



16633 DALLAS PKWY SUITE 150 ADDISON, TX 75001

PAIN MANAGEMENT AGREEMENT

You have agreed to receive opioid (narcotic) medications for the treatment of chronic pain. These medications are being prescribed to decrease your pain and/or increase your ability to function. Chronic opioid therapy is only ONE part of your overall pain management plan (which may also include therapeutic injections, exercise, physical therapy, or other therapies/treatments) - if at any point you discontinue adherence to your overall treatment plan, your provider will no longer prescribe pain medication.

Please read this contract carefully. If you do not understand any of the information contained below, or require additional clarification on the policies of this office regarding the prescribing of opioid medications, please ask. **You will be required to complete and sign this contract before receiving any opioid medications.**

I, _____ (*print name*), understand that adhering to the following is important in continuing to receive opioid medications prescribed by Addison Pain Management / East Rehabilitation, PA.

I understand that I will (*initial by each condition to signify your understanding and agreement*):

_____ take medications **only** as they are prescribed by this provider (dose and frequency).

_____ not increase or change medications without the approval of this provider.

_____ **not request or fill other opioid or pain medication prescription from any other provider.**

Prescription history will be monitored through the Texas DPS, and any patient with a record of "doctor-shopping" will be immediately discharged. In the event of emergency room treatment, this provider should be contacted and the problem will be discussed with the ER or other treating physician. No more than three (3) days of medications may be prescribed by the ER or other physician without this doctor's approval.

_____ inform my provider of all the medications that I am taking, both prescription and OTC.

_____ only obtain my medications from one pharmacy. If I need to change or obtain medications from a different pharmacy, I will inform Addison Pain Management immediately.

_____ safeguard and protect my prescriptions and medications. I understand that these will not be replaced if they are lost, left behind, or destroyed. If my medication is stolen, I will complete a police report.

_____ agree to participate in psychiatric or psychological treatment or counseling, if needed.

_____ not use illegal or street drugs, or other medications that were obtained illegally or that were intended for use by someone other than me.

_____ 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.

_____ obtain refills of my prescriptions only at the time of an office visit or during regular office hours. No routine refills will be available during evenings, after 5 pm, or on weekend, holidays, or



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through the emergency room. Medications will not be mailed or refilled without being seen at monthly pain clinic appointment (if patient is receiving opioids from the pain clinic).

_____ attend all appointments, treatments and consultations as requested by my providers. I will attend all pain appointments and follow pain management recommendations. I understand that failure to keep appointments may lead to discontinuation of treatment.

_____ authorize the provider and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication

I understand that that this office **will stop prescribing medications or change my treatment plan if** (initial by each condition to signify your understanding and agreement):

_____ I receive opioid medications from sources other than this provider.

_____ I trade, sell, or misuse my prescribed medication.

_____ I refuse to undergo a drug screen urinalysis or blood test when requested.

_____ my blood or urine test shows the presence of medications the staff is not aware of, the presence of illegal drugs, or does not show medications that I am receiving a prescription for.

_____ any member of the professional staff of this clinic feels it is in my best interests that opioid medications are stopped.

_____ I consistently miss appointments or refuse to schedule medication refill appointments.

_____ I become tolerant to, addicted to or have complications from the opioid medications.

_____ I have violated any part of this agreement.

I have completely read and understood each provision of this Pain Management Agreement. I understand that it is my responsibility to take my medication only as prescribed. I will not request or fill opioid/narcotic prescriptions from any other doctor while I am receiving pain medication from Addison Pain Management.

**PLEASE
REWRITE
BELOW**

Printed Name: _____

Patient Signature: _____

Date of Agreement: _____



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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

I acknowledge that ADDISON PAIN MANAGEMENT provided me with a written copy of the office's Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

PATIENT SIGNATURE

DATE

PERSONAL REPRESENTATIVE SIGNATURE (IF APPLICABLE)

RELATIONSHIP TO PATIENT



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PATIENT REGISTRATION FORM

PATIENT INFORMATION

Legal First Name _____ Middle Name _____ Last Name _____
Date of Birth: ____/____/____ Age: _____ Sex: M / F
Social Security #: _____ Marital Status: Married / Single / Divorced / Widowed
Address: _____
Home/Work/Cell #: _____ Home/Work/Cell #: _____
Email: _____
Referring or Primary Care Physician: _____

