Pain Resources, Inc.
3115 College Park, Ste. 103C
The Woodlands, TX 77384
Tel: (936) 273-1133Fax: (936) 273-1335

Patient Information

Name ______________________ Birth Date: ______________________

Address: ____

Home Phone: ______________________ Social Security #: ______________________

Work Phone ______________________ Cell Phone: ____________ Fax #: ____________

Employer: ______________________ E-mail: ______________________

Spouse: ______________________ Social Security #: ____________ Birth Date: ____________

Spouse Employer: ______________________ Work Phone ____________ Fax #: ____________

Nearest Relative: ______________________ Relationship: ______________________

Address: ______________________ Home Phone: ____________ E-mail: ____________

PRIMARY INSURANCE

Insurance Company: ____

Subscriber #: ____

ID# ______________________ Group #: ______________________

SECONDARY INSURANCE

Insurance Company: ____

Subscriber #: ____

ID# ______________________ Group #: ______________________

WORKERS COMPENSATION

Carrier: ______________________ Date of Injury: ______________________

Address: ______________________ Claim #: ______________________

Adjuster: ______________________ Adjusters Phone: ______________________

Referring Doctor: ______________________ Family Doctor: ______________________

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I authorize Pain Resources, Inc., Drs. Egerman and Durham to release by mail or fax to any third party payer, such as an insurance company or government agency, any medical information contained in my records when such material is required in connection with determining a claim for payment.

I authorize Pain Resources, Inc., Drs. Egerman and Durham to release by mail or fax any medical information accumulated in the course of my examination or treatment to my referring doctors and/or any other requesting doctor, hospital or nursing home.

I authorize payment directly to Pain Resources, Inc. for the surgical and/or medical benefits, if any otherwise payable to me under the terms of my insurance and/or Medicare.

I hereby accept responsibility for payment of services not covered by Medicare or my insurance company.

I authorize Pain Resources, Inc. to call me as a reminder of appointment dates and to advise me of my financial responsibility for my visit and/or procedure. This may include leaving a message on my behalf.

I hereby acknowledge that I have received a copy of Pain Resources, Inc. Notice of Privacy Policies.

Physician Ownership Disclosure:
Carlos Durham, M.D. and Mark Egerman, M.D. have an ownership interest in Creekside Surgery Center.

Signature: ______________________________ Date: ______________________________

Pain Assessment Questionnaire

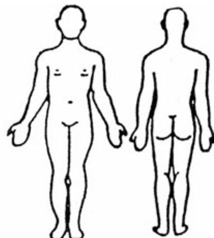
Date: ____________________

Name: ____________________

Age: __________ DOB: __________

Location of Pain: ____________________

Place an X to describe the location of your pain:



Pain is: ☐ Constant ☐ Comes and Goes

RATE YOUR PAIN USING THIS SCALE:

0 1 2 3 4 5 6 7 8 9 10

No Pain Moderate Severe

At your worst Times: ______ At your best times: ______

DESCRIBE YOUR PAIN:

☐ Throbbing	☐ Shooting
☐ Stabbing	☐ Sharp
☐ Dull	☐ Sore
☐ Crushing	☐ Heavy
☐ Tingling	☐ Numb
☐ Pressing	☐ Squeezing

WHAT MAKES THE PAIN BETTER?

____

WHAT MAKES THE PAIN WORSE?

____

ARE YOU SLEEPING WELL? ☐ YES ☐ NO

IS YOUR INJURY WORK RELATED?

☐ YES ☐ NO

IF YES, DATE OF INJURY: ____________________

ARE YOU INVOLVED IN A LAWSUIT?

☐ YES ☐ NO

NAME OTHER TREATING PHYSICIANS:

____

MD: ____________________

REFERRING MD: ____________________

MEDICAL TREATMENTS FOR PAIN:

☐ Bed Rest	☐ Physical Therapy
☐ Chiropractic	☐ Acupuncture
☐ TENS Traction	☐ Ultrasound
☐ Massage Pool	☐ Biofeedback

List Previous Pain Medications:

____

☐ Injections: epidural steroids

Other: ____________________

Imaging Studies:

☐ X-Rays	☐ MRI
☐ CT Scan	☐ Myelogram
☐ Bone Scan	☐ Discograms
☐ EMG / Nerve Conduction Test	

PAST MEDICAL PROBLEMS:

____

PAST SURGERIES:

____

ALLERGIES TO MEDICATIONS:

____

MEDICATIONS:

____

FAMILY HISTORY:

____

WHEN DID YOUR PAIN BEGIN?

