AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (_____)_____ **ALT. PHONE** (_____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____)_____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)). **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.

Greater Austin Pain Center
www.greateraustinpain.com

Alan Silberberg, MD
Timothy Bednar, MD
Kristin Jarzombek, MD
Jonathan Julia, MD
Alexander Hynes, DO
Board certified by the American Board of Anesthesiology in Pain Medicine and Anesthesiology

Dear Patient,

Welcome to Greater Austin Pain Center! We are dedicated to delivering compassionate care and helping you to manage your chronic or current pain symptoms. We will make every effort to ensure that your experience with Greater Austin Pain Center is as pleasant as possible.

To better serve you, please complete the information provided prior to your appointment.

Please note that if all of the required information is not completed and with you by your scheduled appointment time, your visit may be rescheduled.

Prior to your appointment, please send in:

- Medical records from your primary care and/or referring physician
- Referrals or prior authorizations that are required by your insurance carrier.

What to bring with you to your first appointment:

- New Patient forms (please allow 45 min for completion)
- Medical insurance card(s)
- State or government issued photo identification (example: driver's license)
- Relevant imaging reports and/or films
- Payment for visit: Payment for services is expected at the time of service (co-pay, coinsurance, self-pay). We accept cash, check, and credit cards.

*Please note, medications will not be prescribed without a valid form of identification. If you are paying out of pocket (not under insurance), then cash or credit card are the only acceptable forms of payment.

Please do not hesitate to contact us if you have any questions at **(512) 298-1645**. Thank you for choosing Greater Austin Pain Center.

Greater Austin Pain Center

FINANCIAL POLICY

Thank you for choosing Greater Austin Pain Center as your healthcare provider. We are committed to your treatment being successful, and we believe that part of a good healthcare practice is to establish and communicate a financial policy to our patients. Please read and sign our financial policy prior to your treatment and let us know if you have any questions.

Payment is expected at the time of your visit. The patient is responsible for all co-payment amounts, co-insurance amounts, applicable deductible amounts, or non-covered charges from your insurance company. If our office cannot verify insurance benefits, payment is due in full before services will be provided. Please be advised that some, and perhaps all, of the services provided may be non-covered services under your plan and they may become your responsibility regardless of your insurance coverage. You may be referred to a provider, specialist, and/or facility that is out of network with your plan. While Greater Austin Pain Center does our best to verify benefits as a courtesy, the patient is ultimately responsible for determining and verifying network status with the service provider.

If your insurance carrier sends payment directly to you, then payment in full is due at each visit. If you are waiting for coverage to become effective or have no medical insurance coverage, payment in full will be expected at the time of service. For your convenience, we accept payment by cash, checks, and credit card. We do not accept third party assignments nor do we recognize or enforce the terms of divorce decrees.

If your insurance coverage changes, please notify the office as soon as possible so we can make the appropriate changes to help you receive your maximum benefits. Failure to provide complete and accurate insurance information may result in full patient responsibility for the services provided. Should an overpayment occur on the deductible or percentage amounts charged, we will apply a credit to your account. A refund is available upon request.

In the event of a returned check, a $30.00 service charge will be applied to the patient's account in addition to the amount of the check. Non-sufficient funds (NSF) plus the amount of the check must be redeemed with certified funds (cashier's check, credit card, money order, certified check, cash) at or before the next date of service. Stop payments constitute a breach of payment and are subject to the $30.00 service fee. Please note that if any unpaid balance is sent to an outside collections agency, you will be subject to a fee in addition to the unpaid balance. Greater Austin Pain Center is authorized to release any information required to secure payment or as evidence of services rendered to third party organizations including, but not limited to, insurance companies, banks, and creditors.

In consideration of other patients, please contact our office as soon as possible if you need to cancel or reschedule your appointment. Be sure to cancel at least 24 hours in advance to avoid cancellation or no-show fees: $25.00 for a scheduled office visit, $50.00 for a scheduled procedure. Frequent cancellations and/or NO SHOWS may result in release from the practice.

