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

PAIN RELIEF ASSOCIATES

Dr. Laura Champagne

NEW PATIENT INFORMATION

Last Name: _____ First Name: _____

DOB: _____ Sex: Male Female

Address: _____ City: _____

State: _____ Zip code: _____

Home Phone: _____ Cell Phone: _____

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

Referral Information

How did you hear about us? _____

_____

_____

Reason for Visit

☐ Finding a new Psychiatrist ☐ Second opinion diagnosis ☐ Change my medication

☐ Therapy to help with my relationships ☐ Talk therapy but I'm not sure what the problem is

☐ Professional support during a difficult time

☐ Seeing if I need medication for: _____

☐ Other: _____

_____

In Case of Emergency

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

May we share information regarding treatment, medication, appointments, or billing inquires with your spouse or immediate family member(s)? Yes No

Patient Signature: _____ Date: _____

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PAIN RELIEF ASSOCIATES

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PRA POLICY INFORMATION

We are committed to providing our patients with the best possible care and we are pleased to discuss our professional services with you at any time. Your clear understanding of our Office Procedures and Financial Policies is very important. All patients must complete our Patient Information forms before seeing our professionals.

Payment of services is handled prior to your visit. The patient must stay current with the payment of their deductibles and co-payments. All information this office gives in reference to your insurance coverage is based on information obtained from your insurance company, is only descriptive of your benefits, and is not a guarantee of payment by your insurance company. An insurance company may quote benefits and give authorization, but clearly state in their disclaimer this is not a guarantee of payment. Therefore, any amount we collect at the time of service or quote as your responsibility is an estimate only. You are ultimately responsible for any and all balances on your account.

All Medicaid patients must present their current Medicaid insurance card at every visit as mandated by Medicaid or the visit will be rescheduled without exception.

If any insurance information has changed it is the patient's responsibility to inform our office at least 5 business days prior to scheduled appointment.

We charge for missed or cancelled appointments, unless we are notified at least 24 hours in advance. Our policy is to charge $50.00 for missed or cancelled appointments. Please do not rely on appointment reminder calls, as this is a courtesy. Having 3 or more no shows or cancellations of appointments may result in termination of treatment. Please help us serve you better by keeping scheduled appointments. NOTE: You may be asked to reschedule if you are more than 15 minutes late for your appointment. If you feel you were charged in error, please discuss this matter with our Practice Manager.

We charge a service fee for certain forms and/or letter that must be completed and signed by our medical professionals. Please allow us 2 business days to complete requested forms.

If you choose, this office will provide you with a completed receipt showing charges and payments within 2 business days of your visit which you may file with your insurance company.

In the event of a divorce, we must have copy of the Divorce Decree signed by a judge. The decree must state which parent has Managing Conservator Privileges for the minor (child). A biological parent must be present at initial appointment.

Childcare is not provided for children. Please do not leave children unattended in the reception area.

Forms of payment we accept: Cash, Visa, MasterCard, Discover, American Express, and HSA cards.

Patient Signature: _____ Date: _____

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PAIN RELIEF ASSOCIATES

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POLICIES FOR TREATMENT

1. FEMALE PATIENTS – If taking medication, I agree to notify Pain Relief Associates in the event that I am planning to become pregnant or I become pregnant so that I may discuss the risks/benefits of the continued use of medication(s).

_____ (Initials)

2. ALCOHOL/DRUG/HERBAL SUPPLEMENTS – It is recommended not to use alcohol, drugs, or herbal supplements in combination with prescription psychiatric medication and I agree to notify Pain Relief Associates if this is a concern.

_____ (Initials)

3. MEDICATION REFILLS – I agree to take my medication as prescribed by Pain Relief Associates. Medication is prescribed to last until my next appointment. I will make an appointment and be seen before a medication refill is required.

_____ (Initials)

4. LETTERS AND/OR FORMS – There will be a $75.00 charge for any forms and/or letters that must be completed and signed by physicians or office staff of Pain Relief Associates.

_____ (Initials)

5. TREATMENT SESSIONS –Patients must be on time. We request that all patients show up at least 10 minutes prior to their schedule appointments. Any late arrives may be subject to reschedule.

_____ (Initials)

6. CONFIDENTIALITY – All information is guarded by strict confidentiality. We require your written consent in order to release/obtain information.

