Pain Relief Associates
Tel: 713-863-7246 Fax: 713-863-9524 LiveWithRelief.com

New Patient Questionnaire

Patient Information **Today's Date:** / /

First Name (MI) Last Name		Gender: ☐ Male ☐ Female
Street Address	City/State	Zip Code
Home Phone ( )	Work Phone ( )	Cell Phone ( )
Email Address	Date of Birth	Current Age
Social Security #	Emergency contact Name and Telephone number:	
Preferred Language: ☐ English ☐ Spanish ☐ Other	Ethnicity: ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Asian ☐ Other	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow	Spouse's Name / Significant Other:	If a Minor – Parent or Guardian's Name

Work Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disable ☐ Student ☐ Other

Employer's Name:	Occupation:	
Employer Address:	City / State:	Zip Code:

Health Insurance Information:

Name of Insurance Company:	Billing Address	Policy #:

Referred by:

☐ Patient Name:	☐ Physician Name & address:	tel:
		fax:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Pain Relief Associates, insurance company or providers to release or obtain any information required to process my claims, render medical care to me or participate in my care.

X ____

PATIENT/GUARDIAN SIGNATURE DATE

Patient's Name:

Please list all your medical complaints in order of severity:

1.	2.
3.	4.
5	6.

History:

How did your pain begin: ☐ Immediate ☐ Gradually

How often do you experience these symptoms?

☐ Constant ☐ Intermittent (comes and goes)

Is this condition progressively getting:

☐ Worse ☐ Better ☐ Unchanged

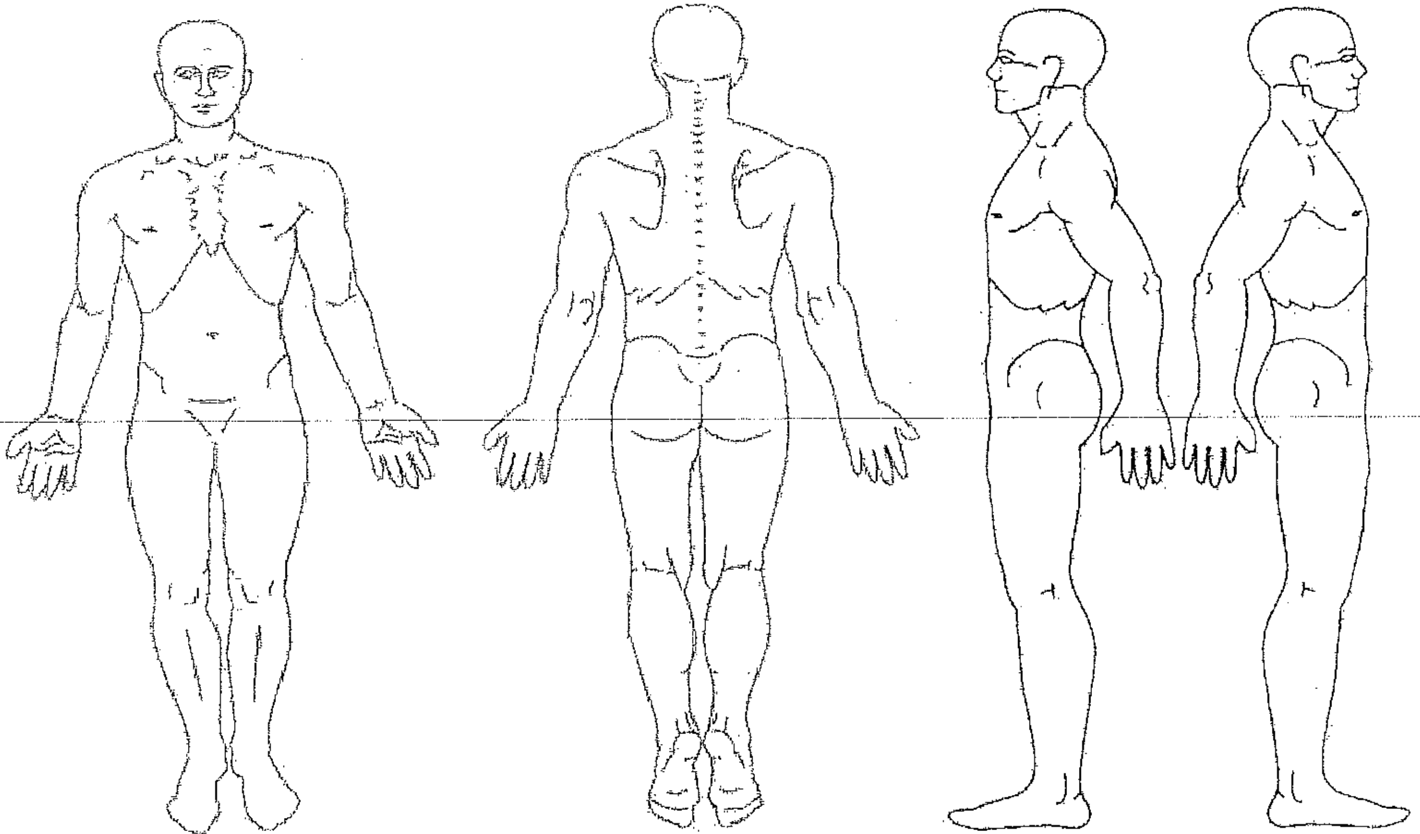
Rate your symptoms on a scale of 1-10 considering 1 (minimal) and 10 (severe / excruciating pain)

