NEW PATIENT INTAKE FORMS

Date: ____/____/_____

Name: ____
Last First Middle

Gender: ☐ Male ☐ Female

Date of Birth: ___________________________ Height: _____________________Weight:_____________________

Patient Contact Information: (Check your preferred method of contact for reminders and updates)

Mobile Number: __________________________________

May we leave a detailed message at this number? ☐ Yes ☐ No

☐ Text Message Notifications

☐ Phone Message Notifications

Home Number:___________________________________

May we leave a detailed message at this number? ☐ Yes ☐ No

☐ Phone Message Notifications

Email: ____

☐ Patient Portal Notifications to Email

Current Mailing Address: ____

____

Marital Status: Single_________Married_________Spouse's Name:____

Emergency Contact:

Name: ____
Relationship to Patient: ____
Contact Phone Number(s): ____
May we share your medical information with this person? ☐ Yes ☐ No

Payment Information

Form of Payment:

- ☐ Health Insurance
- ☐ Auto Insurance
- ☐ Worker's Compensation
- ☐ Self-Pay
- ☐ Other (Please specify): ____

Primary Insurance

Primary Company: __________________________ Insured's Name: _________________________

Policy #: __________________________________ Group #: _______________________________

Secondary Insurance

Secondary Company: ________________________ Insured's Name: _________________________

Policy #: _________________________________ Group #: _______________________________

Referral Source

How did you hear about us?

- ☐ Primary Care Physician
- ☐ Other Physician (Please specify physician and specialty):
  ____
- ☐ Other healthcare provider
- ☐ Insurance Company
- ☐ Attorney
- ☐ Friend/Word of Mouth
- ☐ Internet
- ☐ Social Media
- ☐ Other (Please describe below):
  ____

Preferred Pharmacy/Location: ____

Preferred Imaging Center/Location:____

Referring Provider/Location:____

Primary Care Provider/Location: ____

Other Physicians seen for Pain: ____

Pain Diagram

Please mark the locations of your pain in the diagrams below:

Current Medications:

Please list ANY medications, whether over-the-counter or prescription, that you are currently taking:
(Please add to back of page as needed)

Medication	Dosage	Frequency

Pain Description

Describe where your pain is worst:

When did your pain begin?

What caused your pain?

○ Accident ○ Illness ○ Other ○ Unknown Cause

If known, please describe what caused your pain.

If your pain is the result of an accident, is there litigation?

○ Yes ○ No ○ Not Applicable

Please select the words that best describe your pain.

☐ Aching ☐ Stinging ☐ Constant ☐ Dull ☐ Stabbing ☐ Intermittent ☐ Sharp ☐ Tingling
☐ Coldness ☐ Burning ☐ Radiating ☐ Numbness ☐ Cramping

Heat Treatment/Stimuli

○ Increases Pain ○ Decreases Pain ○ No Change in Pain

Cold Stimuli/Treatment

○ Increases Pain ○ Decreases Pain ○ No Change in Pain

Weather Changes

○ Increases Pain ○ Decreases Pain ○ No Change in Pain

Lying Down

○ Increases Pain ○ Decreases Pain ○ No Change in Pain

Sleep

○ Increases Pain ○ Decreases Pain ○ No Change in Pain

Physical Activity

○ Increases Pain ○ Decreases Pain ○ No Change in Pain

Sexual Intercourse

○ Increases Pain ○ Decreases Pain ○ No Change in Pain

Urination

○ Increases Pain ○ Decreases Pain ○ No Change in Pain

Sitting

○ Increases Pain ○ Decreases Pain ○ No Change in Pain

Standing

○ Increases Pain ○ Decreases Pain ○ No Change in Pain

Fatigue

○ Increases Pain ○ Decreases Pain ○ No Change in Pain

Sneezing/Coughing

○ Increases Pain ○ Decreases Pain ○ No Change in Pain

Tension

○ Increases Pain ○ Decreases Pain ○ No Change in Pain

Massage Therapy

○ Increases Pain ○ Decreases Pain ○ No Change in Pain ○ Not Applicable

Physical Therapy

◯ Increases Pain ◯ Decreases Pain ◯ No Change in Pain ◯ Not Applicable

Opioid Risk Tool

Are you between the ages of 16 and 45?

◯ Yes ◯ No

Do you have a history of alcohol abuse?

◯ Yes ◯ No

Do you have a history of Attention Deficit Disorder (ADD), Obsessive Compulsive Disorder (OCD), bipolar disorder or schizophrenia?

◯ Yes ◯ No

Do you have a history of depression?

◯ Yes ◯ No

Do you have a history of illegal drug abuse?

◯ Yes ◯ No

Do you have a history of prescription drug abuse?

◯ Yes ◯ No

Is there a history of prescription drug abuse in your family?

◯ Yes ◯ No

Is there a history of alcohol abuse in your family?

◯ Yes ◯ No

Is there a history of illegal drug abuse in your family?

◯ Yes ◯ No

Alcohol Screen (Audit-C)

Did you have a drink containing alcohol in the past year?

◯ Yes ◯ No

How often did you have 6 or more drinks on one occasion in the past year?

◯ Never (0 point) ◯ Less than monthly (1 point) ◯ Monthly (2 points) ◯ Weekly (3 points) ◯ Daily or almost daily (4 points)

How many drinks did you have on a typical day when you were drinking in the past year?

◯ 1 or 2 drinks (0 point) ◯ 3 or 4 drinks (1 point) ◯ 5 or 6 drinks (2 points) ◯ 7 to 9 drinks (3 points) ◯ 10 or more drinks (4 points)

How often did you have a drink containing alcohol in the past year?