_____ (Initials)

7. CONSENT FOR TREATMENT – (must be signed prior to the start of care) I hereby give consent for myself or the above named patient to be treated/tested by Pain Relief Associates. If above named patient is a minor who is/has been involved in any court proceedings, I have provided proof by the attached court document(s), that I have the legal rights to request treatment for the above named minor. If you are 15-17 years of age, you must have a guardian co-sign. If you are 18 years of age, you must sign yourself and are allowed the right to choose whether your wish anyone, including parents, to be present during your evaluation and treatment. Both parties must sign consent for treatment if seen for marital or co/joint therapy. A parent/guardian may not come in for an appointment without patient. The patient must be present at every visit. Patients under 18 years of age will only be seen with a parent or guardian present.

_____ (Initials)

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8. TERMINATION OF TREATMENT – Assault or verbally threatening behavior towards staff, other patients, or physical property of Pain Relief Associates by a patient will be cause to terminate treatment. The patient will also be held responsible for any damages. Firearms and other weapons are prohibited, with exception for an officer of the law.

_____ (Initials)

9. CANCELLATIONS – Cancellations must be made 1 business day (24 hours) before your session. Your session time is reserved for you and you will be charged a $50.00 fee for no-shows or late cancellations. You may cancel appointments after hours with the answering service at no charge. Our office policy allows 3 no-shows fees before terminating services.

_____ (Initials)

10. OUTSIDE LAB OR OTHER DIAGNOSTIC TESTS – We do not get authorization from your insurance for any ordered tests that are performed outside our office. We suggest you contact your insurance carrier to insure that you will be reimbursed for the charges and are aware of your benefit coverage.

_____ (Initials)

11. MANAGED CARE PLANS – This practice has contracted with several managed care plans and charges will be handled according to our agreement with them. All co-payments must be paid at the time of services. It is your responsibility to be aware of your coverage variables, such as preventive health care, deductibles, etc., and to pay for services not covered by your insurance company. Following notifications from the insurance company, any denied amounts would be due immediately, upon being notified by our office.

_____ (Initials)

12. ASSIGMENT OF INSURANCE BENEFITS/REALEASE OF INFORMATION – I hereby authorize my insurance carrier to pay benefits directly to Pain Relief Associates for services provided to myself or my inured dependent(s), realizing I am responsible to pay for all services provided. I hereby authorize the release of pertinent information required by insurance carrier to process insurance claims for payment by Pain Relief Associates.

_____ (Initials)

13. EMERGENCY PROVIDER CONTACT SYSTEM – There is an afterhours system available to contact the provider on-call for emergency situations. There is a $50.00 charge for non-emergency afterhours calls.

_____ (Initials)

14. EMERGENCY SERVICES – I agree to contact Pain Relief Associates or 911 in the even that I feel suicidal or violent in order to follow steps to protect the safety of others and myself.

_____ (Initials)

15. NOTICE OF PRIVACY PRACTICES – I acknowledge that I have received a copy of the Notice of Privacy Practices of this office.

_____ (Initials)

16. BILLING IQUIRY – If you have billing questions, we will be pleased to help you. Contact our office and ask for the billing department.

_____ (Initials)

17. IN-OFFICE (OUT-PATIENT) SERVICES ONLY – I understand that Dr. Laura Champagne only provides out-patient services in her office. Any in-patient hospital services shall be treated by the attending hospital psychiatrist. I shall return back to Dr. Champagne's office at Pain Relief Associates for follow-up treatment after being discharged from the hospital.

_____ (Initials)

Items 1-17, initialed by me, indicate my understanding of legal terms and conditions in connection with the treatment of the patient.