We require that an adult (parent or legal guardian) accompany a minor patient. The adult accompanying the minor patient is required to pay in accordance with our policies. In the case of divorced parents of the minor patient, we will communicate about treatment and payment with the parent who signs the new patient registration paperwork. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

NOTICE TO PATIENTS: Alan D. Silberberg, MD, directly or indirectly, holds ownership interests in one or more of the following companies and may receive, directly or indirectly, remuneration for services provided to patients by these companies: Legent Surgery Center and Plum Creek Surgery Center.

Accordingly, I hereby acknowledge that my attending physician has disclosed to me his/her affiliation with the foregoing healthcare providers for whom I, the patient, am being referred. I understand that I, personally, am financially responsible to Greater Austin Pain Center for charges not covered by the assignment of insurance benefits. I have read and understand the forgoing Financial Policy and agree to be bound and abide by the terms of the policy. I understand that I have the right to choose the providers of my healthcare services and I have the option of receiving healthcare services from any healthcare provider and/or facility I choose.

Printed Patient Name: _____ Legal Guardian Name: _____

Signature of Patient (or Guarantor, if applicable): _____Date: _____

Greater Austin Pain Center
www.greateraustinpain.com

Alan Silberberg, MD
Timothy Bednar, MD
Kristin Jarzombek, MD
Jonathan Julia, MD
Alexander Hynes, DO

PATIENT REGISTRATION

Personal Information

Name (*First, M.I., Last*):_____ Date of Birth.: _____ M/F SSN: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ **Mobile Phone:** _____ **Email Address:**_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Significant Other's Name: _____

Race: ☐ Hispanic ☐ Asian ☐ Caucasian ☐ African-American ☐ Native American ☐ Alaskan Native ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Other or Undetermined

Primary Care Physician: _____ Referring Physician: _____

Employer: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____ Cell/Home/Work

Responsible Party (if applicable)
Name of Subscriber: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Date of Birth: _____ Social Security #: _____

Employer: _____ Phone: _____

Insurance Information

Please bring your government issued photo identification and insurance card(s) to your visit.

Primary Insurance Company: _____ Member ID #: _____

Address: _____ Group #: _____

**If insured's information is same as patient's, you can leave it blank*
Insured's Name: _____ Relationship to Patient: _____ Date of Birth: _____ M/F

Insured's Employer: _____Insured's SSN: _____ Phone Number: _____

Secondary Insurance Company: _____ Member ID #: _____

Address: _____ Group #: _____

**If insured's information is same as patient's, you can leave it blank*
Insured's Name: _____ Relationship to Patient: _____ Date of Birth: _____ M/F

Insured's Employer: _____Insured's SSN: _____ Phone Number: _____

Greater Austin Pain Center
www.greateraustinpain.com

Alan Silberberg, MD
Timothy Bednar, MD
Kristin Jarzombek, MD
Jonathan Julia, MD
Alexander Hynes, DO

Is today's visit due to a work related injury? ☐ **Yes** ☐ **No** **Have you notified your personnel department?** ☐ **Yes** ☐ **No**

What injury was sustained? _____ **Date of Injury:** _____

Is your pain the result of a Motor Vehicle Accident or Personal Injury? ☐ **Yes** ☐ **No** **Date of Accident:** _____

Pharmacy Information

Please provide **ONE** Pharmacy for which all of your medications will be e-prescribed or called in.

Preferred Pharmacy: _____ Pharmacy Phone #: _____

Pharmacy Address: _____City: _____ State: _____ Zip Code: _____

We would like to access your pharmacy records and drug formulary information through a third party database. This service provides Greater Austin Pain Center accurate prescription information from other prescribing physicians and will allow our system to check which medications are on your drug formulary.
I authorize Greater Austin Pain Center to access my prescription history through my pharmacy, pharmacy benefits manager and/or Surescripts.

