TEXAS PAIN INSTITUTE

PATIENT REGISTRATION

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in **ALL** the blanks below the line.

Is your condition a result of a work related injury? YES NO An Auto Accident? YES NO Date of Injury?

Patient's **LEGAL** Name (Last, First, MI)	Social Security #	Appointment Date

Home Address	City	State	Zip

Date of Birth	Sex M F	**Marital Status** **1 Single 2 Married 4 Widowed 5 Divorced 6 Legally Separated**

Email Address	**Race (choose one only)** **1 Asian/Pacific Islander 2 Black 3 Caucasian 4 Hispanic 5 American Indian 9 Other**

Home Telephone Number	Mobile Number

PATIENT'S INSURANCE INFORMATION

PRIMARY Insurance — Relationship to Insured: _ Self _ Spouse _ Child _ Employer

Address City State Zip

Subscriber's Name Subscriber's Date of Birth Subscriber's SSN #.

Insurance ID No.: Group Number: Effective Date:

SECONDARY Insurance — Relationship to Insured: _ Self _ Spouse _ Child _ Employer

Address City State Zip

Subscriber's Name Subscriber's Date of Birth Subscriber's SSN#

Insurance ID No.: Group Number: Effective Date:

Circle if Appropriate: Medigap Policy Retiree Coverage

EMPLOYMENT INFORMATION

Employer's Name (if W/C-employer at time of injury) Employer's Telephone Number

Employer's Address City State Zip

Are you employed (circle one)
Active Duty Full Time Part Time Retired Self Not Employed

Work Telephone Number **Driver's License Number** **State Issued**

NOTIFY IN CASE OF EMERGENCY

Name Relationship

Address City State Zip

Home Number Mobile Number Work Number

Nearest Relative (not living with you) Relationship

Address City State Zip

Home Number Mobile Number Work Number

TEXAS PAIN INSTITUTE
1000 Lipscomb Street, Ste 110 Fort Worth, Texas 76104
Phone: (817) 348-8600 Fax: (817) 348-8602
651 Main Street, Suite 105, Keller, Texas 76248
Phone:(817) 741-0800 Fax: (817) 741-0805

Patient Name: _____

PATIENT AUTHORIZATION AND CONSENT

Ved V. Aggarwal, M.D., P.A. (Texas Pain Institute), is committed to fulfilling all the requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 2003.

Section A: *Authorization*

Must be completed for all authorizations. The patient or the patient's representative must read and initial the following statements:

1. I authorize Ved V. Aggarwal, M.D., P.A. (Texas Pain Institute) to release any of my medical or insurance information necessary to process my medical claims and coordinate or manage my healthcare.

   INITIALS: _____

2. I understand that I may revoke this authorization at anytime by notifying Ved V. Aggarwal, M.D. P.A. (Texas Pain Institute) in writing. But, if I revoke this authorization, my revocation will not have an effect on any actions Ved V. Aggarwal, M.D., P.A. (Texas Pain Institute) took before they received my revocation.

   INITIALS: _____

   You may revoke this authorization by signing a Revocation Authorization form and returning it to Ved V. Aggarwal, M.D., P.A. (Texas Pain Institute). To request a Revocation Authorization form, you may ask the receptionist or contact our office at:

   Ved V. Aggarwal, M.D., P.A. (Texas Pain Institute)
   928 Lipscomb St.
   Fort Worth TX 76104

3. Ved V. Aggarwal, M.D., P.A. (Texas Pain Institute) will not base condition for treatment or payment for healthcare services on your completing and signing this authorization.

   INITIALS: _____

For additional information regarding disclosures of uses of my health information, I acknowledge I may obtain a copy of Ved V. Aggarwal, M.D., P.A, (Texas Pain Institute) "Notice of Privacy Practice" at any time from the receptionist or by contacting the above business office.

INITIALS: _____

Section B: *Consent*

In the event of a family member or care giver attends my office visit and is in the exam room at the time of the evaluation and/or treatment, I give Ved V. Aggarwal, M.D., P.A and it's physicians or employees my permission to discuss freely my condition, treatment, diagnosis or insurance/payment issues with that person.