Patient Signature: _____ Date: _____ Initials: _____

Parent/Guardian: _____ Date: _____ Initials: _____

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PAIN RELIEF ASSOCIATES

Dr. Laura Champagne

CLIENT'S RIGHTS

1. You have all the rights of any other resident of the State of Texas and the United States of America.
2. You have the right to not be discriminated based on age, race, ethnicity, gender, sexual orientation, religion, national origin, physical or mental disability, or other attributes.
3. You have the right to a humane environment that provides reasonable protection from harm and appropriate privacy for your personal needs.
4. You have the right to be free from abuse, neglect and exploitation.
5. You have the right to be treated with dignity and respect.
6. You have the right to be told about the treatment you will be given, the risks, side effects, and benefits of all medications and treatment you will receive, the other treatments that are available, and what may happen if you refuse treatment.
7. You have the right to accept or refuse treatment after receiving this explanation.
8. You have a right to a treatment plan designed to meet your needs, and you have the right to take part in developing that plan.
9. You have the right to know the qualifications of the staff responsible for your treatment.
10. You have the right to refuse to take part in research without affecting your regular care.
11. You have the right not to be given medication you do not need, or too much medication.
12. You have the right to have information about you kept private and to be told about the times when the information can be released without your permission.
13. Unless otherwise provided by law, you have the right to withdraw at any time your permission for something you agreed to earlier.
14. You have the right to make a complaint and receive a fair response from this practice within a reasonable amount of time.
15. You have the right to contact and consult with counsel at your expense.
16. You have the right to select practitioners of your choice at your expense.
17. You have the right to choose whether your parents may be present and participate in your treatment if you are at least 18 years of age.

I acknowledge having read and understood the above client rights.

Patient Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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PAIN RELIEF ASSOCIATES

Dr. Laura Champagne

INITIAL EVALUATION & FOLLOW-UP MEDICATION VISITS

Welcome to our practice. Please take a moment to read the following information regarding our office procedures.

On your first visit:

- A clinician will obtain a detailed medical and psychiatric history; taking up to 40 minutes.
- In a few cases, when the diagnosis is not clear from history, the clinician may need additional testing before making treatment recommendations.
- The clinician then explains the diagnosis, treatment recommendations and answers any questions you may have.
- The clinician will also direct you to check out to schedule a follow-up appointment. It is wise to schedule that appointment while you are at the office, if at all possible.

For follow-up Medication Management visits:

- Patients routinely are scheduled with the clinician for follow-up medication management visits to assess your treatment response and monitor for side effects. The clinician will meet with you; obtain information regarding your response to the treatment plan.
- For your safety, medication changes are generally not made over the phone. However, if you feel you are having an adverse reaction, please call immediately.
- You will typically see the clinician for return visits.

If you need Psychotherapy:

- Psychiatrists, Nurse Practitioners and Physicians Assistants do not see patients for psychotherapy.
- The clinician will refer you to a therapist in our office, if possible, on your insurance plan.

I have read the above policy and understand it.

Signature: _____ Date: _____

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PAIN RELIEF ASSOCIATES

CONTRACT 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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PAIN RELIEF ASSOCIATES

If you have any questions about the notice, please contact HIPAA grievance officer at (281) 367-1015. All complaints must be submitted in writing. You will not be penalized or retaliated against for filing a complaint.

WHO WILL FOLLOW THIS NOTICE?
Any physician or health care professional authorized to enter information into your chart and any employee or other personnel in the practice. In addition we may share with each other and third party specialists for treatment, payment and purposes described in the notice.

WE ARE REQUIRED BY LAW TO:
Make sure that medical information that identifies you is kept private. Give you notice of our legal duties. Follow the term of the notice this is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:
Treatment – We may use medical information about you to provide you with medical treatment services. We may disclose medical information about you to people outside the office who may be involved in your care. These entities include third party physicians, hospitals, nursing homes, pharmacies or clinical labs with who the office consults or makes referrals

Payment – We may use and disclose medical information about you so that treatment and services you receive at our office may be billed to and payment collected from you, an insurance company or a third party.

Appointment Reminders – We may use and disclose medical information to contact you as a reminder that you have an appointment for medical services at the office. We do notify our patients by telephone.

As Required By Law – We will disclose medical information about you when required to do so by federal, state or local law.

SPECIAL SITUATION:
Health Oversight Activities – We may disclose medical information to a health oversight agency for activities authorized by law.

Lawsuits and Disputes – If you are involved in a lawsuit or a dispute we may disclose medical information about you in response to a court order. We may also disclose information about you in response to a subpoena.

Coroners, Medical Examiners, and Funeral Directors – We may release medical information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU:
Right to inspect and copy – If you request a copy of the information we may deny your request due to mental health liabilities.

Right to Amend – If you feel that medical information we have about you is incorrect or incomplete you may ask us to amend the information. In addition you must provide a reason that supports your request. We may deny your request for an amendment but your request will be put into your permanent file as you requested it be changed.

Right to Request Restrictions – You have the right to request a restriction or limitation on the medical information we disclose about you for treatment, payment or health care operations

CHANGES TO THIS NOTICE:
We reserve the right to change this notice.