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Please describe your pain (choose as many as needed below):

☐ Dull ☐ Sharp ☐ Burning ☐ Aching ☐ Stabbing ☐ Throbbing ☐ Nagging ☐ Tingling

Please draw or mark the location of your pain below:



Are you experiencing any of the following associated symptoms with your pain?

☐ Pins/Needles ☐ Tingling ☐ Numbness ☐ Twitching

☐ Other - please describe:

Has your pain been associated with any of the following conditions:

☐ Loss of Bladder/ Bowel control ☐ Fever/ Chills ☐ Nausea/ Vomiting ☐ Dizziness/ Balance Problems ☐ Blurred Visions

☐ Abdominal Pain ☐ Weight Loss ☐ Flank Pain

☐ Other - please describe:

Please indicate what activities aggravates (make worse) your condition:

☐ Sitting _____ min. ☐ Standing ☐ Walking ☐ Lying ☐ Pushing ☐ Pulling ☐ Lifting _____ lbs.

☐ Coughing ☐ Sneezing ☐ Bowel Movements ☐ Mental Stress ☐ Bright lights

Please indicate what helps to alleviates (make better) the pain.

☐ Lying ☐ Sitting ☐ Walking ☐ Standing ☐ Rest ☐ Heat ☐ Cold ☐ Medication ☐ Nothing

Does your pain wake you from sleep? ☐ No ☐ Yes – How often? – / times per night

Please list any doctors or specialists that you have seen for this condition.

1.

2.

3.

4.

5.

6.

What treatments have you've tried in the past to help your pain.

☐ Spine Injections ☐ Trigger point injections ☐ Physical Therapy ☐ TENS ☐ Chiropractic ☐ Acupuncture ☐ Massage

PAST MEDICAL HISTORY: Did you have any of the following?

Illnesses / Hospitalizations: ☐ No ☐ Yes – Please list and briefly describe below.

1.

2.

3.

4.

Injuries / Accidents / Falls ☐ No ☐ Yes – Please list and briefly describe below.

1.
2.
3.
4.
5.

Surgeries: ☐ No ☐ Yes – Please list and briefly describe below

1.
2.
3.
4.

Please list any allergies to Medicine below and briefly describe the adverse reaction. ☐ NKDA / none

1.
2.
3.
4.
5.
6.

Medications: Please list all your current medications below.

Patient's Name:

Social History

Cigarettes / Cigars	☐ None ☐ Yes - How many per day? How many years?
Alcohol	☐ None ☐ Yes - How many drinks per day / week? Type of Alcohol?
Recreational Drugs	☐ None ☐ Yes - Types? Frequency? Years of Usage?
Exercise	☐ None ☐ Yes – Hours / Days per week? Types?
Water	☐ None ☐ Yes - Glasses per day?
Soft Drinks/ Coffee	☐ None ☐ Yes - Amount per week?
Sleep	Average hours per night? Do you have difficulty falling asleep or staying asleep? ☐ Yes ☐ No – Explain.