INITIALS: _____

May we leave a message on your Home answering device? Yes _____ No _____ Phone # _____

May we leave a message on your Work voicemail? Yes _____ No _____ Phone # _____

May we leave a message on Mobile phone voicemail? Yes _____ No _____ Phone # _____

May we leave a message at one of the numbers listed above about appointments with this office? Yes _____ No _____
We address our patients by name in our office and reception area. If you do not wish us to do this please note here.

_____

With whom may we NOT discuss or release information about your care, treatment, or diagnosis?

_____

_____ _____

Print Name _____ Signature _____ Date _____

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Patient Name: _____

PATIENT AGREEMENT

In agreement of Ved V. Aggarwal, M.D., P.A. (Texas Pain Institute) accepting me as a new patient for those problems for which he agrees to see me, I agree to the following:

ASSIGNMENT OF BENEFITS: I hereby assign to Ved V. Aggarwal, M.D., P.A. (Texas Pain Institute), all medical insurance benefits to which I may now be or in the future become entitled in relationship to medical services provided Ved V. Aggarwal, M.D./Kent Mitchell, M.D./Rodolfo Herrera, M.D.. I hereby authorize and direct third party (insurance) payment directly to Ved V. Aggarwal, M.D., P.A. (Texas Pain Institute) of benefits due to me for his services.

PAYMENT/DEFAULT: I understand and agree that payment is due at the time that medical services are rendered, unless other arrangements have been previously made. I understand that I am financially responsible for charges not paid for by a third party (insurance). In case of my default of payment for bills related to my treatment by Dr Ved V. Aggarwal, M.D./Kent Mitchell, M.D./Rodolfo Herrera, M.D., I hereby agree to pay for any and all collection and other charges, including attorney's fees and court costs, resulting from collection effort or litigation related to said bills.

RELEASE OF INFORMATION: I hereby consent for Ved V. Aggarwal,, M.D., P.A. (Texas Pain Institute) to release any and all of my protected health information or to deliver verbal reports that they deem useful for the following purposes:

- To carry out treatment, obtain payment for services rendered, or for healthcare operations (including delivering message related to my appointments, lab or other reports, or my medical status, to persons or answering devices, telephone numbers I may identify as a means of reaching me, including cellular, work or home telephone or facsimile numbers, or by email at any e-mail address I identify as a means of reaching me.
- To facilitate communication by telephone, fax or e-mail with individuals identifying themselves as representing any state or federal governmental agencies regulating health care or any insurance company that may be responsible for payment of Ved V. Aggarwal, M.D., P.A. (Texas Pain Institute) bills or other benefits due me.
- To any individual accompanying me in the event that I undergo a surgical procedure or other procedure.
- For research purposes and scientific papers, providing that I am not specifically identified.
- To previous and future physicians, facilities or other health care providers involved in my care, or to any attorneys I may from time to time designate as representing me.
- To me in the presence of any individual who accompanies me to clinic visits or other encounters with Dr. Aggarwal, Dr. Mitchell, Dr. Herrera or his staff. I specifically accept that it is my responsibility to exclude from such encounters, individuals who I do not wish to be knowledgeable of my protected health information.

I understand that I have the right to review the Notice of Privacy practices of Ved V. Aggarwal, M.D., P.A. (Texas Pain Institute) and to revoke consents related to use of protected health information for which consent is required.

I understand that Ved V. Aggarwal, M.D./Kent Mitchell, M.D./Rodolfo Herrera, M.D. has the right to refuse to treat me in the event that I do not sign this consent and I understand and agree that no physician-patient relationship will exist between Ved V. Aggarwal, M.D./Kent Mitchell, M.D./Rodolfo Herrera, M.D. and me unless and until I sign this agreement without restriction. I understand that I have the right to revoke this agreement at any time. This agreement shall remain valid and in full force and effect until such time as I may revoke it. My authorization for disclosures or other actions under the authority of this agreement undertaken prior to said revocation shall survive said revocation. Additionally, I agree that if I revoke any part of this consent, my act of revocation will unilaterally from my side terminate our physician-patient relationship. In the event of my revocation of any part of this consent, I further agree not to attempt to again be seen by Dr. Aggarwal/Dr. Mitchell/Dr. Herrera or his staff as a patient without resigning or reactivating this consent in full, or in the event that this consent has be amended, revised, replaced, to whatever amended, revised or replaced consent that Ved V. Aggarwal, M.D., P.A. (Texas Pain Institute) requires at that time. Further, I hereby release and discharge Ved V. Aggarwal, M.D., P.A. (Texas Pain Institute) from any liability due to any prior act performed by Ved V. Aggarwal, MD/Kent Mitchell, MD/Rodolfo Herrera, M.D. or his staff.