Patient Signature: _____ Date: _____

Authorization of Assignment of Benefits from my private insurance carrier

I hereby authorize Greater Austin Pain Center to file claims with my insurance company and to receive payment for my medical care and/or procedures**. I also understand that I am financially responsible for all charges not covered by my insurance for services rendered on my behalf or my benefits**. I further authorize payment directly to Greater Austin Pain Center of all insurance benefits related to my care. Greater Austin Pain Center has my permission to release any information required (including, but not limited to, information on psychiatric conditions, alcohol and drug abuse, and HIV or communicable disease) to secure payment of benefits. **I understand that I am responsible for any co-payment or co-insurance, plus any applicable deductible amounts, due at the time of any and all office visit(s) and/or procedures.** In the event that I choose to continue utilizing my healthcare benefits for the services rendered to me for the injuries I sustained as a result of a motor vehicle accident, I hereby agree to notify my insurance carrier to make them aware of the motor vehicle accident I was involved in for **Subrogation**. The Subrogation process to recover payments made to Greater Austin Pain Center for any costs incurred for the services rendered, including examinations, treatments, reports, deposition and trial testimony; will be handled between my healthcare insurance carrier and the party at fault (or my auto insurance carrier). If I choose to be treated under my healthcare insurance plan benefits, I understand and agree that I am responsible for payment to Greater Austin Pain Center for any copays, deductibles and coinsurance amounts under the standard, direct contract agreement between my Insurance company and Greater Austin Pain Center, or the Non-Covered fee amount assigned to my responsibility by my Insurance Company. **I authorize the use of this signature on all insurance submissions.**

Signature of Patient (or Guarantor, if applicable): _____Date: _____

Witness Signature: _____ Date: _____

Medicare Authorization

I request that payment of my Medicare benefits be made to Greater Austin Pain Center on my behalf for any services furnished by Greater Austin Pain Center or under their direction. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the charge determination of the Medicare carrier.

Signature of Patient (or Guarantor, if applicable): _____Date: _____

Witness Signature: _____ Date: _____

Greater Austin Pain Center
www.greateraustinpain.com

Alan Silberberg, MD
Timothy Bednar, MD
Kristin Jarzombek, MD
Jonathan Julia, MD
Alexander Hynes, DO

PAIN DESCRIPTION

Are you currently seeing or have seen a pain management healthcare provider in the last 3 years? ☐ Yes ☐ No

Name of pain management provider: _____

Address: _____ Provider's Phone: _____

1. Where is your worst pain located?_____

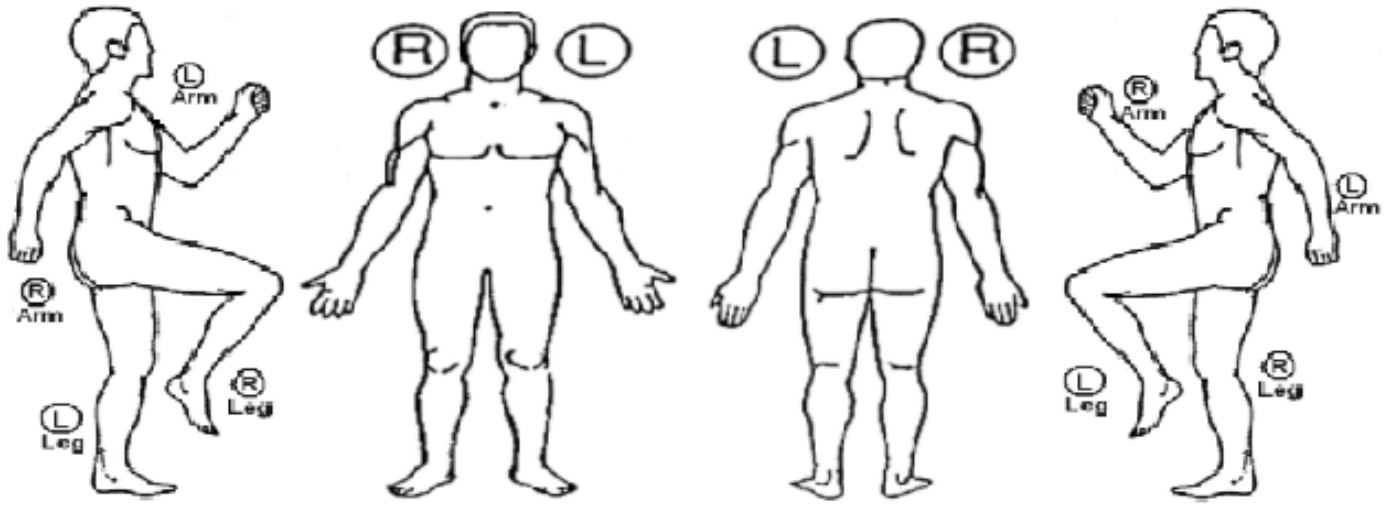
   If any, please include other areas of the body that have pain, and where? _____
   Please check the word(s) that best describe your pain:

   ❑Aching ❑Dull ❑Constant ❑Numbing ❑Coldness ❑Burning
   ❑Sharp ❑Stinging ❑Stabbing ❑Tingling ❑Cramping ❑Radiating

2. When did your pain begin?_____
   My pain is the result of an: ❑accident ❑illness ❑Other/Unsure

   a. Please describe illness or accident:_____
   b. If an accident, is there litigation involved? ❑Yes ❑No
      Please explain: _____

3. Please indicate the locations of your pain in the diagrams below, by shading in the areas.



4. What makes your pain worse (I.e. heat, cold, sitting, standing, etc.)?

   _____

   What makes your pain better (I.e. heat, cold, sitting, standing, etc.)?

   _____

5. Please rate your present pain level on a scale of 0 (no pain) to 10 (worst pain). _____

MEDICAL HISTORY

Have you ever been diagnosed with the following? Check all that apply.

❑ AIDS
❑ Epilepsy
❑ High blood pressure
❑ Osteoarthritis
❑ Rheumatoid arthritis
❑ Fibromyalgia
❑ Hypothyroidism (low thyroid)
❑ Cancer, please specify: _____
❑ HIV positive
❑ Kidney disease
❑ Asthma
❑ Diabetes
❑ Heart Disease
❑ Lupus
❑ Shingles
❑ Emphysema
❑ Hepatitis A/B/C/D
❑ Migraines
❑ Tuberculosis
❑ Peripheral Vascular Disease
❑ Stroke or TIA

Family Medical History

Please list any family members that may have or are currently suffering from any medical or psychiatric conditions.

a. Specific family member:_____Condition: _____
b. Specific family member:_____Condition: _____
c. Specific family member:_____Condition: _____

MEDICATIONS

Please list prescription medications you are taking.

Name of Medication(s)	Dosage (mg)	Frequency

Please list over-the-counter medications, vitamins or herbal supplements you are taking.

Name of Medication(s)	Dosage (mg)	Frequency

6. Do your pain medications provide relief? ❑ Yes ❑ No ❑ I do not take pain medications
If yes, how much relief do you receive on a scale of 0 (no pain) to 10 (worst pain)? _____

7. Do your pain medications improve your function? ❑ Yes ❑ No ❑ I do not take pain medications
If yes, how much improvement in function do you receive on a scale of 0 (no pain) to 10 (worst pain)? _____

8. Please check any side effects caused by your pain medications.

❑Nausea ❑Vomiting ❑Constipation ❑Upset Stomach ❑Sedation ❑Rash
❑Dizziness ❑Acid Reflux ❑Itching ❑No side effects ❑Other:_____

Pain Medication History

9. Please check off all of the medications that you have tried in the past:

Opioid

❑ **Fentanyl** (Actiq, Fentora, Duragesic)
❑ **Morphine** (Avinza, Kadian, Embeda, MS Contin)
❑ **Oxycodone** (Oxycontin, Percocet)
❑ **Propoxyphene** (Darvocet, Darvon)
❑ **Demerol**
❑ **Oxymorphone** (Opana, Opana ER)
❑ **Hydromorphone** (Dilaudid, Exalgo)
❑ **Buprenorphine** (Suboxone, Subutex, Butrans patch)
❑ **Hydrocodone** (Lortab, Norco, Vicodin, Vicoprofen)
❑ **Methadone**
❑ **Tapentadol** (Nucynta)
❑ **Codeine**
❑ **Tramadol** (Ultram ER, Ultram)

Muscle Relaxants

❑ **Baclofen**
❑ **Methocarbamol** (Robaxin)
❑ **Carisoprodol** (Soma)
❑ **Cyclobenzaprine** (Flexeril, Amrix**)**
❑ **Metaxalone** (Skelaxin)
❑ **Tizanidine** (Zanaflex)
❑ **Other:**_____