Do you currently have or had any of the following condition(s):

☐ Alcoholism	☐ Diabetes	☐ Hepatitis A☐ B☐ C☐	☐
☐ Anemia	☐ Drug Addiction	☐ Hepatitis D☐ E☐	☐ HIV
☐ Osteoarthritis	☐ Epilepsy	☐	☐ STD"s
☐ Rheumatoid	☐ Insomnia	☐ Infectious Disease	☐ Thyroid Disease
☐ Lupus	☐ Glaucoma	☐ Mental Disorders	☐ Tuberculosis
☐ Chicken Pox	☐ Heart Disease	☐ Insomnia	☐ Tumors
☐ Shingles	☐ Heart Attack	☐ Sleep Apnea	☐ Cancer
☐ High Blood Pressure	☐ Migraine	☐ Pneumonia	☐

Review of Systems ***Check all that applies below***

SKIN	NOSE	GI	MUSCULOSKELETAL
☐ Rashes	☐ Stuffiness	☐ Heartburn	☐ Ankle / Foot Pain
☐ Lumps	☐ Discharge	☐ Change in appetite	☐ Arm / Elbow Pain
☐ Itching	☐ Itching	☐ Nausea	☐ Difficulty Chewing
☐ Dryness	☐ Hay fever	☐ Change in bowel habits	☐ Difficulty Walking
☐ Color changes	☐ Nosebleeds	☐ Rectal bleeding	☐ Face Pain
☐ Hair and nail changes	☐ Sinus pain	☐ Constipation	☐ Jaw Pain
HEAD	**THROAT**	☐ Diarrhea	☐ Leg / Arm Fatigue
☐ Headache	☐ Bleeding	☐ Yellow eyes or skin	☐ Lower Back Pain
☐ Head injury	☐ Dentures	**RESPIRATORY**	☐ Mid Back Pain
☐ Neck Pain	☐ Dry mouth	☐ Cough	☐ Neck Pain
EAR	☐ Sore tongue	☐ Sputum	☐ Thigh / Knee Pain
☐ Decrease hearing	☐ Sore throat	☐ Coughing up blood	☐ Wrist / Hand Pain
☐ Ringing in ear	☐ Hoarseness	☐ Shortness of breath	**NEUROLOGIC**
☐ Earache	☐ Thrush	☐ Wheezing	☐ Dizziness
☐ Drainage	☐ Non-healing sores	☐ Difficulty breathing	☐ Fainting
EYE	**NECK**	**CARDIOVASCULAR**	☐ Seizures
☐ Vision loss/ changes	☐ Lumps	☐ Chest pain	☐ Weakness
☐ Glasses or contacts	☐ Swollen glands	☐ Tightness	☐ Numbness
☐ Redness	☐ Pain	☐ Palpitations	☐ Tingling
☐ Glaucoma	☐ Stiffness	☐ Difficulty breathing	☐ Tremor
☐ Cataracts	**ENDOCRINE**	lying down	☐ Slurred speech
☐ Blurry or double vision	☐ Heat or cold intolerance	☐ Arrhythmias	☐ Facial drooping
PSYCHIATRIC	☐ Sweating	☐ Swelling in legs	☐ Drooling
☐ Nervousness	☐ Frequent urination	☐	**HEMATOLOGIC**
☐ Stress	☐ Increase thirst	☐	☐ Easy bruising
☐ Depression	☐ Change in appetite	☐	☐ Easy bleeding
☐ Memory loss	☐ Unexplained weight gain	☐	☐ Anemia

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: ______________________________ DATE: ______________

Over the last *2 weeks,* how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	____ +	____ +	____

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL: ____

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	
Not difficult at all	______
Somewhat difficult	______
Very difficult	______
Extremely difficult	______

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A2663B 10-04-2005

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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A2662B 10-04-2005

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
-

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

- Date of Notice: April 14, 2016
- David Lane
Practice Manager
Phone: (713) 863-9524
David@LiveWithRelief.com

PAIN RELIEF

ASSOCIATES

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I Acknowledgement of Practice's *Notice of Privacy Practices*:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose).

______________________ ______________ ______________________

Name of Patient | Date of Birth | Signature of Patient/Parent/Guardian Date

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

______________________ ______________________

Print Name | Last four digits of his/her SSN (required)

______________________ ______________________

Print Name | Last four digits of his/her SSN (required)

______________________ ______________________

Print Name | Last four digits of his/her SSN (required)

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home Telephone Number:

____

____OK to leave message with detailed information

____Leave message with call back numbers only

Written Communication Address:

____

____OK to mail to address listed above

____Mail me at: ______________________

Work Telephone Number:

____

____OK to leave message with detailed information

____Leave message with call back numbers only

Fax Communication:

____

____OK to FAX to address listed above

____FAX me at: ______________________

OK to E-mail me at: ____

______________________ ______________________

Name of Patient (Print) | Signature of Patient/Parent/Guardian | Date

PAIN RELIEF
ASSOCIATES

To All Patients:

As part of our continued effort to provide you with the best care and accommodate all appointment requests, we have implemented a Cancellation Policy as of August 1, 2014.