CONFIDENTIALITY OF MINORS: If I am under the age of 18 years old, I hereby authorize Ved V. Aggarwal, M.D., P.A. (Texas Pain Institute) to share all current or further information regarding my medical condition(s) with my parents or guardians.

LIMITATION OF PHYSICIAN-PATIENT RELATIONSHIP: I understand that Ved V. Aggarwal, M.D./Kent Mitchell, M.D./Rodolfo Herrera, M.D. is sub-specialized in and restricted to those areas in which he is fellowship-trained: interventional pain management. In order to have access to his expertise within his sub-specialties, as limited above, I agree to hold Ved V. Aggarwal, , M.D., P.A. (Texas Pain Institute) harmless for any and all failure to diagnose, treat or disclose medical conditions, other conditions or facts that are not part of this clinic restriction, including but not limited to all non-pain management conditions. I further agree that our physician-patient relationship is limited to management of only those problems that Ved V. Aggarwal M.D./Kent Mitchell, M.D./Rodolfo Herrera, M.D.. from time to time agrees to treat, and specifically agree that Ved V. Aggarwal, M.D./Kent Mitchell, M.D./Rodolfo Herrera, M.D. has the right to refuse to diagnose or treat any additional problems that I may have or may develop in the future. For example, by way of illustration but not by way of limitation, Ved V. Aggarwal, M.D./Kent Mitchell, M.D./Rodolfo Herrera, M.D. shall have no obligation to see me for or treat me for a shoulder or neck pain which I develop the day following the date of this agreement of any time thereafter, unless he agrees to at the time of such occurrence.

LEGAL TESTIMONY: In the event that the patient or patient's, legal guardians, heirs, estate, assigns, or personal representatives makes a claim against a third party that results in any obligation for Ved V. Aggarwal, M.D./Kent Mitchell, M.D./Rodolfo Herrera, M.D. to prepare for legal testimony, whether as an expert or material witness, the patient agrees to compensate Ved V. Aggarwal, M.D./Kent Mitchell, M.D./Rodolfo Herrera, M.D. for all time expended by Ved V. Aggarwal, M.D./Kent Mitchell, M.D./Rodolfo Herrera, M.D. to provide or prepare testimony, including but not limited to time spent in traveling, at his usual and customary rate as an expert witness in force at the time of said testimony, and to reimburse Ved V. Aggarwal, M.D./Kent Mitchell, M.D./Rodolfo Herrera, M.D. for all expenses incurred in the provision of said testimony, including but not limited to the cost of travel, and further agrees that payment for said testimony shall be pre-paid. In the event of failure to pre-pay, the patient agrees that payment shall be made of any recovery form said claim as a first priority over all other claims, prior to disbursement of any said recovery to the patient.

SEVERABILITY: This agreement shall be legally binding upon me, the patient, and the parents or legal guardians thereof if a minor, their heirs, estate, assigns, including all minor children, and personal representatives, and it shall be interpreted according to the laws of the State of Texas. Any disputes arising under this agreement, including the interpretation thereof, shall be litigated in and venue shall be Tarrant County, Texas. If any part, clause, provision or condition of this agreement is held to be void, invalid or inoperative such voiding, invalidity, or inoperativeness shall not affect any other part, clause, provision of condition thereof, but the remainder of this agreement shall be effective as though the void, invalid or inoperative part, clause or provision or condition has not been contained herein.

Patient Name: _____

MEDICAL RECORDS OF OTHER PROVIDERS: I hereby authorize and direct all prior, current and future health care providers to provide Ved V. Aggarwal, M.D./Kent Mitchell, M.D./Rodolfo Herrera, M.D. upon his request, any part or all, of their medical records, x-rays, reports or other information pertaining to my health care in their possession.

