

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

## 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 can give you a copy per your request and also retain a copy for your file. Thank you.

1. Please call your pharmacy with your prescription number for refills. The pharmacy will then call or fax our office for an approval.
2. Approval for refills called into the pharmacy less than 24 hours ahead will not be guaranteed until the next business day.
3. Refills will not be approved on weekends, holidays, or approved out of state. **Please plan ahead**
4. 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 Pain Resources, Inc.
5. If you are on a controlled substance, it is your responsibility to make sure you do not run out of medication. If you wait until you are completely out of medication your doctor may not be available to approve and sign your prescriptions.
6. Please keep in mind you must be seen in office to receive any medication refills for controlled substances. This means you will not be handed a prescription, **you will need an appointment.**

Please list your preferred pharmacy to provide you with any prescriptions that are prescribed by your doctor.

Pharmacy Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Pain Resources, Inc. 3115 College Park Dr. Suite 103C The Woodlands, Texas 77384*

# Pain Assessment Questionnaire

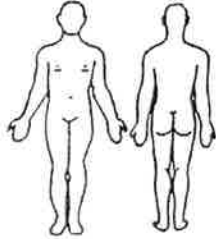
Date: \_\_\_\_\_

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:

- |                                    |                                    |
|------------------------------------|------------------------------------|
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Shooting  |
| <input type="checkbox"/> Stabbing  | <input type="checkbox"/> Sharp     |
| <input type="checkbox"/> Dull      | <input type="checkbox"/> Sore      |
| <input type="checkbox"/> Crushing  | <input type="checkbox"/> Heavy     |
| <input type="checkbox"/> Tingling  | <input type="checkbox"/> Numb      |
| <input type="checkbox"/> Pressing  | <input type="checkbox"/> 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:

- |  |   |
|--|---|
| <input type="checkbox"/> Bed Rest      | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Chiropractic  | <input type="checkbox"/> Acupuncture      |
| <input type="checkbox"/> TENS Traction | <input type="checkbox"/> Ultrasound       |
| <input type="checkbox"/> Massage Pool  | <input type="checkbox"/> Biofeedback      |

List Previous Pain Medications:

\_\_\_\_\_

Injections: epidural steroids

Other: \_\_\_\_\_

Imaging Studies:

- |  |                                     |
|--|-------------------------------------|
| <input type="checkbox"/> X-Rays                      | <input type="checkbox"/> MRI        |
| <input type="checkbox"/> CT Scan                     | <input type="checkbox"/> Myelogram  |
| <input type="checkbox"/> Bone Scan                   | <input type="checkbox"/> Discograms |
| <input type="checkbox"/> 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.*

## **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 or 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

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## 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.

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Name of Patient (Print or Type)

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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:

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Name of Person / Relation / Organization

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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

Print Form