INSURANCE POLICY

Insurance Network _____ Group Number _____ Subscriber ID Number _____
Claims Mailing Address: _____
Primary Policyholder Name: _____
Date of Birth: ____/____/____ Social Security #: _____
Employer Name & Address: _____
Relationship to patient: Spouse / Parent / Other: _____

EMERGENCY CONTACT

Name: _____ Relationship to patient: _____
Address: _____
Home/Work/Cell #: _____ Home/Work/Cell #: _____

LETTER OF PROTECTION COVERAGE

LOP: Attorney's Name: _____ Phone & Fax #: _____
Attorney's Address: _____

AUTHORIZATION TO RELEASE INFORMATION I hereby authorize the above-named agency to release any treatment information requested by attorneys, physicians, insurance companies, employees, health care providers, or any other entity which may be concerned with the payment of charges incurred for the treatment services of East Rehabilitation, P.A.

ASSIGNMENT OF INSURANCE BENEFITS I hereby do authorize payment directly to East Rehabilitation, P.A. I am responsible for payment of all services rendered not covered by insurance.

PATIENT SIGNATURE

DATE



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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Addison Pain Management recognizes the patient's right to confidentiality of protected health information ("PHI"). This form obtains permission to discuss and/or release information regarding your care at our practice to a person whom you designate as an authorized representative. Authorization is optional- you may opt to not designate any authorized representatives.

Please bear in mind, if you intend for anyone else to schedule your appointments, manage your prescriptions, or receive billing/account/medical record information on your behalf, you must authorize them on this form.

PATIENT NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

I AUTHORIZE ADDISON PAIN MANAGEMENT TO DISCLOSE MY PHI TO THE LISTED PERSON(S):

NAME:	PHONE NUMBER	RELATIONSHIP TO PATIENT

PROTECTED HEALTH INFORMATION DISCLOSURE OVER THE PHONE

The provider(s) and/or staff have my permission to:

- Leave a detailed message with the person(s) listed above
- Leave a detailed message on my primary voicemail: (_____) - _____ - _____
- Leave a detailed message on my business voicemail: (_____) - _____ - _____

I UNDERSTAND THAT INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT IF THEY ARE NOT A COVERED ENTITY UNDER THE FEDERAL PRIVACY RULE. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFYING ADDISON PAIN MANAGEMENT IN WRITING, TO BE EFFECTIVE ON THE DATE NOTIFICATION IS RECEIVED. I AGREE THAT MY AUTHORIZATION IS VOLUNTARY.

PATIENT SIGNATURE

DATE

INITIAL PATIENT VISIT

PATIENT NAME: _____ AGE: _____ SEX: M / F DATE: _____

REFERRED BY: _____ PHARMACY: _____

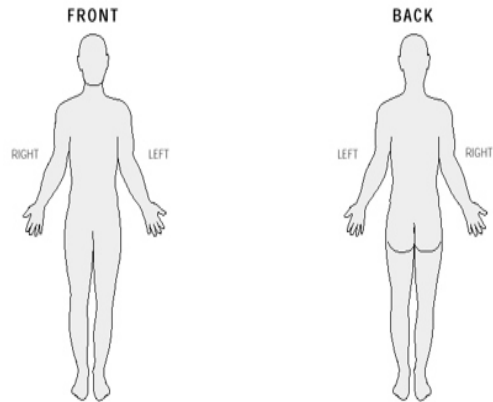
REASON FOR VISIT: _____

Primary Insurance: _____ Secondary Insurance: _____ Self Pay Attorney

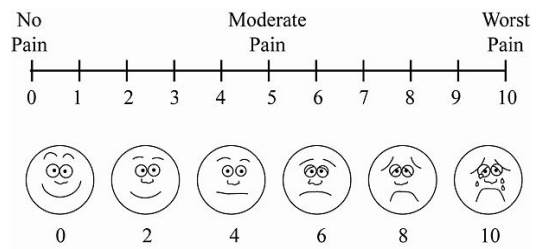
Policyholder's Employer: _____ Are you currently covered under a Medicare plan? Yes No

Please describe how your problems began, including **when** and **how** the pain started

Indicate your pain location(s) by drawing on the figure below:



What is your current pain level?