NURSE PRACTITIONER/PHYSICIAN ASSISTANT CONSENT: Ved V. Aggarwal, M.D./Kent Mitchell, M.D./Rodolfo Herrera, M.D., employs Physician Assistants and Nurse Practitioners to assist him in the delivery of your medical care. Physician Assistants and Nurse Practitioners are not doctors. A Physician Assistant (PA) is a graduate of a certified training program and is licensed by the state board. A nurse Practitioner (NP) is a registered nurse who has received an advanced education and training in the provision of health care. Physician Assistants and Nurse Practitioners of Ved V. Aggarwal, M.D./Kent Mitchell, M.D./Rodolfo Herrera, M.D., P.A. (Texas Pain Institute) can diagnose, treat and monitor routine and complex pain disorders. If you are seen by a PA or NP, typically Ved V. Aggarwal, M.D./Kent Mitchell, M.D./Rodolfo Herrera, M.D. will review your case on the day of your visit. I have read and understand that in this practice a "team approach" is used, with my unique problems and/or needs presented and discussed with one or both physicians in the development of my care plan. I also understand that typically one MD will direct my overall care, but from time to time I may be seen by any or all or the practitioners in this practice, including a Physician Assistant or Nurse Practitioner. By signing this form you consent to the services provided by a Physician Assistant or Nurse Practitioner.

I hereby acknowledge that the accuracy of the information on the forms I have filled out is critical in providing appropriate medical care to me and the likelihood of errors in diagnosis and treatment are significantly increased by inaccuracies or omissions on these forms, I hereby certify that the information I have given in the patient Information packet is accurate and complete to the best of my knowledge and belief.

_____ _____

Patient Signature Date

_____

Patient Name Printed

_____ _____

Parent or Guardian Signature Date

_____ _____

Printed Name of Parent or Guardian Relationship

FINANCIAL POLICY

In order to inform you of our current financial and office policy, please read the document below and sign the financial agreement. Our providers, clinical, and office staff are here to help you in any way possible and strive to make your experience with us pleasant and comforting. Keep a copy of this document for your records and should you have any questions please do not hesitate to ask one of our associates.

Please keep us informed of any address, telephone number, insurance, or name changes. If we are unable to contact you regarding your bill, we will refer the balance to our outside collection agency.

Please notify our office within 24 hours to reschedule or cancel an appointment. This will allow our staff to offer this time slot to another patient in need of an appointment.

We accept the following forms of payment: cash, credit cards (VISA, MasterCard and Discover) , cashier's checks, money orders, and personal checks.

Returned Checks

- Returned checks will accrue a $35.00 returned check fee, $10.00 administration fee, as well as any applicable bank fees to your account.

Insurance

- It is your responsibility to know your level of benefits for services provided. Being that our providers are specialists, many services are required to have prior authorization by the insurance company and/or PCP. Please contact your insurance company before your appointment to ensure proper authorization is granted. Our insurance specialists do verify benefits for all patients but these are definitely an estimate of payment due as we are not certain what the patient balance will be until the insurance company processes your claim.
- Payment of fees, co-pays, co-insurance and deductibles are due at the time of service.
- Co-pays are a requirement placed on you by your insurance company and therefore can not be waived or reduced. Should you forget or can not provide your co-pay at the time of visit, you will be asked to reschedule your appointment.
- You are solely responsible for your balance in the form of co-insurance, deductible, or non-covered services as required by your insurance company.
- You will be contacted prior to your appointment and notified of any balance due on your account and will be expected to bring payment to your appointment. You will be required to make arrangements with the financial counselor if you can not pay the balance in full.
- Should any balance remain unpaid more than 90 days past the processing date with the insurance company, a statement will be sent to the guarantor of the account and payment will be due upon receipt of the statement.

Worker's Compensation

- Please keep in contact with your adjuster prior to and after your appointment to receive any pertinent information regarding your claim and injury.
- Authorizations may be required for certain procedures and could take up to 1 week to obtain.
- Should your case become closed, undergo peer review, or determined that Maximum Medical Improvement has been met you must contact your referring physician and adjuster for written approval before scheduling any appointment or services.

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Patient Name: _____

Financial Policy

I _____, have read and understand the financial policy and agree to it's terms. I understand that insurance billing is a courtesy provided to me by Ved V. Aggarwal, M.D./Kent Mitchell, M.D./Rodolfo Herrera, M.D., P.A. (Texas Pain Institute) and I assume full financial responsibility of the balance I incur. I understand co-pays, co-insurance, and deductibles are due at the time of my visit as well as any prior balance I may owe.