Anti-inflammatories and Tylenol

❑ **Diclofenac** (Arthrotec, Voltaren, Voltaren Gel)
❑ **Oxaprozin** (Daypro)
❑ **Meloxicam** (Mobic)
❑ **Nabumetone** (Relafen)
❑ **Aspirin**
❑ **Indomethacin** (Indocin)
❑ **Ibuprofen** (Motrin, Advil)
❑ **Acetaminophen** (Tylenol)
❑ **Celecoxib** (Celebrex)
❑ **Etodolac** (Lodine)
❑ **Naproxen** (Naprosyn)
❑ **Other:**_____

Antidepressants

❑ **Cymbalta**
❑ **Nortriptyline** (Pamelor)
❑ **Amitriptyline** (Elavil)

Other

❑ **Lyrica**
❑ **Gabapentin** (Neurontin)
❑ **Topamax**
❑ **Lidoderm Patch**
❑ **Frova**
❑ **Other:**_____

ALLERGIES

Please list the medication(s) and its adverse reactions. Include allergies to latex and/or surgical tape, if any.

Allergies	Reaction

HOSPITALIZATIONS & SURGERIES

Do you currently have an implanted ICD, pacemaker, or defibrillator? ❑ Yes ❑ No

Please list surgeries and/or hospitalizations you have undergone.

Surgery/Procedure	Rendering Physician	Date

Pain Treatment History:
Please list the diagnostic tests you have received. Please indicate the approximate date and location in which the test was performed.

Diagnostic Test	Part of Body	Date	Location
X-ray			
MRI scan			
CT scan			
EMG/Nerve conduction study			
Myelogram			

Please indicate the amount of relief and approximate date of the following treatments (if applicable):

Treatment	No Relief	Moderate Relief	Excellent Relief	Date
Surgery	❑	❑	❑	
Injection therapy	❑	❑	❑	
Nerve block	❑	❑	❑	
Physical therapy	❑	❑	❑	
Chiropractic care	❑	❑	❑	
Acupuncture	❑	❑	❑	
TENS unit	❑	❑	❑	

LIFESTYLE

10. What is your current work status? ❑ Employed ❑ Retired ❑ Disabled ❑ Unemployed

11. Is your current work status due to your present pain condition? ❑ Yes ❑ No

12. Do you smoke? ❑ Yes ❑ No
    a. If yes, how many packs do you smoke per day? _____
    b. How long have you smoked? Years:_____

13. Do you use alcohol? ❑ Yes ❑ No If yes, how much?_____

14. Have you ever had a problem with prescription medications (e.g., misuse, abuse, addiction, etc)?
    ❑ Yes, currently ❑ Yes, in the past ❑ No, never

15. Have you ever used any drugs? (e.g., cocaine, marijuana, intravenous drugs, etc)?
    ❑ Yes, currently ❑ Yes, in the past ❑ No, never If yes, which drug(s)? _____

16. Have you ever been treated for addiction or alcoholism? ❑ Yes ❑ No

17. Are you pregnant? ❑ Yes ❑ No

PSYCHOLOGICAL TREATMENT

18. Have you ever had psychiatric, psychological or social work treatments/evaluations for any diagnosis/problem, including your current pain? ❑Yes ❑No

    a. If yes, for what diagnosis or problem were you treated? _____

19. Have you ever considered/planned/attempted suicide? ❑Yes ❑No

REVIEW OF SYSTEMS

Indicate if you currently have or have **EVER** had the following:

General:
- ❑ Unplanned Recent Weight Gain/ Weight loss of 10lbs or more

Cardiovascular:
- ❑ Artificial Heart Valve
- ❑ Heart Disease
- ❑ Heart Murmur
- ❑ Heart Attack or MI
- ❑ Heart Surgery (CABG, Heart Catheterization, etc.)
- ❑ High Blood Pressure-Hypertension
- ❑ Pacemaker
- ❑ Swollen Ankles

Endocrine:
- ❑ Diabetes
- ❑ Polycystic Ovarian Syndrome
- ❑ Thyroid Disorders
- ❑ Hirsutism-Excessive Hair