____

SOCIAL HISTORY

Patient Name: ______________________ Date: ______________________

Date of Birth: ______________________ Doctor: ______________________

Occupation: ______________________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Do You Smoke? ☐ Yes ☐ No If yes, how much? ______________________

Do you drink Alcohol? ☐ Yes ☐ No If yes, how much? ______________________

Do You Have A History of Alcohol or Drug Abuse ? ☐ Yes ☐ No

Do You Exercise? ______________________ How Often? ______________________

REVIEW OF SYSTEMS (please select any of the following that apply)

Constitutional:

- ☐ Fever
- ☐ Chills
- ☐ Nausea
- ☐ Vomiting
- ☐ Unusual Tiredness

Endocrine:

- ☐ Unusual Sweating
- ☐ Loss of Appetite
- ☐ Unexplained Weight Loss

Skin:

- ☐ Rashes
- ☐ Itching

ENT:

- ☐ Hearing Loss
- ☐ Oral/Nasal Discharge
- ☐ Sore Throat
- ☐ Sinus Problems

Cardiovascular:

- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Arrhythmia

Respiratory:

- ☐ Heavy Cough
- ☐ Trouble Breathing
- ☐ Change in Sputum

Hematologic/Lymphatic:

- ☐ Easy bruising or bleeding
- ☐ Abnormal Lumps or bumps
- ☐ Swollen Glands

GI/GU:

- ☐ Change in bowel/bladder habits
- ☐ Blood in Urine or Stool
- ☐ Impotence

Eyes:

- ☐ Change in Vision
- ☐ Abnormal Discharge

Neuro:

- ☐ Seizures
- ☐ Syncope
- ☐ Tingling
- ☐ Weakness

Musculoskeletal:

- ☐ Traumatic Injury
- ☐ Joint Swelling

Mood:

- ☐ Depression
- ☐ Changes in Mood
- ☐ Sleep Problems

PAIN*Resources, Inc.*

an Interventional Pain Center

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Carlos J. Durham, M.D.
Board Certified, A.B.A.
Anesthesiology &
Pain Management

Mark J. Egerman, M.D
Board Certified, A.B.A.
Anesthesiology &
Pain Management

Medication Agreement

In order to meet your medication needs, we have developed guidelines for refills. Please read these thoroughly and sign at the bottom. We will give you a copy and retain a copy for your file. Thank you.

1. Please call your pharmacy with your prescription number for refills. The pharmacy will then call our office for an approval.

2. Please call in refills 24 hours prior to pick-up. Approval for refills called in less than 24 hours ahead will not be guaranteed until the next working day.

3. Our office calls the pharmacy back with refill approvals between 3:00pm and 4:30p.m., Monday through Friday. Please plan accordingly for medication pickup.

4. Refills will not be approved on weekends, holidays or approved out of state. ***Please plan ahead.***

5. You may not request or accept controlled substance medication from any other physician or individual while you are receiving such medication from your physician at PainResources.

6. Please list your preferred pharmacy to provide you with E-Prescriptions.

Pharmacy Name: ______________ Address: ______________

Phone Number: ______________

Patient Signature: ______________ Date: ______________

Witness: ______________ Date: ______________

PAIN RESOURCES, INC.

MEDICAL RECORDS

Your medical records are protected for confidentiality and will not be released without a signed release by you, or as otherwise authorized by law.

If you want a copy of your medical records or wish to transfer them to another provider, please stop by Pain Resources, Inc. and fill out a medical record release form. After you have filled out a medical record release form, your records will be available within 24 hours. You may choose to pick up your medical records in person or we will be happy to mail your records.

PAYMENT

Fees for services will be collected at the time of service and may be paid for by cash, check, credit card or money order. We participate with many insurance plans and will bill your insurance company as a courtesy to you. However, health plans vary in what they will cover. Therefore, we ask that you be aware of what your health plan covers, and your responsibilities for deductibles and co-payments. It is your responsibility to follow the referral guidelines of your health plan coverage before seeking care. Please remember that insurance coverage is a contract between you and the health plan carrier. Pain Resources, Inc. will look to you for payment in full of any balance owed. Compliance with the requirements of your plan is your responsibility.

APPOINTMENTS

We see patients by appointment only. To schedule an appointment, please call (936) 273-1133 during business hours. Our business hours are Monday through Thursday, from 8:00 am. to 4:30 p.m. and Friday 8:00 am till 12:00 pm. If you call between 12:00 and 1:00, our answering service will take your call.

If you must cancel your appointment, please give us 24 hours notice. After three cancellations, there will be a $35.00 fee.

When you call us during business hours, a receptionist will answer your call and direct you to the appropriate person. If the person you need to speak with is unavailable, a message will be taken and given to the requested staff member. All calls will be returned within 24 hours.