_____ Initials

It has been explained to me that should I decide to have any procedures performed at Ved V. Aggarwal, M.D./Kent Mitchell, M.D./Rodolfo Herrera, M.D., P.A. (Texas Pain Institute) my insurance company and I will receive two statements, one for the anesthesiologist's fees and one for the professional services rendered by the providers at Ved V. Aggarwal, M.D./Kent Mitchell, M.D./Rodolfo Herrera, M.D., P.A. (Texas Pain Institute).

_____ Initials

I assign benefits to be paid by my insurance company directly to the provider of services rendered to me. Furthermore, should the insurance company issue a check in my name I will notify Ved V. Aggarwal, M.D./Kent Mitchell, M.D./Rodolfo Herrera, M.D., P.A. (Texas Pain Institute) immediately and arrange for payment of my balance. Should I cash any check issued by my insurance company meant for reimbursement of services provided to me, I will assume full responsibility of the balance and will pay the balance within 30 days. I understand that Ved V. Aggarwal, M.D./Kent Mitchell, M.D./Rodolfo Herrera, M.D., P.A. (Texas Pain Institute) will provide a discounted rate to match my benefits on an in network basis if I have any out of network coverage available.

_____ Initials

I understand my balance will automatically be referred to an outside collection agency should my account surpass 90 days without payment activity. I agree to pay all reasonable attorneys, collection, or returned check fees in the event of default of payment of my charges or balance arrangements.

_____ Initials

MINOR PATIENTS: For all services rendered to minor patients, the parent registering the patient is responsible for payment, and MUST accompany the minor patient.

I have read and understand the financial policy of the practice and I agree to be bounded by it's terms. I also understand/agree that such terms may be amended from time to time.

I also authorize Ved V. Aggarwal, M.D./Kent Mitchell, M.D./Rodolfo Herrera, M.D., P.A. (Texas Pain Institute) to obtain any medical records from other medical facilities as needed in the collection of my account.

Patient Printed Name	Guarantor's Signature	Date

Witness Printed Name	Signature	Date

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Patient Name: _____

NARCOTIC AGREEMENT

The purpose of this agreement is to maintain a safe controlled treatment plan. I am asking for narcotic pain medication because other treatments and medications I have received have not provided enough pain relief. It is unlikely that any medication will completely take away my pain, but narcotic pain medication may be given to me as long as my pain continues, provided that I follow the terms of this agreement.

I understand that the possible complications of long-term narcotic therapy include: chemical physical dependence and addiction, constipation which could be severe enough to require medical treatment, difficulty with urination, drowsiness, nausea, itching, slowed respiration, and reduced sexual function. If I take more medication than is prescribed a dangerous situation could result, such as coma, organ damage, or even death. I understand that if I run out of my medication too soon, or if my medication is stopped suddenly, I could have narcotic withdrawal symptoms, which can be very uncomfortable or dangerous. If I become pregnant, there are known and unknown risks to the unborn child. These include narcotic addiction of the infant, and the possibility of the infant experiencing narcotic withdrawal after birth. I take responsibility to let my doctors know if I am pregnant. I understand that they will help me find ways of controlling my pain without narcotics.

The terms of the narcotic agreement include the following:

1. Only one pharmacy will be used for filling narcotic prescriptions. That pharmacy's name, address, and telephone number is:

_____

_____

2. I agree to receive narcotic medications **ONLY** from Texas Pain Institute and not from any other physicians or source.

3. Texas Pain Institute does not give refill on narcotic medications without seeing the patient. For other medications, it is necessary to have my pharmacist call Texas Pain Institute for prescription refill phone line at 817-348-8600 Option 4. I understand that it is my responsibility to make sure that I have enough medication to get through the weekend, holiday, or after hours *and that all refill requests require 72 hour notice.*

4. The physicians on call after hours, holidays, and on weekends **WILL NOT** refill my medications. They do not have the charts available for review to make decisions regarding medications.

5. I agree to be under the care of a primary care physician. I will inform Texas Pain Institute if I change to a different primary care physician. My primary care physician is:

_____

Initials: _____

Patient Name: _____

6. I will sign a release of information to allow Texas Pain Institute staff to communicate with any other health care providers involved in my care, past or current regarding any and all aspects of my treatment.

7. I will notify Texas Pain Institute about narcotic and other pain related medications and side effects. I **WILL NOT** contact physicians who do not work at Texas Pain Institute regarding the above concerns, unless for some reason I cannot get through to the Texas Pain Institute physicians. If I have a severe side effect that occurs after hours, on a holiday, or during a weekend, it is appropriate to go to the Emergency Room at the nearest hospital.