Gastrointestinal:
- ❑ Liver Problems
- ❑ Ulcers
- ❑ Reflux-GERD

Hematology:
- ❑ Abnormal Bleeding
- ❑ Bruise Easily
- ❑ Anemia
- ❑ Blood Diseases
- ❑ Blood Transfusion
- ❑ Hemophilia
- ❑ Sickle Cell Disease
- ❑ Spider or Varicose Veins

Infections:
- ❑ Rheumatic Fever
- ❑ Hepatitis A/B/C
- ❑ HIV Positive
- ❑ AIDS
- ❑ Shingles

Musculoskeletal:
- ❑ Arthritis (Rheumatoid Arthritis/ Osteoarthritis)
- ❑ Artificial Joints (hip, knee, etc.)
- ❑ Chronic Back Problems

If yes, have you had surgery?

_____

When was the surgery?

_____

Neurologic:
- ❑ Epilepsy/Seizures
- ❑ Fainting/Dizzy Spells
- ❑ Frequent Headaches
- ❑ Stroke or TIA
- ❑ Other Neurological Disorders_____

Oncology:
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Radiation Therapy

Respiratory:
- ❑ Asthma
- ❑ Chronic cough
- ❑ Difficulty Breathing
- ❑ Emphysema
- ❑ Tuberculosis

Greater Austin Pain Center
www.greateraustinpain.com

Alan Silberberg, MD
Timothy Bednar, MD
Kristin Jarzombek, MD
Jonathan Julia, MD
Alexander Hynes, DO
Phone: (512) 298-1645 | Fax: (512) 298-1795

PATIENT CONSENT TO TREAT

I hereby give my consent to **Greater Austin Pain Center** and authorize them to provide my medical treatment. I understand that I have the right to discuss my condition(s), any foreseeable risks, and the methods of treatment for my condition(s) with my physician before treatment is provided. I authorize **Greater Austin Pain Center** to perform any additional or different treatment that is thought necessary if, in an emergency situation, a condition is discovered that was not previously known. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

At this point in time, no specific treatment plan has been discussed or recommended. This consent form is simply an effort to obtain my permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner or Physician Assistant), and other health care providers or designees as deemed necessary, to perform reasonable and necessary medical examination, testing, and treatment for the condition which has brought me to seek care at this practice. I certify that I have carefully read and fully understand the contents of this *Patient Consent to Treat* form, and all of my questions have been adequately answered.

For *female patients only,* please initial below:
_____ To the best of my knowledge I am not pregnant, and if I am or become pregnant it is my responsibility to **inform the physician/mid level provider immediately.**
_____ I understand that at the present time, there have not been enough studies conducted regarding opioid/narcotic use with expecting mothers to be deemed safe. With full knowledge of this, I will hold harmless Greater Austin Pain Center, its facilities, and its employees from serious injury or death to the embryo/fetus/baby.

Patient Name:_____

Legal Guardian Name:_____Relationship Status:_____

Patient or Legal Guardian Signature:_____ Date:_____

Witness Name:_____

Witnessed Signature:_____ Date:_____

Greater Austin Pain Center

CONTROLLED SUBSTANCES AGREEMENT

The following outline is a medication contract between _____(patient name) and Greater Austin Pain Center concerning the usage of controlled substance medications. Examples of controlled substances include Xanax, Ritalin, hydrocodone, oxycodone, methadone, lyrica, tramadol, and morphine. Controlled substances may not completely relieve pain symptoms. If the physicians at Greater Austin Pain Center feel that you are not responding to therapy by showing substantial improvement in function, your medications will be tapered. Please read and initial each statement:

_____There are risks associated with chronic controlled substance therapy including but not limited to constipation, itching, addiction, physical dependence, respiratory depression, sexual dysfunction, nausea, vomiting, drowsiness, and death.

_____Controlled substance therapy may have sedative or cognitive effects and interfere with your ability to concentrate or think clearly. Greater Austin Pain Center recommends that ALL patients on chronic controlled substance medications not participate in the operation of motor vehicles or machinery. If the patient chooses to engage in these activities, Greater Austin Pain Center bears no responsibility for the outcome of such events.