PRESCRIPTIONS

Often, we can refill prescriptions over the phone. For certain prescriptions, however, we request that you come in for a follow up visit with the nurse. Please call your pharmacy and have the pharmacy call our office during business hours. Refills will be called in to your pharmacy within 24 hours, no exceptions. Refills will not be given on weekends of holidays. Some medications cannot be called in out of state. Please plan ahead.
If you are experiencing a medical emergency, call 911.

I have read and agree to adhere to the policies and guidelines as mentioned above.

Patient Signature: ______________________ Date: ______________________

PAINRESOURCES, INC

Consent to Use and Disclose Protected Health Information

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION
Your protected health information will be used by Pain Resources, Inc. or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

THE NOTICE OF PRIVACY PRACTICES
Pain Resources, Inc. is required to provide you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the "Notice of Privacy Policies and Practices" brochure provided to you. PLEASE REVIEW IT CAREFULLY.

YOU MAY PLACE RESTRICTIONS ON THE USE OR DISCLOSURE OF YOUR HEALTH INFORMATION.
You may request a restriction on the use or disclosure of your protected health information. However, Pain Resources, Inc. may or may not agree to your request to restrict the use or disclosure of your protected health information. You may be asked to complete an authorization to activate this request. Please consult with a practice representative if you would like additional information or clarification.

It is a violation of the federal privacy standards if Pain Resources, Inc. agrees and fails to comply with your request. The restrictions requested will not affect use and disclosure of your information before the date of your request. If you still have questions after reviewing the Notice of Privacy Brochure, please consult with a practice representative or Office for Civil Rights at the location and contact information listed in our Policy Manuel.

YOU MAY REVOKE THIS CONSENT AT ANYTIME
You may revoke this consent at anytime however Pain Resources, Inc. requires that you must revoke this consent in writing. If you choose to revoke this consent, the revocation will not affect use and disclosure of your information before the date of your request.

CHANGES TO PRIVACY PRACTICES
Pain Resources, Inc. reserves the right to change or modify the privacy practices outlined in the Notice of Privacy Brochure. Pain Resources, Inc. will notify you of any changes of privacy practices at your next appointment, or any other pre-approved method that you request.

SIGNATURE
I have reviewed this consent form, read and carefully reviewed the Binder entitled" Notice of Privacy Policies and Practices" and give my permission to Pain Resources, Inc. to use and disclose my health information in accordance with this consent and the notice provided.

____________________________ Name of Patient (Print or Type)

____________________________ Signature of Patient/ Date

____________________________ Patient Representative (Print or Type)

____________________________ Signature of Representative/Date

____________________________ Relationship of Patient Representative to Patient

PAIN RESOURCES, INC.

Authorization of Use and Disclosure of Protected Health Information

Appointment Reminders. The practice may use your information to remind you about upcoming appointments. Typically, appointment reminders from our office are a brief, non-specific message which may be left on your answering machine. Occasionally, we may also use alternative methods (i.e. e-mail). If you don't approve this method and would like an alternative method, please indicate this in the space provided below.

How would you like to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Pain Resources, Inc.? (Check all that apply)

☐ Regular Mail	☐ Home Telephone	☐ Work Telephone
☐ E-mail	☐ Home Fax Machine	☐ Cell Phone

Other: ____

If you have an answering machine, may we leave messages regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Pain Resources, Inc.

☐ Yes ☐ No ☐ N/A

If "NO" , how else may we contact you regarding information?

____

Please list any other restrictions regarding messages or reminders about your healthcare:

____

Other Uses and Disclosures: Disclosure of your health information or its use for any purpose other than those listed in the "Notice of Privacy Practices" binder and/or consent requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision. You have the right to request restrictions on use and disclosure of your health information

PAIN RESOURCES, INC.

Authorization of Use and Disclosure of Protected Health Information

I would like the following restrictions regarding the use and disclosure for my health information.

Persons Authorized to Receive Information:
Health information Pain Resources, Inc. collects or receives about you may be disclosed to the following person:

____
Name of Person / Relation / Organization

____
Name of Person / Relation / Organization

Use and Disclosure of Information: (Please Initial the appropriate paragraphs below)

☐ I authorize the person(s) listed above to receive health information about my appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at Pain Resources, Inc.

☐ I do not authorize the following information to be disclosed to any other parties except to me as the patient.

Please Specify: ______________________________

Expiration date of Authorization
The authorization is effective through ______________ unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Pain Resources, Inc. You should contact our office or other authorized representative to terminate this authorization.

PAIN RESOURCES, INC.

Authorization of Use and Disclosure of Protected Health Information

Potential for Re-disclosure
The person or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

______________________________	______________________________
Name of Patient (Print or Type)	Signature of Patient / Date
______________________________	______________________________
Signature of Patient Representative	Relationship of Representative to Patient