8. I agree to take the narcotic medication exactly as instructed by Texas Pain Institute. I **AM NOT ALLOWED** to change dosage amounts or alter the time schedule of taking the medication without *the approval of my* Texas Pain Institute *physician or his representative.*

9. I am responsible for the security of my medications. I understand it is not the policy of Texas Pain Institute to replace any misplaced, spilled, inaccessible, or lost narcotic medications or prescriptions. If stolen I must bring in a police report and the Texas Pain Institute may contact the police to verify my report.

10. I must keep all appointments as recommended by the Texas Pain Institute Physicians.

11. The Texas Pain Institute **WILL NOT** accept telephone requests for any prescriptions or refills from anyone other than *my pharmacist.*

12. All narcotic prescriptions must be picked up by me. If I am too disabled or sick, an exception may be allowed at the Texas Pain Institute discretion and that person I designate to pick-up my narcotic prescription is: _____ (a government issued ID is necessary).

13. I understand that the benefits of narcotic medications will be evaluated regularly using the following criteria: (1) increase in general level of functioning and increase in life activities; (2) decrease in pain intensity levels; (3) absence of unacceptable or intolerable adverse side effects; and (4) improvement in mood.

14. I agree to participate in psychotherapy sessions and psychological testing as deemed appropriate by Texas Pain Institute staff.

15. I agree to participate in a pain medication management group if recommended by Texas Pain Institute staff.

16. I agree to submit to urine drug testing for other medications and drugs. I realize that these charges will be submitted to my insurance company for payment, but if payment is denied by my insurance company I will be responsible for payment in full for this test.

17. I have been given information about the use of narcotic medications, including possible risks and adverse side effects such as the development of tolerance, dependence, addiction, and withdrawal. I agree to undergo narcotic therapy.

18. I will not hold any staff member of Texas Pain Institute liable for problems caused by taking narcotic medication or discontinuation of narcotic medications.

Initials: _____

Patient Name: _____

19. I will not hoard narcotic medication.

20. I will not alter the narcotic prescription.

21. I will not combine my narcotic medications with the consumption of alcohol.

22. I will not use any illegal controlled substances, including marijuana, cocaine, etc.,

23. I will not share, sell or trade my medication with anyone.

24. I understand that a verbal conversation with a Texas Pain Institute clinical staff member constitutes appropriate notification of violation of any terms of this contract, including the terms of the Narcotic Treatment Monitoring noted *in the following section.*

25. **I understand that, if any of the terms of this agreement are violated,** my case will be reviewed immediately by Texas Pain Institute staff. I understand that:

- I might have my narcotic medication discontinued.
- I might be referred to an addiction specialist or a drug detoxification program.
- I could be terminated from the practice.

26. I understand that Texas Pain Institute is a multidisciplinary center. This means that there are many different professionals on staff who all work together as a team. I understand that the team meets regularly to discuss my treatment and progress. I give permission for the team to share information about my case.

27. I attest to the following:
   a) That I am not using illicit drugs or prescription drugs prescribed for someone other than myself.
   b) I am not undergoing treatment for substance dependence or abuse.
   c) That I have never been involved in the sale, illegal possession, or transport of any drugs.
   d) For women only**:** That I am not pregnant and that I will inform the medical staff at Texas Pain Institute if I become pregnant. I understand that there may be harmful effects on the unborn baby if I take narcotic medications.

28. I understand that the use of narcotic pain medicine in the elderly or severely debilitated can predispose them to impairment of balance resulting in falls. This will increase their risk of head trauma, broken bones, and internal organ injury. I agree that this increased risk is acceptable compared to the risks of untreated pain.

29. I understand that the absolute safety or relative risk of operating motorized vehicles (automobile, boat, airplane, all terrain vehicle, lawnmower, etc.,) while taking narcotic pain medications has not been determined. If I operate a motorized vehicle while taking narcotic pain medicine and become involved in any accident resulting in personal injury or property damage to myself or others, I agree to not hold liable Texas Pain Institute or any member thereof.

Initials: _____

Patient Name: _____

30. I understand that Texas Pain Institute can, at its sole discretion, discontinue the prescribing of narcotic pain medications at any time.