◯ Never (0 point) ◯ Monthly or less (1 point) ◯ 2 to 4 times a month (2 points) ◯ 2 to 3 times a week (3 points) ◯ 4 or more times a week (4 points)

PHQ-9

Little interest or pleasure in doing things

◯ Not at all ◯ Several days ◯ More than half the days ◯ Nearly every day

Feeling down, depressed, or hopeless

◯ Not at all ◯ Several days ◯ More than half the days ◯ Nearly every day

Trouble falling or staying asleep, or sleeping too much

◯ Not at all ◯ Several days ◯ More than half the days ◯ Nearly every day

Feeling tired or having little energy

◯ Not at all ◯ Several days ◯ More than half the days ◯ Nearly every day

Poor appetite or overeating

○ Not at all ○ Several days ○ More than half the days ○ Nearly every day

Feeling bad about yourself or that you are a failure, or have let yourself or your family down

○ Not at all ○ Several days ○ More than half the days ○ Nearly every day

Trouble concentrating on things, such as reading the newspaper or watching television

○ Not at all ○ Several days ○ More than half the days ○ Nearly every day

Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual

○ Not at all ○ Several days ○ More than half the days ○ Nearly every day

Thoughts that you would be better off dead or of hurting yourself in some way

○ Not at all ○ Several days (Consider Suicide Assessment Risk) ○ More than half the days (Consider Suicide Assessment Risk) ○ Nearly every day (Consider Suicide Assessment Risk)

Tobacco Use/Smoking

Are you a

○ current smoker ○ current every day smoker ○ current some day smoker ○ Smoker current status unknown ○ former smoker ○ nonsmoker ○ unknown if ever smoked ○ light tobacco smoker ○ heavy tobacco smoker ○ Uses tobacco in other forms

How long has it been since you last smoked?

○ < 1 month ○ 1-3 months ○ 3-6 months ○ 6-12 months ○ 1-5 years ○ 5-10 years ○ > 10 years ○ 10-15 years ○ >20 years

Are you interested in quitting?

○ Ready to quit ○ Thinking about quitting ○ Not ready to quit

How many cigarettes a day do you smoke?

○ 5 or less ○ 6-10 ○ 11-20 ○ 21-30 ○ 31 or more

How soon after you wake up do you smoke your first cigarette?

○ within 5 minutes ○ 6-30 minutes ○ 31-60 minutes ○ after 60 minutes

How often do you smoke cigarettes?

○ every day ○ some days, but not every day

Pain Scales

Please rate your HIGHEST pain level. 0=None, 10=Highest

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

Please rate your LOWEST pain level. 0=None, 10=Highest

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

Please rate your PRESENT pain level. 0=None, 10=Highest

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

Functional Scales

Rate your ability to cope with pain. 0=Unable,10=Able

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

Rate your ability to perform daily tasks. 0=Unable,10=Able

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

Rate your ability to interact socially. 0=Unable,10=Able

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

Rate your ability to work. 0=Unable,10=Able

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

Past Treatments

Have you tried surgery treatments in the past? If yes, last date and how long?

PLEASE LIST IN THE PROVIDED AREA AT THE END OF THE QUESTIONNAIRE.

Have you tried traction treatments in the past? If yes, last date and how long?

Have you tried spinal injection treatments in the past? If yes, last date and how long?

Have you tried joint injection treatments in the past? If yes, last date and how long?

Have you tried muscle injection treatments in the past? If yes, last date and how long?

Have you tried ketamine infusion treatments in the past? If yes, last date and how long?

Have you tried nerve block treatments in the past? If yes, last date and how long?

Have you tried physical therapy treatments in the past? If yes, last date and how long?

Have you tried chiropractic treatments in the past? If yes, last date and how long?

Have you tried psychology treatments in the past? If yes, last date and how long?

Have you tried TENS unit treatments in the past? If yes, last date and how long?

Have you tried acupuncture treatments in the past? If yes, last date and how long?

Medications

List ANY medications over the counter or prescription that you are currently taking (Name of Medication, Dosage, Frequency):

PLEASE LIST IN THE PROVIDED AREA AT THE END OF THE QUESTIONNAIRE.

Please describe any side effects you are experiencing with your medications:

PLEASE LIST IN THE PROVIDED AREA AT THE END OF THE QUESTIONNAIRE.

Select any opioids that you are taking/have taken.

☐ N/A ☐ Fentanyl ☐ Morphine(ER/IR) ☐ Oxycodone(ER/IR) ☐ Hydrocodone ☐ Hydromorphone
☐ Buprenorphine ☐ Methadone ☐ Tramadol ☐ Tapentadol(Nucynta) ☐ Codeine ☐ Suboxone ☐ Other

List any other opioids you are taking/have taken.

Select any anti-inflammatory that you are taking/have taken.

☐ N/A ☐ Diclofenac ☐ Indomethacin ☐ Ibuprofen ☐ Tylenol ☐ Aspirin ☐ Etodolac ☐ Naproxen
☐ Topical Patch ☐ Celecoxib(Celebrex) ☐ Meloxicam ☐ Nabumetone ☐ Other

List any other anti-inflammatories you are taking/have taken

Select any muscle relaxants that you are taking/have taken.

☐ N/A ☐ Baclofen ☐ Methocarbamol ☐ Tizanidine ☐ Cyclobenaprine ☐ Metaxalone ☐ Other

List any other muscle relaxants you are taking/have taken.

Select any antidepressants that you are taking/have taken.

☐ N/A ☐ Cymbalta ☐ Nortriptyline ☐ Remeron ☐ Wellbutrin ☐ Effexor ☐ Paxil ☐ Zoloft ☐ Amitriptyline ☐ Lexapro ☐ Pristiq ☐ Imipramine ☐ Prozac ☐ Trazadone ☐ Other

List any other antidepressants you are taking/have taken.

Select any sleep aids that you are taking/have taken.

☐ N/A ☐ Zolpidem(Ambien) ☐ Sodum Oxybate(Xyrem) ☐ Lunesta ☐ Temazepam(Restoril) ☐ Ramelteon (Rozerem) ☐ Zaleplon(Sonata) ☐ Other

List any other sleep aids you are taking/have taken.

Select any anticonvulsants that you are taking/have taken.