_____The patient will use only one pharmacy and will notify us with the name of the chosen pharmacy. In the situation of an extenuating circumstance, the patient must notify the primary pain management physician or covering physician of the circumstances and identify the pharmacy that dispensed the medication at or before the next date of service.

_____Do **NOT** use alcohol or other non-prescribed, mind altering substances when using controlled substances.

_____Take your medications **ONLY** as prescribed. Taking medications in amounts not prescribed may result in coma and/or death. If there are changes in your pain, call and speak to our office staff to schedule an office visit for an evaluation. DO **NOT** SELF-INCREASE YOUR MEDICATION.

_____Unannounced random urine drug screens (UDS) will happen during the course of treatment and you are expected to comply. Positive results of illicit drugs and excessive alcohol or negative results of the prescribed drug may result in discontinuation of controlled substances.

_____Our clinic must be notified **FIVE BUSINESS DAYS** prior to an anticipated refill date.

_____Lost or stolen medications will not be replaced for **ANY REASON**. In addition, refills will not be given for any reason after hours or on weekends. Early refills will only be given if authorized by the physician or if a dosage is changed.

_____Patients will not seek opioid analgesic from any other physician, or health care provider (e.g. dental) for treatment of their chronic condition. This policy in no way prevents a patient from seeking acute care for acute problems.

_____Treatment with any controlled substance may be stopped if you:

- Sell, share, abuse, overtake, or misuse your medication
- Develop significant side effects
- Obtain pain medication from other sources
- Have urine drug screen results that are inconsistent with your medical history
- Have multiple episodes of prescription loss
- Experience worsening of your medical or psychological conditions, do not receive significant pain control, or unable to increase/maintain your activity level and/or function

_____If you are coming in for an early office visit, you will need to bring all unused controlled substance medications to your appointment. Random pill counts may be conducted during the course of treatment and you are expected to comply.

I affirm that I have read, understand, and accept the terms in this agreement, and that I have full right and power to sign and be bound by the agreement.

Signature of Patient (or Guarantor, if applicable): _____Date: _____

Greater Austin Pain Center representative:_____ Date:_____

Greater Austin Pain Center
www.greateraustinpain.com

Alan Silberberg, MD
Timothy Bednar, MD
Kristin Jarzombek, MD
Jonathan Julia, MD
Alexander Hynes, DO
Phone: (512) 298-1645 | Fax: (512) 298-1795

ACKNOWLEDGMENT OF REVIEW OF **NOTICE OF PRIVACY PRACTICES**

Contact permission
In the event that Greater Austin Pain Center needs to contact you about your medical care but is unable to reach you directly, we would like to know if you would like us to attempt any of the following commonly requested alternatives. Please take into consideration that these messages could include information about your medication(s), test results, insurance coverage, payment collection, or other personal information regarding your account with us.

If unable to contact me directly, I, _____, authorize Greater Austin Pain Center to:
(Print Name)

- Leave a voicemail message at this phone number: _____
- Speak to or leave a message with the family members/friends listed below

Emergency contact:_____ Relationship to patient:_____ Contact number:_____

Name:_____Relationship to Patient:_____Contact number:_____

Name:_____Relationship to Patient:_____Contact number:_____

Disclosure of Health Information
Greater Austin Pain Center, using our best judgment, may disclose to a member of your family, a relative, a close friend or any other person you identify, your health information that directly relates to that person's involvement in your health care, unless you object **in writing**. If you are unable to object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose your health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to coordinate uses and disclosures to family or other individuals involved in your health care. If there are any persons and/or facilities that you **do not** authorize to have access to your personal information please specify below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

Review of Notice of Privacy Practices Acknowledgment
I acknowledge that Greater Austin Pain Center provided me with a written copy of its Notice of Privacy Practices. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____
Signature of Patient or Guardian Date

_____ _____
Name of Patient or Personal Representative Relationship to Patient

Obtaining Protected Health Information (PHI)
Please complete the medical records release form (available for download on http://greateraustinpain.com/) to assist us in obtaining medical records as defined in the Health Information Accountability and Portability Act (HIPAA). Please note that Greater Austin Pain Center will provide you with one set of records free of charge. There may be a fee applied to any records requested for your personal use beyond the first set.