I authorize the doctor 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 medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

This form has been fully explained to me, I have read it or have had it read to me, and I fully understand all items listed. **I have received a copy of all 4 pages of this agreement and the additional 2 pages of narcotic informational sheets and I agree to all of the terms therein.**

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

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Patient Name:_____

NARCOTIC MEDICATION INFORMATION

Narcotic medication can be an effective and safe part of my pain management. My use of narcotics will be carefully monitored and controlled. Even when my medications are taken as prescribed, complications and side effects are possible. Texas Pain Institute wants me to be fully aware of all the problems that can be associated with the type of medications I am receiving.

The following is a list of the most common side effects and complications related to the use of narcotic medications. Other less common side effects and complications are also possible. Texas Pain Institute has also prepared a list of the precautions and preventative treatments for some of these problems.

PROBLEMS	**TREATMENT**
Constipation (Common complaint)	Increase your regular exercise and increase fluid intake and add more bulk forming foods to your diet. You may occasionally take over-the-counter laxatives.
Nausea & Vomiting	Stop the medications and call Texas Pain Institute.
Excessive Drowsiness	This will usually improve as you continue the medication. DO NOT drive or operate machinery during this time. Your family should be aware of the medication you are taking and be instructed to call Texas Pain Institute, to take you to the Emergency Room if you become difficult to arouse. If your pain has caused you to lose sleep, you may find that you are sleeping a lot after taking the narcotic medications. You may simply be getting the rest you need. In this case, you are not experiencing a side effect of the drug but a benefit of the medication.
Itching	Call Texas Pain Institute
Urinary Retention (cannot urinate)	Call Texas Pain Institute. You may need temporary catheterization of your bladder to help drain the urine.
Insomina	Call Texas Pain Institute.
Depression	Call Texas Pain Institute as soon as possible.
Impairment of Reasoning and Judgment	Call Texas Pain Institute as soon as possible.
Respiratory Depression (if there is slowed and shallow breathing or if breathing stops)	This is an extremely rare but potentially serious side effect. Stop the medications. Contact Texas Pain Institute immediately and/or take the patient to an Emergency Room or call 911. If respiratory depressions remain undetected, there is a risk of complications related to the lack of oxygen, including death.
Impotence	Call Texas Pain Institute.
Tolerance (the need for an increasing amount of a drug to achieve the same pain relief)	Chronic pain patients occasionally develop tolerance to the narcotic medications. If tolerance develops new medications of equal strength can be substituted for the medications you've been taking.

Patient Name: _____

Physical & Emotional Dependence on Narcotics and even Addiction may occur	Those problems are rare in chronic pain patients, but it may be worthwhile to risk in order to achieve pain relief. Occasionally, withdrawal and detoxification may be needed.
Sudden Discontinuation of Medication	Follow your prescription exactly and decrease medications only as directed by physician. This could possibly result in withdrawal symptoms.

Not all pharmacies carry all medications. You may want to call your pharmacy first to see if they will provide it.

MEDICATION REFILLS DO NOT CONSTITUTE AN EMERGENCY.

This form has been fully explained to me, I have read it or have had it read to me, and I understand and agree to the terms of this narcotic medication agreement and I understand the possible side effects and possible problems from the narcotic pain medications. I am fully agreeing to take the narcotic pain medications, I am asking to be placed on narcotic pain medications, and I fully accept the possible risks and side effects associated with taking the narcotic pain medications.

Patient Signature:_____ Date: _____

Witness Signature: _____ Date: _____

ACKNOWLEDGMENT OF PRIVACY PRACTICES

I have been given the opportunity to review this clinic's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of the Notice of Privacy Practices, if you would like a copy, please notify the receptionist and one will be given to you. A copy is hung in the lobby by the reception area for your perusal.

_____ _____

Patient or Guardian Date

_____

Patient Name Printed

TEXAS PAIN INSTITUTE
1000 Lipscomb Street, Ste 110 Fort Worth, Texas 76104
Phone: (817) 348-8600 Fax: (817) 348-8602

651 Main Street, Suite 105, Keller, Texas 76248
Phone:(817) 741-0800 Fax: (817) 741-0805

Pain Management History

Date	Age
Name	Date of Birth Age
Referring Doctor	Date of Injury
Insurance Name	Height Weight

Current Pain Problem

1. Date of onset of pain: _____ Describe Briefly: _____
2. In what part of the body is the pain localized? _____
3. Describe your pain. _____
4. What makes the pain worse: _____
5. What eases the pain? (Massage, rest, medication, etc.) _____
6. In the last 24 hours, how would you rate your average pain?