☐ N/A ☐ Gabapentin(Neurontin) ☐ Topiramate(Topomax) ☐ Valproic Acid(Depakote) ☐ Lyrica(Pregabalin) ☐ Levetiracetam(Keppra) ☐ Luminal(Phenobarbital) ☐ Carbamazepine(Tegretol) ☐ Primidone(Mysoline) ☐ Other

List any other anticonvulsants you are taking/have taken.

Select any migraine medications that you are/have taken.

☐ N/A ☐ Fiorcet ☐ Zolmitriptan(Zomig) ☐ Diclofenac(Cambia) ☐ Cafergot ☐ Sumatriptan(Imitrex) ☐ Frovatriptan(Frova) ☐ Naratriptan(Amerge) ☐ Excedrin ☐ Eletriptan(Relpax) ☐ Almotriptan(Axert) ☐ Fiorinal ☐ Pamprin ☐ Rizatriptan(Maxalt) ☐ Prodrin ☐ Other

List any other migraine medication you are taking/have taken

Do your pain medications provide significant relief?

○ Yes ○ No ○ I do not take pain medications.

What percentage relief do you receive from your pain medication?

○ Less than 50% ○ 50% ○ 60% ○ 70% ○ 80% ○ 90% ○ 100% ○ I do not take pain medication

Do your pain medications improve your function?

○ Yes ○ No ○ I do not take pain medication

If yes, how much improvement in function do you receive from your pain medication?

○ I do not take pain medication ○ 50% ○ 60% ○ 70% ○ 80% ○ 90% ○ 100%

Patient Care Team

Do you have a cardiologist? If yes, please list name of physician.

Do you have a pulmonologist? If yes, please list name of physician.

Have you seen an orthopedic surgeon? If yes, please list name of physician.

Have you seen a neurosurgeon? If yes, please list name of physician.

Do you have a neurologist? If yes, please list name of physician.

Please list any other past surgeons you have seen:

Do you have a rheumatologist? If yes, please list name of physician.

Do you have an oncologist? If yes, please list name of physician.

Diagnostic Studies

List any x-ray studies that you have had performed and the facility the study was done at.

List any MRI studies that you have had performed and the facility the study was done at.

List any CT scans that you have had performed and the facility the study was done at.

List any EMG studies that you have had performed and the facility the study was done at.

Treatment Goals

List any activities goals you would like to improve on.

Sleep Behavior

Have you been evaluated for sleep apnea with a sleep study?

○ Yes ○ No

If yes, were you diagnosed with sleep apnea?

○ Yes ○ No ○ Not Applicable

If you have sleep apnea, are you using a CPAP or BIPAP?

○ Yes ○ No ○ Not Applicable

General/Constitutional

Currently Experiencing: Chills?

○ Yes ○ No

Currently Experiencing: Fever?

○ Yes ○ No

Currently Experiencing: Night sweats?

○ Yes ○ No

Gastrointestinal

Currently Experiencing: Constipation?

○ Yes ○ No

Currently Experiencing: Nausea?

○ Yes ○ No

Currently Experiencing: Vomiting?

○ Yes ○ No

Psychiatric

Currently Experiencing: Anxiety?

○ Yes ○ No

Currently Experiencing: Depressed Mood?

○ Yes ○ No

Currently Experiencing: Auditory/Visual Hallucinations?

◯ Yes ◯ No

Ophthalmologic

Currently Experiencing: Visual Changes?

◯ Yes ◯ No

Currently Experiencing: Double Vision?

◯ Yes ◯ No

Currently Experiencing: Blindness?

◯ Yes ◯ No

Genitourinary

Currently Experiencing: Pain with Urination?

◯ Yes ◯ No

Currently Experiencing: Difficulty Controlling Urine?

◯ Yes ◯ No

Currently Experiencing: Sexual Dysfunction?

◯ Yes ◯ No

Currently Experiencing: Painful Intercourse?

◯ Yes ◯ No

Musculoskeletal

Currently Experiencing: Stiffness?

◯ Yes ◯ No

Currently Experiencing: Swelling?

◯ Yes ◯ No

Currently Experiencing: Joint Pain?

◯ Yes ◯ No

Currently Experiencing: Bone Pain?

◯ Yes ◯ No

Cardiovascular

Currently Experiencing: Palpitations?

◯ Yes ◯ No

Currently Experiencing: Chest Pain?

◯ Yes ◯ No

Currently Experiencing: Arrhythmia?

◯ Yes ◯ No

Skin

Currently Experiencing: Sores?

◯ Yes ◯ No

Currently Experiencing: Rashes?

◯ Yes ◯ No

Currently Experiencing: Loss of Body Hair?

◯ Yes ◯ No

Neurologic

Currently Experiencing: Memory Loss?

◯ Yes ◯ No

Currently Experiencing: Headache?

◯ Yes ◯ No

Currently Experiencing: Tingling/Numbness?

◯ Yes ◯ No

Respiratory

Currently Experiencing: Shortness of Breath?

◯ Yes ◯ No

Currently Experiencing: Productive Sputum?

◯ Yes ◯ No

Hematology

Currently Experiencing: Bleeding Disorder?

◯ Yes ◯ No

Currently Experiencing: Anemia?

◯ Yes ◯ No

Endocrine

Currently Experiencing: Decreased Sex Drive?

◯ Yes ◯ No

Currently Experiencing: Absence of Menstrual Cycle

◯ Yes ◯ No

Currently Experiencing: Heat Intolerance?

