Phone: (832) 592.7997 Fax: (281) 882.8849 www.LiveWithRelief.com

PAIN RELIEF ASSOCIATES

Dr. Laura Champagne

UPDATED PATIENT INFORMATION

Last Name: _____ First Name: _____

DOB: _____

If your information has not changed since your last visit, please sign the bottom of the page and all the consents for our yearly update. If any of the following information has changed since your last visit, please provide us with the updated information. Thank you.

Address: _____ City: _____

State: _____ Zip code: _____

Home Phone: _____ Cell Phone: _____

Marital Status: Single Married Divorced Widowed Spouse's Name: _____

Insurance Information

Policy Member's Name: _____

Relationship to Patient: _____

Insurance Company Name: _____

Policy Number: _____ Group Number: _____

**Please present your insurance card(s) and photo ID to the receptionist along with this completed form.*

May we share information regarding treatment, medications, appointments, or billing inquires with your spouse or immediate family members? Yes No

If yes, name: _____ Relationship: _____

25319 IH 45 North, Ste 101, Spring, TX 77380 psychiatry_pra@yahoo.com

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STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Patient Name: _____ DOB: _____

Pain Relief Associates appreciates the confidence you have shown in choosing us to provide for your health care needs. The services to participate in imply a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees.

As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

_____ (Initials)

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with you insurance carrier. We expect these payments at time of service.

_____ (Initials)

Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician e3lects to continue past your approved period, you will be responsible for your balance in full. I agree to pay any costs incurred by Pain Relief Associates in collecting any amount due including, without limitation, collection agency fees and attorney fees.

_____ (Initials)

I have read the above policy regarding my financial responsibility to Pain Relief Associates, for providing medical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Pain Relief Associates, the full and entire amount of bill incurred by me or the above named patient, or, if applicable any amount due after payment have been made by my insurance carrier.

***All copays must be paid in full at time of appointment and all deductibles must be current to be seen. If self-pay, I agree to pay full amount of service fee(s) at time of appointment.*

Patient Signature: _____ Date: _____

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CONCTRACT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medication (i.e. benzodiazepines and stimulants) are very useful, but have potential for misuse; therefore, they are controlled by local, state, and federal government. They are intended to improve function and/or ability to work, not simply to feel good. Because my provider is prescribing such medication for me to help manage my condition, I agree to the following conditions.

1. I am responsible for my controlled substance medication(s). If the prescription of medication is lost, misplaced, stolen, or if I use it up sooner than prescribed, I understand that it will not be replaced.

   _____ (Initials)

2. I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from Pain Relief Associates. Besides being illegal to do so, it may endanger my health. The only exception is if it is prescribed while I am admitted to a hospital.

   _____ (Initials)

3. Refills of cont4rolled substance medications:
   a. Will not be made if I "run out early". I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
   b. Will not be made as an "emergency", such as a Thursday afternoon because I suddenly realize that I will run out tomorrow and the office will be closed. I will call at least seventy-two (72) hours in advance if I need assistance with a controlled medication prescription.
   c. No controlled medication will be ordered when the office is closed

   _____ (Initials)

4. I understand the importance of following my treatment plan as directed by my physician/provider and agree to:
   a. Keep my appointments (including follow-ups and referrals).
   b. To permit urine drug screening without prior notice.

   _____ (Initials)

5. I understand that if I violate any of the above conditions, my controlled substance prescription(s) and/or treatment with Pain Relief Associates may be terminated immediately. If the violation involves obtaining controlled substance from another individual, as described above, I may also be reported to other healthcare providers, medical facilities, pharmacies, and other authorities.

   _____ (Initials)

I have read this contract and fully understand its content. In addition, I fully understand the consequences of violating this contract.

Patient Signature: _____ Date: _____

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