COMPLAINTS:
If you believe your privacy rights have been compromised, you can file a complaint with our Practice Manager at (713) 863-7246

OTHER USES OF MEDICAL INFORMATION:
Other uses and disclosures of medical information not covered by this notice will only be made with your written permission. You may revoke that permission in writing at any time; if you do we will no longer disclose medical information. Understand that we are unable to take back any disclosures we have already made with your permission and we are required to retain our records of this care that we provided to you

Signature: _____ Date: _____

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PAIN RELIEF ASSOCIATES

PATIENT GUIDELINES AND CONSENT FOR USE OF E-MAIL COMMUNICATIONS

To better serve our patients, this office has established a website for some forms of communication. Our website will allow you to send messages to the appropriate staff member in regards to scheduling, practitioner questions, billing issues and medication refills. Please remember, however, that this form of communication is not appropriate for use in an emergency. The turnaround time for routine patient communications is within 24-48 hours. The service provided may delay message delivery. Should you require urgent or immediate attention, this medium is not appropriate.

Types of communication that are appropriate for e-mail include:

- Scheduling inquires
- Non-urgent medical advice
- Billing or insurance questions
- Test and lab results
- Home health monitoring reports
- Prescription refill request (per practice policy)
- Educational materials

When sending e-mail, please put the subject of your message in the subject line so we can process it more efficiently. Also, be sure to put your name, date of birth, and return telephone number in the body of the message. We also ask that you acknowledge receipt of e-mails coming from this office by using the auto reply feature.

Communications relating to diagnosis and treatment will be filed in your medical records.

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of e-mail, third parties may have access to messages. When communicating from work, you should be aware that some companies consider e-mail corporate property and your messages may be monitored. In addition, you should be aware that, although addressed to me, my staff and/or colleagues would have access to this information.

I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office's control.

I understand and agree to the above e-mail policy.

Signature: _____ Date: _____

E-mail: _____

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PAIN RELIEF ASSOCIATES

PATIENT & FAMILY HISTORY – NEW PATIENTS

PRESENTING PROBLEMS:

Please state the reason and/or symptoms that brought you here today:

_____
_____
_____

Are there any significant events associated with the above? Yes No
If yes, please provide more information: _____
_____
_____

Are you presently having thoughts of suicide? Yes No
If yes. Please provide more information: _____
_____
_____

Have you ever made a suicide attempt? Yes No
If yes, please provide more information: _____
_____
_____

PATIENT MEDICAL HISTORY:

Have you ever had psychiatric treatment? Yes No

If yes, please describe: Date: _____ Provider: _____

Reason: _____
_____
_____

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HISTORY OF SUBSTANCE USE AND/OR ABUSE:

Have you ever used illegal/street drugs? Yes No

Substance	Age began	Frequency/amount	Last time used
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Current Medications: (Example: Prozac 20 mg one a day. Include all medications, not just psychiatric meds. Also include ay over-the-counter meds, vitamins, etc.)

Medication Name	Dose	How often	Reason/Treatment of
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

FAMILY MEDIACAL HISTORY:

Check and list – i.e. Mother (M), Father (F), Paternal Grandmother (PGM), etc.

- Diabetes - _____
- Thyroid Disorder - _____
- Heart Attack or Heart Disease - _____
- High Blood Pleasure - _____
- Stroke - _____
- Alzheimer's Disease - _____
- Parkinson's Disease - _____
- Migraine Headaches - _____
- Other (list): _____

Family Psychiatric History (check and list as above):

- Depression - _____
- Bipolar Disorder (Manic Depression) - _____
- Schizophrenia - _____
- Alcoholism - _____
- Drug Abuse or Dependency - _____
- ADD or ADHD - _____
- Obsessive Compulsive Disorder - _____
- Anxiety or Panic Symptoms - _____
- Other (list): _____

Check all symptoms you have been experiencing:

- Recent weight gain. How much? _____
- Recent weight loss. How much? _____
- Difficulty falling sleep (insomnia)
- Middle of the night awakening
- Restlessness or agitation
- Frequent mood swings
- Complaints of despair, hopelessness, worthlessness
- Inability to experience pleasure
- Withdrawal from others
- Loss of libido
- Difficulty focusing resulting in unfinished task(s)
- Excessive sleeping
- Decreased energy
- Frequent anger
- Inability to express feelings
- Loss of thought process
- Fatigue
- Lack of motivation
- Increased appetite
- Irritability
- Inattention

Religious Preference:

Are there any cultural issues or religious beliefs that might affect your treatment? Yes No

If yes, explain: _____
_____

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PAIN RELIEF ASSOCIATES

SYPTOMS CHECKLIST

Name: _____

For the following symptoms, please check those that you believe are a current or recent problem. Please estimate when these first occurred.