◯ Yes ◯ No

Family History

Mother

☐ Addiction/Substance Abuse ☐ Alcoholism ☐ Alzheimer's Disease ☐ Anxiety ☐ Arthritis ☐ Cancer
☐ Chronic Pain ☐ Dementia ☐ Depression ☐ Diabetes ☐ High Blood Pressure ☐ Borderline Personality
☐ Schizophrenia ☐ Stroke ☐ Other

Father

☐ Addiction/Substance Abuse ☐ Alcoholism ☐ Alzheimer's Disease ☐ Anxiety ☐ Arthritis ☐ Cancer
☐ Chronic Pain ☐ Dementia ☐ Depression ☐ Diabetes ☐ High Blood Pressure ☐ Borderline Personality
☐ Schizophrenia ☐ Stroke ☐ Other

Siblings

☐ Addiction/Substance Abuse ☐ Alcoholism ☐ Alzheimer's Disease ☐ Anxiety ☐ Arthritis ☐ Cancer
☐ Chronic Pain ☐ Dementia ☐ Depression ☐ Diabetes ☐ High Blood Pressure ☐ Borderline Personality
☐ Schizophrenia ☐ Stroke ☐ Other

Other Family

☐ Addiction/Substance Abuse ☐ Alcoholism ☐ Alzheimer's Disease ☐ Anxiety ☐ Arthritis ☐ Cancer
☐ Chronic Pain ☐ Dementia ☐ Depression ☐ Diabetes ☐ High Blood Pressure ☐ Borderline Personality
☐ Schizophrenia ☐ Stroke ☐ Other

Lifestyle

What is your current work status?

◯ Employed ◯ Retired ◯ Disabled ◯ Unemployed

Has your pain restricted your ability to work? If so, how?

What are your current work restrictions, if any?

Psychological Treatment

Select any of the following you have been diagnosed with:

☐ Alzheimer's ☐ Anxiety ☐ Bipolar Disorder ☐ Depression ☐ Schizophrenia ☐ Mania ☐ Borderline Personality ☐ Other

Select any conditions you have received treatment for:

☐ Alzheimer's ☐ Anxiety ☐ Bipolar Disorder ☐ Depression ☐ Schizophrenia ☐ Mania ☐ Borderline Personality ☐ Other

Have you ever considered suicide?

○ Yes ○ No

Have you ever planned suicide?

○ Yes ○ No

Have you ever attempted suicide?

○ Yes ○ No

Past Medical History

Have you ever been diagnosed with asthma?

○ Yes ○ No

Have you ever been diagnosed with cancer?

○ Yes ○ No

Have you ever been diagnosed with hypertension?

○ Yes ○ No

Have you ever been diagnosed with epilepsy?

○ Yes ○ No

Have you ever been diagnosed with human immunodeficiency virus (HIV)?

○ Yes ○ No

Have you ever been diagnosed with lupus?

○ Yes ○ No

Have you ever been diagnosed with kidney disease?

○ Yes ○ No

Have you ever been diagnosed with shingles?

○ Yes ○ No

Have you ever been diagnosed with sleep apnea?

○ Yes ○ No

Have you ever been diagnosed with stroke?

○ Yes ○ No

Have you ever been diagnosed with peripheral vascular disease?

○ Yes ○ No

Have you ever been diagnosed with osteoarthritis?

○ Yes ○ No

Have you ever been diagnosed with migraine headaches?

○ Yes ○ No

Have you ever been diagnosed with heart disease?

○ Yes ○ No

Have you ever been diagnosed with hepatitis A?

○ Yes ○ No

Have you ever been diagnosed with hepatitis B?

○ Yes ○ No

Have you ever been diagnosed with hepatitis C?

○ Yes ○ No

Have you ever been diagnosed with hepatitis D?

○ Yes ○ No

Have you ever been diagnosed with emphysema?

○ Yes ○ No

Have you ever been diagnosed with fibromyalgia?

○ Yes ○ No

Have you ever been diagnosed with diabetes?

○ Yes ○ No

Please list any other medical conditions/diagnoses you have received:

Do you have an implanted pacemaker?

○ Yes ○ No

Do you have a defibrillator?

○ Yes ○ No

Do you have an implanted cardioverter-defibrillator (ICD)?

○ Yes ○ No

Do you have an implanted spinal cord stimulator?

○ Yes ○ No

Are you currently pregnant?

○ Yes ○ No ○ Unsure

Have you had a pneumonia vaccination in the past?

○ Yes ○ No

Do you currently have an advanced directive? If so, where is it on file?

GAD-7

Over the last two weeks have you experienced becoming easily annoyed or irritable?

○ NOT AT ALL ○ SEVERAL DAYS ○ MORE THAN HALF OF THE DAYS ○ NEARLY EVERY DAY

Over the last two weeks have you experienced being so restless that it is hard to sit still?

○ NOT AT ALL ○ SEVERAL DAYS ○ MORE THAN HALF OF THE DAYS ○ NEARLY EVERY DAY

Over the last two weeks have you experienced feeling afraid as if something awful might happen?

○ NOT AT ALL ○ SEVERAL DAYS ○ MORE THAN HALF OF THE DAYS ○ NEARLY EVERY DAY

Over the last two weeks have you experienced feeling nervous, anxious or on edge?

○ NOT AT ALL ○ SEVERAL DAYS ○ MORE THAN HALF OF THE DAYS ○ NEARLY EVERY DAY

Over the last two weeks have you experienced not being able to stop or control worrying?

◯ NOT AT ALL ◯ SEVERAL DAYS ◯ MORE THAN HALF OF THE DAYS ◯ NEARLY EVERY DAY

Over the last two weeks have you experienced trouble relaxing?

◯ NOT AT ALL ◯ SEVERAL DAYS ◯ MORE THAN HALF OF THE DAYS ◯ NEARLY EVERY DAY

Over the last two weeks have you experienced worrying too much about different things?

