in recent years, injury, addiction, and death due to misuse of opioids have also increased.

Potential Risks or Side Effects of Opioid Treatment

Physical Side Effects - May include mood changes, drowsiness, nausea, constipation, urination difficulties, depressed breathing, itching, bone thinning and sexual difficulties such as lowering of male hormone in men and cessation of menstrual periods in women.
Tolerance - A dose of an opioid may become less effective over time even though there is no change in your physical condition. If this happens repeatedly your medication may need to be changed or discontinued.
Addiction - Is more common in people with personal or family history of addiction, but can occur in anyone.
Hyperalgesia - Increased sensitivity to and/or increasing experience of pain caused by the use of opioids may require change or discontinuation of medication.
Overdose - Taking more than the prescribed amount of medication or using with alcohol or other drugs can cause you to stop breathing resulting in coma, brain damage, or even death.

Responsibilities in Opioid Therapy of Chronic Pain

Your responsibilities: In order to maximize the potential benefit of opioid medications and to minimize the potential risks, it is important that you accept the following responsibility. In signing this consent, you

Agree to:
*Use your opioid medications as prescribed for the purpose of relieving pain.
*Keep your medications locked up to avoid intentional or unintentional use or diversion by others.
*Discard all unused medications.
*Be honest with your providers about your medications or other drug use.
*Use no illegal drugs, alcohol, or benzodiazepines, while being prescribed opioids.
***Do NOT share, sell, trade or in any way provide your medications to others.**
***Receive opioid medication from this practice only.** If opioids are prescribed unexpectedly by another office (For example: Due to an accident or dental procedure), inform this office within 24 hours.
***Fill your opioid medications at one pharmacy only**. Inform this practice within 24 hours if you must use a pharmacy different from your usual one.
*Have urine tests on a regular basis and as requested by your provider.
*Opioid may be discontinued if illicit drugs are found or medication is not present when it should be.
*Bring your opioid medications to the practice when requested.
*Participate in other pain treatments agreed to with your provider.
*Keep all appointments scheduled for your care.

Medications may be discontinued if your treatment plan is not met, if you experience any negative effects from using them, or if you do not abide by this agreement. If you develop complications of opioid use, such as addiction, we will assist you in finding treatment. Please be aware, however, that our practice cooperates fully with law enforcement, the US Drug Enforcement Agency and other agencies in the investigation of opioid-related crimes including sharing, selling, trading or other potential harmful use of these powerful medications. I also understand that in order to receive a medication or a medication refill, I may be required to see a Physician in the office before this prescription request can be filled.

Pharmacy Information
While under the care of Texas Partners in Healthcare Group I understand that I am ***required*** to fill ***ALL*** prescriptions at ***ONE*** pharmacy during the course of my entire treatment plan.

I have reviewed this document and been given the opportunity to have any questions answered. I understand the possible benefits and risks of opioid medications and accept the responsibilities described above.

Patient Name:_____

Patient Signature:_____

New Patient Medical History

1) Personal Medical History: Conditions - current or treated in the past. (Check all that apply)

- ❒ Angioplasty/Heart Catheter
- ❒ Anemia
- ❒ Anxiety
- ❒ Arthritis
- ❒ Asthma
- ❒ Backaches
- ❒ Mental Disorder
- ❒ Blood Clot
- ❒ Cancer (add comments below)
- ❒ Neck Pain
- ❒ Congestive Heart Failure
- ❒ COPD / Breathing Problems
- ❒ Chest Pain
- ❒ Cataracts
- ❒ Dementia / Memory Loss
- ❒ Depression
- ❒ Diabetes
- ❒ Diverticulosis
- ❒ Eating Disorder
- ❒ Emphysema
- ❒ Fibromyalgia
- ❒ Glaucoma
- ❒ None
- ❒ Gout
- ❒ Heart Attack
- ❒ Heart Disease
- ❒ Heartburn / Gastric Reflux
- ❒ Hepatitis
- ❒ High Cholesterol
- ❒ HIV/Aids
- ❒ High Blood Pressure
- ❒ Kidney Disease
- ❒ Kidney Stones
- ❒ Joint / Back Pain
- ❒ Liver Disease
- ❒ Migraine/Headaches
- ❒ Obesity
- ❒ Osteoporosis
- ❒ Pneumonia
- ❒ Seizures
- ❒ Stroke
- ❒ Thyroid Disease
- ❒ Tuberculosis
- ❒ Ulcers
- ❒ Urinary Tract Infections

Comments: _____

Allergies: _____

_____

Current Medications: _____

_____

New Patient Medical History

2) Surgical History (Check all that apply).