When the pain first start? 1 week 2 week 1 month 3 months 6 months 1 year 2 years

How often is the pain present? always usually occasionally rarely only when I _____

Describe the pain: aching shooting sharp burning tiring numbing throbbing
 stabbing tender tightness

What makes the pain better? rest medication changing position massage heat or cold pack sitting
 standing walking lying down relaxation techniques other: _____

What makes the pain worse? physical activity sitting standing walking other: _____

How is your mood affected? daytime sleepiness insomnia depression anxiety

PLEASE COMPLETE ALL QUESTIONS, CIRCLING ITEMS BELOW THAT APPLY TO YOU:



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PRIOR IMAGING Back: MRI/CT Scan/XRays Neck: MRI/CT Scan/XRays Other: _____

PRIOR PROCEDURES Trigger Point Injections Epidural Injection Joint Injection Rhizotomy Nerve Block

PRIOR THERAPIES Have you ever had physical therapy? yes no If yes, when was the last time? _____
Have you had chiropractic treatment? yes no If yes, when was the last time? _____
Do you do exercises or stretching at home? yes no Have you had massage therapy? yes no
Have you used durable medical equipment, like a back or knee brace? yes no

PRIOR MEDICINES Lortab/Lorcet/Vicodin Norco Darvocet Percocet Percodan Codeine Celebrex/ Vioxx
Motrin/Advil Lodine Mobic Alleve/Naproxen Oxycontin MS Contin Methadone
Duragesic Patch Morphine Actiq Neurontin Elavil Topamax/Zonegran Ambien Xanax Restoril
Trazodone Robaxin Skelaxin Flexeril Zanaflex Baclofen Soma Prozac Celexa Lexapro Paxil
Remeron Zoloft Other _____

DRUG ALLERGIES _____

MEDICAL PROBLEMS Arthritis Asthma Cancer Chronic pain Depression Diabetes Deep vein thrombosis Reflux
Gastric ulcer High blood pressure Mental illness Migraines Neurological disorder Obesity
Osteoporosis Muscle pain / inflammation Thyroid disorder Seizure Other: _____

PRIOR SURGERIES Appendectomy C-section Cholecystectomy Hernia repair Hysterectomy Tonsillectomy Tubal
ligation Joint replacement Spinal fusion Back surgery Shoulder surgery Knee surgery Ankle
surgery Vertebral fusion Laminectomy Hip surgery Hip replacement Knee replacement

FAMILY HISTORY Neck pain Lower back pain Alcohol abuse Substance abuse Cancer Heart disease Mental illness
Bleeding problems Arthritis Other: _____

FUNCTIONAL Circle all the actions you are unable to perform:
Dress Bathe Groom Toilet Walk Run Perform sport

SOCIAL HISTORY Do you smoke? yes no How many packs per day? _____ For how long? _____
Do you use alcohol? no yes, socially yes, heavy consumption recovering alcoholic
Any Illicit drug use? no yes: _____
What are your diet and exercise habits? _____

Are you: married single divorced widowed
Describe your work: office heavy labor homemaker driver retired student
Do you drive yourself? yes no because _____

REVIEW OF SYMPTOMS Circle all the symptoms you are currently experiencing:
Fatigue Fever Chills Night sweats Weight loss Weight gain Anxiety Sleeping excessively
Difficulty falling asleep Irritability Headache Sinus pain Migraine Chest pain Palpitations
Increased heart rate Leg pain with exercise Limb swelling Snoring Difficulty breathing Shortness
of breath Waking at night due to shortness of breath Cough Decreased appetite Anorexia Heartburn
Nausea Vomiting Abdominal pain Diarrhea Constipation Muscle weakness Muscle aches Joint
pain Joint swelling Joint stiffness Knee swelling Muscle cramps Dizziness Vertigo Fainting
Confusion Memory loss Difficulty with balance Tingling Numbness Anxiety Depression



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PATIENT MEDICATION FORM

Addison Pain Management is dedicated to providing the highest quality medical care to our patients. Please assist us in our efforts to ensure your complete, accurate electronic medical record by providing us with a list of your known allergies, as well as all medications you are currently taking.

