Addison
Pain & Regenerative Medicine

16633 DALLAS PKWY SUITE 150 ADDISON, TX 75001

PAIN MEDICATION AGREEMENT

You have agreed to receive opioid (narcotic) medications for the treatment of chronic pain. These medications are being prescribed by Addison Pain and Regenerative Medicine ("APRM") to decrease your pain and/or increase your ability to function. Opioid therapy, whether chronic or short term, 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. <u>You will be required to complete and sign this contract before receiving any opioid medications.</u>

I, ________________________________ (*print name*), understand that adhering to the following is important in continuing to receive opioid medications prescribed by Addison Pain and Regenerative Medicine / 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 APRM 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

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 am currently taking a benzodiazepine medication (examples: Xanax, Valium, Klonipin, Ambien, Lunesta, Alprazoloam, Clonazepam). Benzodiazapines cannot be taken with schedule II opioid medications.

_____I fill a prescription for a benzodiazepine medication while taking an opioid

_____ 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 and Regenerative Medicine.

PLEASE REWRITE BELOW

____
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____

16633 DALLAS PKWY SUITE 150 ADDISON, TX 75001

Printed Name: ____

Patient Signature: ______________________________________ Date of Agreement: ____________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name: ____

Date of Birth: ______________________________________

Social Security Number: ______________________________

I acknowledge that ADDISON PAIN AND REGENERATIVE MEDICINE 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 and Regenerative Medicine ("APRM") 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 APRM 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 AND REGENERATIVE MEDICINE IN WRITING, TO BE EFFECTIVE ON THE DATE NOTIFICATION IS RECEIVED. I AGREE THAT MY AUTHORIZATION IS VOLUNTARY.

______________________________ ______________

PATIENT SIGNATURE DATE

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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

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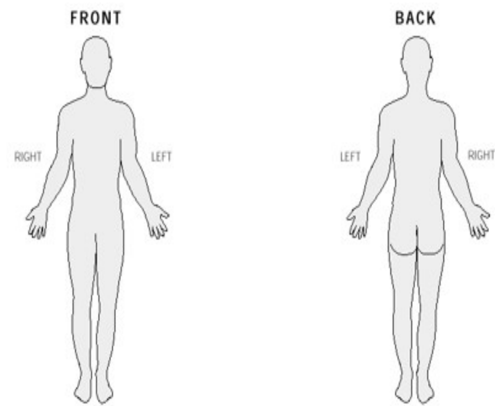
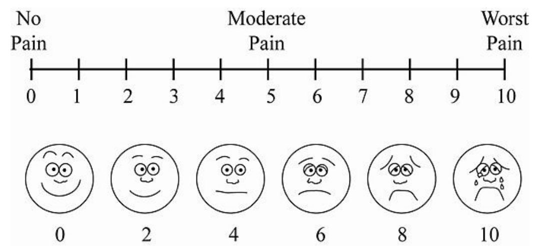
Indicate your pain location(s) by drawing on the figure below:



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____
MEDICATION 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 <u>currently</u> 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 and Regenerative Medicine 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 and Regenerative Medicine ("APRM") 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 and Regenerative Medicine. 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 quality 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 AND REGENERATIVE MEDICINE 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 APRM. 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 and Regenerative Medicine 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. is a physician owner of the following clinical facilities: Sagecrest Hospital of Grapevine, Yellow Wolf Monitoring, and Quorum Voss Anesthesia.

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, Yellow Wolf Monitoring, or Quorum Voss Anesthesia. 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: ____