- ❒ Appendectomy..... Date of Surgery: _____
- ❒ Cardiac Bypass Surgery..... Date of Surgery: _____
- ❒ Cholecystectomy..... Date of Surgery: _____
- ❒ C-Section..... Date of Surgery: _____
- ❒ Hernia Repair..... Date of Surgery: _____
- ❒ Hip Surgery..... Date of Surgery: _____
- ❒ Hysterectomy..... Date of Surgery: _____
- ❒ Knee Surgery..... Date of Surgery: _____
- ❒ Spine Fusion..... Date of Surgery: _____
- ❒ Tonsillectomy..... Date of Surgery: _____
- ❒ None

Comments: _____

_____

3) Smoking Status

- ❒ Never Smoker
- ❒ Former Smoker
- ❒ Current Every Day Smoker

Has Smoked For: _____

Quit Date, If Applicable: _____

4) Alcohol Use

Do you drink alcohol? _____

Type of Alcohol: _____

Drinks/ Week: _____

New Patient Medical History _____

5) Recreational Drugs:

6) Employment:

7) Past Pain Treatments (Check All that Apply):

- ❒ Anti-inflammatory Medications
- ❒ Home Excercises
- ❒ Heating Pad
- ❒ Chiropractic Care
- ❒ Narcotic Pain Medications
- ❒ Facet Injections
- ❒ Joint Injections
- ❒ Spinal Cord Stimulator
- ❒ Other
- ❒ Over the Counter Medications
- ❒ Massage
- ❒ Physical Therapy
- ❒ Accupuncture
- ❒ Nerve Medications (gabapentin, etc)
- ❒ Epidural Steroid Injections
- ❒ RF Neurotomy (Rhizotomy)
- ❒ Intrathecal Pump

Comments:_____

_____

9) Family History

	Mother	Father	Sister	Brother
Arthritis	❒	❒	❒	❒
Back Pain	❒	❒	❒	❒
Thyroid	❒	❒	❒	❒

New Patient Medical History

Family History Cont.

	Mother	Father	Sister	Brother
Depression	❒	❒	❒	❒
Diabetes - Type I	❒	❒	❒	❒
Diabetes - Type II	❒	❒	❒	❒
Heart Disease	❒	❒	❒	❒
High Blood Pressure	❒	❒	❒	❒
High Cholesterol	❒	❒	❒	❒
Kidney Disease	❒	❒	❒	❒
Obesity	❒	❒	❒	❒
Osteoporosis	❒	❒	❒	❒
Stroke	❒	❒	❒	❒
Substance Abuse	❒	❒	❒	❒
Cancer (provide details in Comments)	❒	❒	❒	❒

Comments: _____

_____

Primary Care Physician _____

_____

How did you hear about us?

_____

Let's be sure we can stay in contact with you!

How do you prefer your courtesy reminder calls?

- ❒ Text Messages
- ❒ Email Reminders
- ❒ Phone Calls

Emergency Contact Information:

Emergency Contact Name:

Relation: ❒ **Parent** ❒ **Sibling** ❒ **Child** ❒ **Friend** ❒ **Other:**_____

Cell/Mobile Phone:_____

Work/Alt Phone:_____

HIPAA/Privacy Contact: ❒ No ❒ Yes

In order for our office to release your information to another doctors office, family member, or for a friend to contact us on your behalf we must have your signed consent on file. will only be able to release information with your signed consent on file.
In the event that your information needs to be release, having a signed consent already on file, will help us release that information faster!

****Please see the front desk in order to complete/ udpate your Medical Information Release Form****