◯ NOT AT ALL ◯ SEVERAL DAYS ◯ MORE THAN HALF OF THE DAYS ◯ NEARLY EVERY DAY

Epworth Sleepiness Scale

Your likelihood of falling asleep as a passenger in a car for an hour without a break:

◯ Would Never Doze ◯ Slight Chance of Dozing ◯ Moderate Chance of Dozing ◯ High Chance of Dozing

Your likelihood of falling asleep while in a car while stopped for a few minutes in traffic:

◯ Would Never Doze ◯ Slight Chance of Dozing ◯ Moderate Chance of Dozing ◯ High Chance of Dozing

Your likelihood of falling asleep while lying down to rest in the afternoon when circumstances permit:

◯ Would Never Doze ◯ Slight Chance of Dozing ◯ Moderate Chance of Dozing ◯ High Chance of Dozing

Your likelihood of falling asleep while sitting and reading:

◯ Would Never Doze ◯ Slight Chance of Dozing ◯ Moderate Chance of Dozing ◯ High Chance of Dozing

Your likelihood of falling asleep while sitting and talking to someone:

◯ Would Never Doze ◯ Slight Chance of Dozing ◯ Moderate Chance of Dozing ◯ High Chance of Dozing

Your likelihood of falling asleep while sitting in a public place:

◯ Would Never Doze ◯ Slight Chance of Dozing ◯ Moderate Chance of Dozing ◯ High Chance of Dozing

Your likelihood of falling asleep while sitting quietly after a lunch without alcohol:

◯ Would Never Doze ◯ Slight Chance of Dozing ◯ Moderate Chance of Dozing ◯ High Chance of Dozing

Your likelihood of falling asleep while watching TV:

◯ Would Never Doze ◯ Slight Chance of Dozing ◯ Moderate Chance of Dozing ◯ High Chance of Dozing

Oswestry Pain Scale

Please rate the severity of your pain by selecting a number below (0=No Pain, 10=Unbearable Pain):

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

Pain Intensity: Please select one number which most closely describes your pain.

◯ 0. The pain comes and goes and is very mild. ◯ 1. The pain is mild and does not vary much. ◯ 2. The pain comes and goes and is moderate. ◯ 3. The pain is moderate and does not vary much. ◯ 4. The pain comes and goes and is severe. ◯ 5. The pain is severe and does not vary much.

Personal Care (Washing, Dressing, etc.): Please select one number which most closely describes your pain.

◯ 0. I would not have to change my way of washing or dressing in order to avoid pain. ◯ 1. I do not normally change my way of washing or dressing even though it causes some pain. ◯ 2. Washing and dressing increase the pain but I manage not to change my way of doing it. ◯ 3. Washing and dressing increase the pain and I find it necessary to change my way of doing it. ◯ 4. Because of the pain I am unable to do some washing and dressing without help. ◯ 5. Because of the pain I am unable to do any washing and dressing without help.

Lifting: Please select one number which most closely describes your pain.

◯ 0. I can lift heavy weights without extra pain. ◯ 1. I can lift heavy weights but it gives extra pain. ◯ 2. Pain prevents me lifting heavy weights off the floor. ◯ 3. Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently positioned (e.g. on a table). ◯ 4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned. ◯ 5. I can only lift light weights at most.

Walking: Please select one number which most closely describes your pain.

○ 0. I have no pain on walking. ○ 1. I have some pain on walking but it does not increase with distance. ○ 2. I cannot walk more than 1 mile without increasing pain. ○ 3. I cannot walk more than 1/2 mile without increasing pain. ○ 4. I cannot walk more than 1/4 mile without increasing pain. ○ 5. I cannot walk at all without increasing pain.

Sitting: Please select one number which most closely describes your pain.

○ 0. I can sit in any chair as long as I like. ○ 1. I can sit only in my favorite chair as long as I like. ○ 2. Pain prevents me from sitting more than 1 hour. ○ 3. Pain prevents me from sitting more than 1/2 hour. ○ 4. Pain prevents me from sitting more than 10 minutes. ○ 5. I avoid sitting because it increases pain immediately.

Standing: Please select one number which most closely describes your pain.

○ 0. I can stand as long as I like without pain. ○ 1. I have some pain on standing but it does not increase with time. ○ 2. I cannot stand for longer than 1 hour without increasing pain. ○ 3. I cannot stand for longer than 1/2 hour without increasing pain. ○ 4. I cannot stand for longer than 10 minutes without increasing pain. ○ 5. I avoid standing because it increases the pain immediately.

Sleeping: Please select one number which most closely describes your pain.

○ 0. I get no pain in bed. ○ 1. I get pain in bed but it does not prevent me from sleeping well. ○ 2. Because of pain my normal nights sleep is reduced by less than 1/4. ○ 3. Because of pain my normal nights sleep is reduced by less than one half. ○ 4. Because of pain my normal nights sleep is reduced by less than 3/4. ○ 5. Pain prevents me from sleeping at all.

Social Life: Please select one number which most closely describes your pain.

○ 0. My social life is normal and gives me no pain. ○ 1. My social life is normal but it increases the degree of pain. ○ 2. Pain has no significant effect on my social life apart from limiting my more energetic interests - such as dancing ○ 3. Pain has restricted my social life and I do not go out very often. ○ 4. Pain has restricted my social life to my home. ○ 5. I have hardly any social life because of the pain.

Traveling: Please select one number which most closely describes your pain.

○ 0. I get no pain when traveling. ○ 1. I get some pain when traveling but none of my usual forms of travel make it any worse. ○ 2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel. ○ 3. I get extra pain while traveling which compels me to seek alternative forms of travel. ○ 4. Pain restricts me to short necessary journeys under 1/2 hour. ○ 5. Pain restricts all forms of travel.

Changing Degree of Pain: Please select one number which most closely describes your pain.

○ 0. My pain is rapidly getting better. ○ 1. My pain fluctuates but is definitely getting better. ○ 2. My pain seems to be getting better but improvement is slow. ○ 3. My pain is neither getting better or worse. ○ 4. My pain is gradually worsening. ○ 5. My pain is rapidly worsening.

SOAPP-R

How often do you have mood swings?

○ 0. Not at all ○ 1. Seldom ○ 2. Sometimes ○ 3. Often ○ 4. Very often

How often have you felt for higher doses of medication to treat your pain?

○ 0. Not at all ○ 1. Seldom ○ 2. Sometimes ○ 3. Often ○ 4. Very often

How often have you felt impatient with your doctors?

○ 0. Not at all ○ 1. Seldom ○ 2. Sometimes ○ 3. Often ○ 4. Very often

How often have you felt that things are just too overwhelming that you can't handle them?