- Often fails to give close attention to details; many carless mistakes: _____
- Often has difficulty sustaining attention in tasks or play: _____
- Often seems not to listen when spoken to ("spacey"): _____
- Trouble following through on instructions; failing to finish homework or chores (not due to being oppositional or defiant): _____
- Often has difficulty organizing tasks or activates: _____
- Often avoid or is hesitant to work on tasks that require sustained mental effort: _____
- Often loses things (toys, assignments, books, etc.: _____
- Often easily distracted by sounds, activities, etc.: _____
- Often forgetful in daily activities: _____
- Fidget or squirms in seat: _____
- Difficulty remaining in seat: _____
- Inappropriate running or climbing, being restless: _____
- Difficulty playing quietly: _____
- Often "on the go" as if "driven by a motor': _____
- Often blurts out answers too quickly: _____
- Difficulty waiting his/her turn: _____
- Often interrupts or intrudes of others: _____
- Often loses temper: _____
- Often argues with adults: _____
- Often actively defies or refuses adult requests or rules: _____
- Often deliberately does things to annoy others: _____
- Is often touchy or easily annoyed: _____
- Often angry or resentful: _____

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- Often spiteful or vindictive: _____
- Depressed or very irritable mood much of the time: _____
- Decreased or excessive sleep: _____
- Poor appetite or overeating: _____
- Marked agitation or unusually sluggish: _____
- Fatigue or loss of energy: _____
- Decreased pleasure or loss of interest in things: _____
- Poor concentration or difficulty making decisions: _____
- Feelings of worthlessness, excessive feelings of guilt: _____
- Suicidal thoughts or attempts: _____
- Low self-esteem, negative self-talk: _____
- Feelings of hopelessness about the future: _____
- Extremely elevated mood: _____
- Severe mood swings: _____
- Grandiose thinking: _____
- Racing thoughts, very rapid speech: _____
- Manic or hypomanic behavior (extremely hyper): _____
- Drug or alcohol use: _____
- Often swears or uses obscene language: _____
- Has stolen without confronting victim: _____
- Stays out at night without permission: _____
- Has run away from home overnight: _____
- Lies to obtain goods or avoid obligation: _____
- Deliberately sets fires: _____
- Often engages in dangerous activities: _____
- Often truant from school: _____
- Has broken into someone's house, car or other: _____
- Deliberately destroyed others' property: _____
- Forces someone into sexual activity: _____
- Used a weapon in a fight: _____
- Initiates physical fights: _____
- Has stolen while confronting the victim: _____
- Physically cruel to people or animals: _____

- Bullies, threatens or intimidates others: _____
- Unrealistic and persistent worry about possible harm to family of friends: _____
- Unrealistic and persistent worry about future events, or terrible events: _____
- Persistent refusal to go to school: _____
- Persistent refusal to sleep alone: _____
- Persistent avoidance of being alone: _____
- Repeated nightmares about separation: _____
- Physical pains or illnesses without known physical causes: _____
- Excessive distress in anticipation of separation from attachment figures: _____
- Excessive distress when separated from home, parents: _____
- Unrealistic concern about past behaviors: _____
- Unrealistic concern about competence: _____
- Marked self-consciousness: _____
- Excessive need for reassurance: _____
- Marked inability to relax: _____
- Compulsive rituals: _____
- Obsessions or intrusive thoughts: _____
- Unusual repetitive behaviors: _____
- Preoccupation with firearms or knives: _____
- Odd Postures: _____
- Excessive reaction to noise or fails to react to out noises: _____
- Overreacts to touch: _____
- Motor tics (muscle twitches): _____
- Loose thinking, hard to follow: _____
- Bizarre ideas, delusions, hallucinations: _____
- Disoriented, confused, “spacey”: _____
- Incoherent speech: _____
- Hears voices: _____
- Other behaviors of concern: _____

_____

_____

_____

_____