   Pain level 0 1 2 3 4 5 6 7 8 9 10
7. Previous Injections/Nerve Blocks? Yes__ No__ Location _____

   Response _____

PAST MEDICAL HISTORY

1. Please circle any of the following illnesses, which you have or had in the past:

High Blood Pressure	Stomach Ulcer	Asthma
Angina	Gallbladder Disease	Tuberculosis
Heart Attack	Gout	Heart Murmur
Heart Surgery	Cancer	Hepatitis
Rheumatoid Arthritis	Diabetes Mellitus	Osteoarthritis
Thyroid Disease	Kidney Disease	Anemia
Glaucoma	Bleeding Disorder	Seizures
Drug Abuse	Recent Weight Loss	Change in Bladder or Bowel Habits
Chronic Pain Syndrome		

Other _____

2. Is there any Family History of any of the above medical conditions? Please write F-Father, M-Mother, S-Sibling, GF-Grandfather, GM-Grandmother, O-Other beside the condition.
3. Please list all previous surgeries: _____
4. List medications you are taking now(over-the-counter, prescription or purchased from a health food store) on the left side and list medication allergies on the right side

Medication	Dose	Frequency (times a day)	Medication Allergies	Reaction

Patient Name: _____

Social History

1. Do you drink alcoholic beverages? Yes _____ No _____ If yes, how much per week? _____

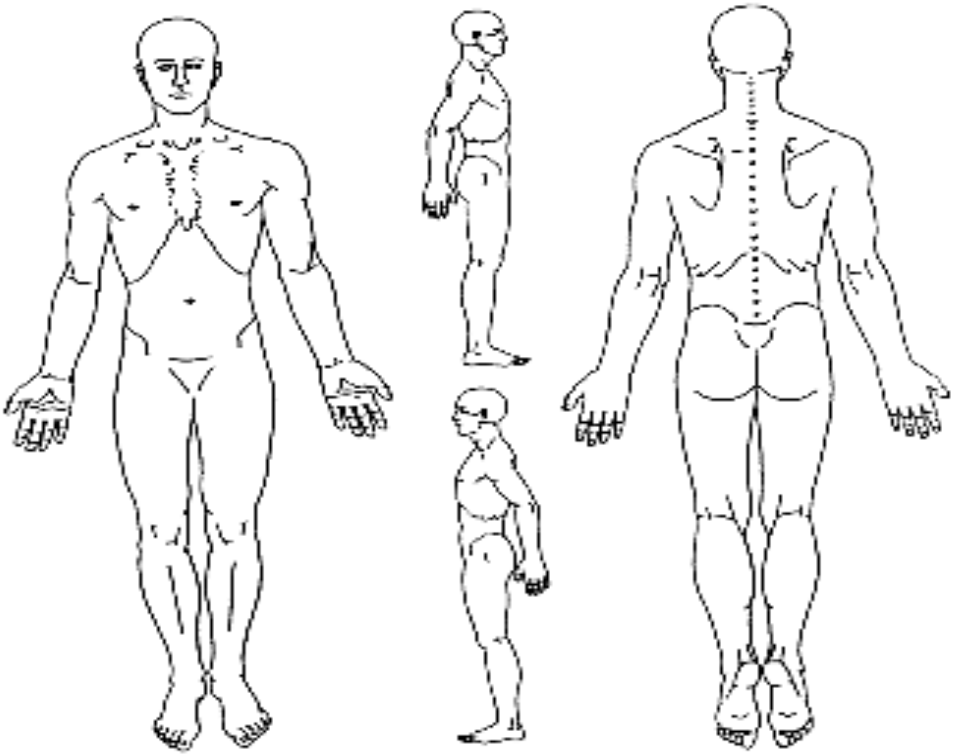
2. Smoking habits? Yes _____ No _____ Past _____

   If yes, how much do you smoke and for how long: _____

3. History of substance abuse? Yes _____ No _____
   History of Drug Detoxification Program? Yes _____ No _____

   Explain _____

Pain Drawing



Mark the areas on your body where you feel the described sensations. Mark the areas of radiation. Include all affected areas.

Thank you for completing this evaluation form. It will assist us in providing an individualized treatment plan.