Time has been specifically reserved for your treatment. Please call at least **24 hours** ahead to cancel or reschedule an appointment.

If you fail to cancel your office appointment at least 24 hours ahead or fail to show up for your scheduled appointment, you will be charged a **"No Show Fee"** of **$25.00** with no exceptions.

If you have any questions or concerns, please contact us at 713-863-7246.

Thank you,

Pain Relief Associates

I, ______________________________, have read and fully understand the cancellation policy above.

______________________________ ______________________________

Patient Signature Pain Relief Associates, Front Desk

____ / ____ / 2016

PAIN RELIEF ASSOCIATES

Medication Management Agreement

This Agreement between____("Patient")
And Pain Relief Associates is for the sole purpose of establishing agreement between Doctor and Patient on clear conditions for the prescription and use of pain controlling medications prescribed by the Doctor for the Patient. Doctor and Patient agree that this Agreement is an essential factor in maintaining the trust and confidence necessary in a doctor/patient relationship.

The Patient agrees to and accepts the following conditions for the management of pain medication prescribed by the Doctor for the Patient.

(1) I understand that a reduction in the intensity of my pain and improvement in my quality of life are the goals of this program
(2) I realize that all of the medication have potential side effects, such as addiction, liver damage, kidney damage, allergic reaction, drowsiness, and mental impairment
(3) I realize that it is my responsibility to keep myself and others from harm, including the safety of my driving or operation of a machinery. If there is any question of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have used my medication for at least four days
(4) I will not use any illegal controlled substances, including marijuana, cocaine, and so forth
(5) I will not share, sell, or trade my medication for money, goods, or services
(6) I will not attempt to get pain medication form any other health care provider without telling them I am taking pain medication prescribed by the Doctor. I understand it is against the law to do so. If my primary care physician is willing to prescribe my medications, the Doctor will have to approve the arrangements to make sure there is no duplication
(7) I will safeguard my medication and prescription from loss or theft and agree that the consequences of my failure to do so is that I will be without my prescribed medication for a period of time
(8) I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the prescribing of my pain medication and I authorize the Doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the Texas Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize the Doctor to provide a copy of this Agreement to my pharmacy.
(9) I agree that I will submit a blood or urine samples for drug testing if requested by my Doctor to determine my compliance with my regimen of pain control at my own expense
(10)I agree that I will use my medication at a rate no greater than the prescribed rate and that use of medication at a greater rate will result in my being without medication for a period of time. I will not call for refills at any time-under any condition. I understand that I will need to be re-evaluated for different medications.
(11) Script altering is a Federal offense and we will report any violations with the proper authorities
(12) Should your medication need to be changed prior to your "due date", all unused medication must be brought to our office prior to receiving new prescription
(13) I understand that this medication regimen will be continued for a period of one month. My case will be reviewed at the end of the period. If there is no evidence that I am improving or that progress is being made to improve my function or my quality of life, the regimen will be tapered to my pre-trial medications and my care will be referred back to my primary care physician.
(14) I agree not to consume alcohol while being prescribed pain medication.

Doctor and patient agree that this Agreement is essential to the Doctor's ability to treat Patient's Pain effectively and that failure of the Patient to abide by the terms of this Agreement may result in the withdrawal of all prescribed medication by the Doctor and the termination of the Doctor/Patient relationship.

This Agreement is entered into on this _______ day of ____________20_______.

____
PATIENT SIGNATURE

I ACKNOWLEDGE RECIEPT OF THIS AGREEMENT ON THE DATES STATED ABOVE. (form date 2-2012)

Consent for Chronic Opiate Therapy

I, ______________________________; (Patient) am fully aware that Dr.______________ / and or any officially designated representative of Pain Relief Associates is prescribing Opiate medicine, sometimes called narcotic analgesics as part of my pain therapy. I attest to the following statements:

1. I am not currently abusing illicit or prescription drugs, and I am not undergoing treatment for substance dependence or abuse.
2. I have never been involved in the sale, diversion or transportation of controlled substance.
3. I will obtain all prescriptions for Opiate analgesics from Pain Relief Associates and reveal all other medications that I am taking
4. I will only use **ONE** Pharmacy for filling prescription analgesics
5. I give my permission to allow Pain Relief Associates staff and physicians to discuss my case with my other physicians, pharmacists, and any other regulatory agency (ie DEA, DPS, local police agencies)
6. I agree to take my opiate pain medications ONLY AS PRESCRIBED by Pain Relief Associates
7. I agree to follow the advice of the physician and physician assistant of Pain Relief Associates regarding the stopping of controlled substance as they advise
8. I understand that Pain Relief Associates reserves the right to order random drug screening at any time and I will comply with such request at my expense
9. I understand that Pain Relief Associates will make NO allowance for lost prescriptions or medications
10. I understand that Pain Relief Associates reserves the right to dismiss me from the treatment program should any violations of the above occur.
11. **(FEMALES ONLY)** I certify that I am not pregnant. If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware, that should I carry a baby to delivery while taking these medicines; the baby will become physically dependent on Opiates. I am aware that use of Opiates is generally not associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an Opiate.
12. **(MALES ONLY)** I am aware that chronic pain Opiate use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

If drug dependence, tolerance or addiction occurs, I agree to accept full responsibility for the risks taken secondary to my consent of Opiate consumption for the management of my pain. Should withdrawal symptoms be encountered, I will notify Pain Relief Associates. This medication should be stopped slowly, with tapering. Medication is not to be stopped on your own without medical advice. **Evidence of medication hoarding, increasing use of medication without communication to the pain clinic staff, hostile behavior towards our staff, refilling your prescription too early, getting the opiate pain medication from multiple physicians or pharmacies, increasing amount of medications, altering prescription, medication sales, unapproved uses of other drugs (alcohol, sedatives or street or "illicit" drugs) during Opiate analgesic treatment or other unacceptable behavior may result in dismissal from Pain Relief Associates.**

Side effects of Opiate medications may include drowsiness, constipation, nausea and or confusion. Risk of psychological dependence with the use of these medications may occur. Physical dependence is frequently encountered in the use of long-term Opiate therapy. Medication needs to be withdrawn gradually to avoid uncomfortable withdrawal symptoms that may include: excessive tearing, runny nose, dilated pupils, "goose pimples" flesh, sweating, yawning, diarrhea, muscle aches, headaches and insomnia. Tolerance to the use of Opiate medication may occur, decreasing it effectiveness.

I authorized the release of medical records from all previous physicians, including psychological reports to Pain Relief Associates.

I have read this entire agreement and have had the opportunity to ask questions. All of my questions have been answered satisfactorily; I consent to the use of opiate analgesics under the terms outlined in the agreements. I will be given a copy of this policy for my reference.

______________________	______________________	______________
Patient Signature	Patient Name (Print)	Date

CONSENT TO DISCLOSE OR OBTAIN
PRIVATE HEALTHCARE INFORMATION
FOR TREATMENT, PAYMENT, AND/OR HEALTHCARE OPERATIONS

I, ____________________________, Social Security Number ________________, date of birth

________________, hereby authorize and consent for Pain Relief Associates,

to (______) ☐ **RELEASE** or (______) ☐ **OBTAIN**
Initials Initials

any and all medical, dental, and / or psychological reports or operative notes, discharge summaries, Doctor's / Dentist orders, Nurse's notes, lab reports, test results, physical therapy progress notes, patients progress reports, diagnosis, pathology reports, x-rays, MRIs, any records reflecting treatment for studies, laboratory slides, clinical abstracts, histories, charts, and other information contained therein, any documents and opinions relevant to past, present, or future physical and mental condition, treatment, care or hospitalization, and any other personal health information regarding my medical / dental care as necessary to carry our treatment, obtain payment, and / or conduct other healthcare operations.

The release or to obtain of the matters listed above is being authorized for purposes of obtaining medical / dental treatment, payment for such services and other health care operations.

A copy of this authorization is agreed by the undersigned to have the same effect and force as an original.

This Consent to Disclose or Obtain Private Healthcare Information may be revoked in writing. However, such revocation shall not be effective on an entity that has take action in reliance upon this Consent Prior to its revocation and / or if this Consent was obtained as a condition of obtaining insurance and a law provides the insurer the right to contest a claim under the policy.

Any person, firm, or entity that releases matters pursuant to this authorization is hereby absolved from any liability that might otherwise result from the release of those matters.

I further acknowledge that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by the privacy regulations.

I further understand that I have the right to review Pain Relief Associate's privacy notice and to request restrictions.

Signed this _______ day of _____________________, 20____.

____
Signature

____
Printed Name

Special Restrictions to withhold Medical Records

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Send Medical Records to:

____
Person or Clinic Name

____
Address

____
City, State Zip code