○ 0. Not at all ○ 1. Seldom ○ 2. Sometimes ○ 3. Often ○ 4. Very often

How often is there tension at home?

○ 0. Not at all ○ 1. Seldom ○ 2. Sometimes ○ 3. Often ○ 4. Very often

How often have you counted pain pills to see how many are remaining?

○ 0. Not at all ○ 1. Seldom ○ 2. Sometimes ○ 3. Often ○ 4. Very often

How often have you been concerned that people will judge you for taking pain medication?

○ 0. Not at all ○ 1. Seldom ○ 2. Sometimes ○ 3. Often ○ 4. Very often

How often do you feel bored?

○ 0. Not at all ○ 1. Seldom ○ 2. Sometimes ○ 3. Often ○ 4. Very often

How often have you taken more pain medication than you were supposed to?

○ 0. Not at all ○ 1. Seldom ○ 2. Sometimes ○ 3. Often ○ 4. Very often

How often are you worried about being left alone?

○ 0. Not at all ○ 1. Seldom ○ 2. Sometimes ○ 3. Often ○ 4. Very often

How often have you felt a craving for medication?

○ 0. Not at all ○ 1. Seldom ○ 2. Sometimes ○ 3. Often ○ 4. Very often

How often have others expressed concern over your use of medication?

○ 0. Not at all ○ 1. Seldom ○ 2. Sometimes ○ 3. Often ○ 4. Very often

Allergies

If you are allergic to any medications, please list the medication name and reaction below:
(Please add to back of page as needed)

Medication	Reaction

Surgical History

Please list prior surgeries or procedures in the table below:

Date	Surgery/Procedure	Physician

I acknowledge that to the best of my knowledge and ability, I have provided Freedom Spine & Pain Center with fully accurate and complete information about my medical history.

Signature of Patient/Guardian/Personal Representative Date

Name of Patient/Guardian/Personal Representative

Guardian/Personal Representative's Relationship to Patient

FINANCIAL POLICY

Because of our commitment to provide you with the highest standard of medical care, we want you to be aware of our policies concerning payment of your medical expenses.

PATIENT PAYMENT RESPONSIBILITY

At all office visits, you will be responsible for any co-payment/co-insurance amounts assigned by the insurance carrier plus any applicable deductible amounts. If there is a balance on your account, you may be asked to pay towards that amount on your visit. Should an overpayment occur on any amount you owe to Freedom Spine & Pain Center, we will apply a credit to your account. A refund is available upon request.

If our office cannot verify your insurance benefits in advance, your insurance carrier sends payment directly to you, you are waiting for coverage to become effective, or if you have no medical insurance coverage, payment in full will be due when you check in for your appointment.

ACCEPTED FORMS OF PAYMENT

Accepted forms of payment are credit card, debit card, or cash. We do not accept checks.

LEGAL GUARDIAN MUST BE PRESENT

We require that a guardian or duly authorized representative accompany a patient who lacks the capacity to make medical treatment decisions, unless the guardian or representative has given prior written authorization to our office to undertake the testing, treatment, or procedure contemplated for the pertinent visit, and Freedom Spine & Pain Center deems it appropriate under the patient's particular circumstances. The guardian or duly authorized representative accompanying the patient is required to pay in accordance with our policies.

CANCELLATION/NO-SHOW POLICY

In consideration of your fellow patients, please contact our office as soon as possible if you need to cancel or reschedule your appointment. **There will be a $50.00 fee for either failing to show up for a scheduled appointment or canceling a scheduled office visit less than 24 hours in advance. There will be a $150.00 fee for either failing to show up for a scheduled procedure or canceling a scheduled procedure less than 24 hours in advance.** Please be sure to cancel more than 24 hours in advance to avoid these fees. Additionally, if you are more than fifteen (15) minutes late for a scheduled office visit or procedure, you may be asked to re-schedule, in which event we will assess the applicable cancellation fee against your account. To avoid these fees, be sure to show up on time or cancel more than 24 hours in advance.

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Patient/Guardian/Personal Representative Signature   Date

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize Freedom Spine & Pain Center to file claims with my insurance company and to receive payment for my medical care and/or procedures. Freedom Spine & Pain Center has my permission to release any information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I further authorize payment directly to Freedom Spine & Pain Center of all insurance benefits related to my care. I understand that I am responsible for any co-payments, co-insurance, or deductibles due at the time of any and all office visits or procedures. I also understand that I am financially responsible for all charges not covered by my insurance benefits for services rendered on my behalf. I acknowledge that Freedom Spine & Pain Center is an assumed name ("d/b/a") of Alliance Spine & Pain Management, PLLC ("Alliance") and that the benefits assigned hereunder will be paid to Alliance. Accordingly, bills from our office, Explanations of Benefits ("EOBs") pertaining to reimbursement for your care, and other correspondence from this medical practice concerning your account may be sent under the name of or make reference to Alliance and/or its Member Physicians, including without limitation Rajesh K. Sharma, M.D. Please take action on these items accordingly.

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Patient/Guardian/Personal Representative Signature Date

MEDICARE AUTHORIZATION

I request that payment of Medicare benefits be made to Freedom Spine & Pain Center on my behalf for any services furnished by Freedom Spine & Pain Center or under its direction. I understand that my signature below requests the assignment of payment for my medical care and authorizes the release of medical information necessary to pay any related claims. I acknowledge that in Medicare assigned cases, Freedom Spine & Pain Center agrees to recognize the allowable charge determined by the Medicare carrier as the full charge, and the patient is responsible only for the difference between the allowable charge and the amount paid by the Medicare carrier pursuant to Medicare regulations. I further acknowledge that although I am a Medicare beneficiary, Freedom Spine & Pain Center may recommend certain procedures or treatments that are either not covered by Medicare or are not covered for use in the manner Freedom Spine & Pain Center has recommended. In such an event, Freedom Spine & Pain Center will undertake its best efforts to consult with me concerning the medical necessity and the unlikelihood of reimbursement for the procedure or treatment in question. I may be asked to sign certain documentation that the Medicare Program requires in such circumstances. I recognize that if I elect to proceed with the procedure or treatment in such an event, I will be personally and fully responsible for payment.