ALLERGIC TO:	DESCRIBE REACTION:

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING, PRESCRIPTION AND OVER-THE-COUNTER. PLEASE INCLUDE MEDICATIONS THAT YOU TAKE ON AN AS-NEEDED BASIS.

DATE STARTED	NAME OF MEDICATION	DOSE	HOW OFTEN DO YOU TAKE IT?



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FINANCIAL POLICY

Addison Pain Management is dedicated to providing the best care we can to all of our patients. In the interest of good healthcare practice it is desirable to establish a financial policy to clarify the practices of our office in regards to patient insurance claims billing and account balance.

Insurance: We will file your insurance claims. This office will accept your insurance company's maximum allowable reimbursement. The patient will be responsible for any deductible, coinsurance and co-payment amount. The patient is responsible for payment of any non-covered service. This includes, but is not limited to, deductibles, co-payments, non-covered charges, and "usual and customary" charges. We will supply factual information as necessary to supplement your claims. We cannot bill third party insurance. It is the responsibility of the patient to provide **ACCURATE** and **TIMELY** insurance information. Inaccurate or untimely information given to the staff that results in denial or non-coverage by your insurance company results in the guarantor being responsible for payment. While the filling of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from the dates services are rendered. Therefore, it is necessary for you to know what benefits your insurance plan provides for you.

Referrals: If a referral is required for your insurance policy, it is your responsibility to obtain this referral from the primary insurance company prior to any appointments. Failure to obtain a referral may result in reduction of benefits.

Self-Pay: Patients are responsible for all visits, treatment and other related services covered by the treating provider at Addison Pain Management. While our office can try to estimate cost of services, the patient agrees in advance to pay for all services, tests and fees the providers feel are necessary for the patient's care.

Co-Pays: Co-payments are due at the time of service.

Unpaid Balances: Patients typically receive a statement from our office after the insurance company has processed the claims. This will include charges that the insurance company has not paid. Payment is due within 30 days of the statement date. Patients with financial hardship may apply for assistance and provide proof of income/assets to qualify for hardship status with our practice.

Returned Checks: The charge for a returned check is \$35.00 payable by cash or money order. This will be applied to your account in addition to the insufficient fund amount.

No Show / Cancellation Fee: The charge for a cancellation without at least 24 hours' prior notice is \$35.00 and will be automatically applied to your account. The charge for "no showing" an appointment with no notice is \$50.00.

I AUTHORIZE PAYMENT OF BENEFITS TO MY TREATING PROVIDER AT EAST REHABILITATION PA / ADDISON PAIN MANAGEMENT AND AUTHORIZE MY PROVIDER TO RELEASE ANY INFORMATION REQUESTED BY MY INSURANCE CARRIER. I HAVE READ AND FULLY UNDERSTOOD THE ABOVE FINANCIAL POLICY SET FORTH BY ADDISON PAIN MANAGEMENT. I UNDERSTAND AND AGREE AND THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE ANY TIME WITHOUT PRIOR NOTIFICATION TO THE GUARANTOR

PATIENT OR GUARANTOR SIGNATURE

DATE



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Disclosure of Physician Ownership Notice to Patients

Addison Pain Management is committed to providing compassionate, individualized, and comprehensive healthcare to improve and restore quality of life to every patient we treat. As a patient of Addison Pain, we are pleased to inform you of the following:

1. John East, D.O. and Brandon Knutson, D.C. are physician owners of the following clinical facilities: Sagecrest Hospital of Grapevine, Yellow Wolf Monitoring
2. We want to ensure that you understand you are not required to utilize these facilities. We can provide you with alternative options upon request. You will not be treated differently by your physician if you choose an alternate healthcare facility.

If you have any questions concerning this notice, please feel free to ask your provider or any representative of Sagest Hospital of Grapevine or Yellow Wolf Monitoring. We appreciate you as a patient and value our relationship with you.

Acknowledgement of Disclosure

By signing this Acknowledgment of Disclosure, you acknowledge that you have read and understand the foregoing Notice to Patients regarding physician ownership.

Signature of Patient or Guardian: _____

Name of Patient: _____

Date: _____