____

Patient/Guardian/Personal Representative Signature Date

NOTICE OF PRIVACY PRACTICES

Effective July 1, 2020

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THE PURPOSE OF THIS NOTICE

Freedom Spine & Pain Center's Notice of Privacy Practices: This is Freedom Spine & Pain Center's Notice of Privacy Practices ("Notice"). It is applicable to all of our patients. Freedom Spine & Pain Center is referred to in this Notice as "us," "we," or "our." This Notice is required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as later modified and updated, and by other Texas and federal laws. In general, HIPAA and related statutes deal with your "Protected Health Information," which HIPAA defines as personal information that identifies you and relates to the diagnosis and treatment of your past, present, or future physical or mental health condition(s). For the sake of simplicity, this Notice uses the term "medical information" instead of "Protected Health Information."

Further Information: We strive at all times to deliver high quality clinical services, and we are dedicated to maintaining the privacy of your medical information. We will provide you with a copy of our current Notice when you come to our office for your first appointment. We will ask you, your parent or guardian, or your personal representative, as applicable, to acknowledge in writing your receipt and review of this document. Our current Notice will also be posted prominently in our office and on our website at www.freedomspine.com. If you desire an additional copy of this Notice or you have any further questions or concerns about your medical information, our Privacy Officer, Chesney Dunning, is available to assist you. You may contact her by calling (210) 920-8945, by writing to Freedom Spine & Pain Center c/o Privacy Officer, 1580 S. Main Street, Suite 101, Boerne, Texas 78006, or by emailing us at cdunning@allspinepain.com.

OUR DUTIES

We are required by law: to maintain the privacy of your medical information (subject to the contents of this Notice); to provide you with notice of our legal duties and privacy practices with respect to your medical information; and to notify you following a breach of the privacy of your medical information (in the manner prescribed by applicable law). We are required to abide by the terms of our current Notice.

HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

We may use and disclose your medical information in a number of circumstances and for a variety of reasons, some of which require your prior authorization. There are many situations, however, in which we are legally permitted or required to use and disclose your medical information without your prior authorization. Many of these instances will occur in connection with: a) your treatment, b) payment for healthcare services that we provide to you, and/or c) our routine healthcare business operations. This Notice describes these situations. In some cases we may completely remove any personal identifiers. Specifically, we may use and disclose your medical information as follows:

Permitted Disclosures of Your Medical Information

We may use and disclose your medical information without your prior authorization in the ordinary course of our routine business operations. Such instances include the following:

***Treatment*:** We may use your medical information to facilitate the provision of our services to you. This includes disclosing your medical information to individuals who may need that information to treat you, such as our physicians, physician assistants, nurses, technicians, and other clinical personnel, and others involved in your care, such as your primary care physician or specialists. We may also use and disclose your medical information to remind you of upcoming appointments, inform you about treatment options or alternatives, tell you about healthcare-related services, or monitor and evaluate your experience with us through follow-up communications.

Payment: We may use your medical information to bill and receive payment from your insurance company, you, or any other person/entity responsible for payment of your account. We may also use your medical information when contacting your health plan to see if it will pay for your treatment with us or for any other customary purpose related to billing and payment. You may also request to pay out-of-pocket for the services we provide to you and, in such a case, you may request that we not bill your insurer for such services.

Healthcare Operations: We may also use or disclose your medical information to conduct our normal business and professional operations. For example, we routinely review past medical and surgical procedures to assess our service and clinical performance. We might also use your medical information for internal and external review purposes. In addition, we may use your medical information to demonstrate our competencies to an accreditation body. Accreditation is important to you and to us because the process assists us in maintaining our proficiency in performing our medical services. Other operational matters that might require us to use or disclose your medical information include professional and staff training, payor credentialing, risk management activities, insurance underwriting, cost and utilization management, legal and regulatory compliance, facility licensing and certification, and financial accounting and auditing.

Emergency Treatment: We may disclose your medical information if you require emergency treatment or are unable to communicate with us.

***Serious Threats to Health or Safety*:** We may disclose your medical information if, in our professional judgment, doing so would help to avert a serious threat to the public's or your health or safety.

Public Health Activities: We may disclose medical information about you for public health activities. These activities generally include the following: to prevent or control disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls of products that they may be using; and/or to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. All such disclosures will be made in accordance with the requirements of Texas and federal laws and regulations.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose your medical information to proper authorities in accordance with applicable law if we reasonably believe it is relevant to instances of abuse, neglect, or domestic violence.

Family and Friends: We may disclose your medical information to a family member, a friend, or any other person you identify as being involved with your care or payment for your care, unless you object.

Worker's Compensation: We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Military and Veterans: If you are a member of the armed forces, we may release information about you as required by military command authorities.

Health Oversight Activities**:** If you are the beneficiary of a government healthcare program, we may be required to disclose your medical information to that program or a related agency if it selects your case for medical review.

Disclosures Required by Law: Federal, state, or local law may require us to disclose our patients' medical information for certain legally-mandated purposes.

Specialized Government Functions**:** We may use and disclose medical information of certain individuals for specific national security, military, intelligence, or protective service purposes.

Law Enforcement**:** We may disclose your medical information when legally required by appropriate authorities in connection with a criminal or other official investigation.

Judicial and Administrative Proceedings**:** If information in your medical record is relevant to a legal proceeding, we may be required to comply with a court or administrative tribunal subpoena commanding us to disclose your medical information.

Organ and Tissue Donation: If you have formally indicated your desire to be an organ donor, we may release medical information to organizations that handle procurement of organ, eye, or tissue transplantations.

Coroners, Medical Examiners, and Funeral Directors: We may release information to a coroner or medical examiner when authorized by law (e.g., to identify a deceased person or determine the cause of death). We may also release medical information about patients to funeral directors.

Sale of Practice: We may use and disclose medical information about you to another health care facility or group of physicians in connection with the sale, transfer, merger, or consolidation of our practice.

Research: We may disclose your medical information for certain research purposes, but only if we have protections and protocols in place to ensure the privacy of your medical information.

Disclosures Requiring Your Authorization

Situations Requiring Written Authorization**:** All uses and disclosures of your medical information not generally described above in this Notice will require your prior written authorization. In those situations, we will ask for the authorization before we release your medical information. Examples of these situations include our: a) compliance with requests to provide medical information to your attorney or to life or disability insurance companies; b) use and disclosure of psychotherapy notes, if any; c) use of your testimonial or photographic images; d) use or disclosure of your medical information for other marketing purposes, including communications intended to inform you of subsidized treatment options offered by specific providers; and e) use or disclosure of your medical information in any way that constitutes its sale.

Revocation of Authorization and Its Effects**:** You may revoke any standing authorization to disclose your medical information by so notifying our Privacy Officer in writing at the physical or email address provided on the first page of this Notice. Your revocation can only be prospective, and we will not request the return of information previously disclosed in reliance on your authorization.

YOUR RIGHTS

You have certain rights with respect to our communication of, your access to, the amendment of, and accounting for the disclosure of your medical information:

Requesting Restrictions**:** You may ask us to limit our use or disclosure of your medical information under certain circumstances. For example, we may disclose your medical information to an immediate family member(s), other relative(s), or close personal friend(s) who are directly involved either in your care or in the payment for your care if we reasonably determine, based upon our professional judgment, that you would not object. You may, however, request a restriction on what medical information we may disclose to someone who is directly involved either in your care or in the payment for your care. You are entitled to request other restrictions as well. We are not required to agree to your request, but if we agree to it, we will abide by your request, except as required by law, in emergencies, or when the information is necessary to treat you. All such requests must be in writing and directed to our Privacy Officer at the physical or email address provided on the first page of this Notice. Your request must describe the information that you want restricted, state if the restriction is to limit its use or its disclosure, and state the party(ies) to whom the restriction applies. You may revoke your restriction at any time by contacting our Privacy Officer at the physical or email address on the first page of this Notice.

Confidential Communications**:** In order to protect your medical information, you may ask that we communicate with you in a particular way or at a certain location. Your request must be in writing, tell us how you intend to satisfy your payment obligation (if your request potentially interferes with our obtaining third party payment), and specify an alternate way that we can contact you confidentially. You do not have to give a reason for your request. You may revoke your request at any time by contacting our Privacy Officer at the physical or email address on the first page of this Notice. We will accommodate your reasonable request, but in determining whether your request is reasonable, we will consider the administrative burden it may impose upon us.

Inspect and Copy**:** You may ask to review and obtain a copy of your medical information. You must make your request in writing to our Privacy Officer at the physical or email address on the first page of this Notice. We may charge a fee for copying or preparing a summary of requested medical information. We will respond within 15 days of receiving your request unless your medical information is not readily-accessible or the information is maintained in an off-site storage location. Additionally, you have the right to access your own e-health record in an electronic format and to direct us to send the e-health record directly to a third party. In connection with transfers of e-health records, we may charge for labor costs only, which may include a notary fee and mailing costs if a notarized and/or paper copy is also requested.

Amendment**:** You may request, in writing, that we make a change or addition to your medical information. To make such a request you may contact our Privacy Officer using the contact information on the first page of this Notice. The law limits your right to change or add to your medical information. Specifically, we may decline to change your medical information: if we did not create the medical information; if it is not included in the medical records we maintain for you; if we believe that the medical information is accurate and complete without any changes; or if the medical information contains information you are not permitted to inspect or copy (such as psychotherapy notes). Under no circumstances will we erase or otherwise delete original documentation in your medical information.

Accounting of Disclosures**:** You may request a list of non-routine disclosures that we have made of your medical information during the six years prior to the date of your request. This list will not include disclosures we make to provide our medical services to you, to seek payment for our medical services, to conduct our normal business operations, or disclosures we make pursuant to your written authorization. Your first request in a 12-month period is free, but we may charge for additional lists in the same 12-month period. If your medical information is maintained in an electronic health record after December 31, 2013, we must also provide an accounting of

disclosures through an e-health record to carry out treatment, payment, and healthcare operations within the three-year period prior to the date of your request. If you make such a request, we must either: provide you with an accounting of all such disclosures made by us and by all of our Business Associates; or provide you with an accounting of all such disclosures made by us and a list of our Business Associates, including their contact information, who will be responsible for providing an accounting of such disclosures upon your request.

Breach Notification**:** We are required to notify you if the privacy of your medical information has been breached (as defined in applicable federal regulations). Notification must occur by first class mail within sixty (60) days of the event. The notice of breach must contain: a) a brief description of what happened, including the date of the breach and the date of discovery; b) the steps you should take to protect yourself from potential harm resulting from the breach; and c) a brief description of what we are doing to investigate the breach, mitigate losses, and protect against further breaches.

Business Associates**:** Like most medical practices we conduct some of our business operations with the help of third party vendors and contractors known under HIPAA as "Business Associates." In accordance with federal law, we have entered into Business Associate Agreements which provide that all of the HIPAA administrative security safeguards, physical safeguards, technical safeguards, and security policies, procedures and documentation requirements that apply to us also apply directly to each of our Business Associates.

Paper Copy of Notice**:** You are entitled to receive a paper copy of our Notice of Privacy Practices by contacting our Privacy Officer using the contact information on the first page of this Notice. You may also take a copy of this Notice with you. Even if you have requested this Notice electronically, you may always request a paper copy.

Changes in Our Privacy Practices: We reserve the right to change our medical records privacy practices, as permitted by applicable law. Any changes we make will apply to all medical information we then-currently maintain as well as medical information developed in the future. If we make such a change, this Notice will be amended accordingly, posted prominently in our office and on our website at www.freedomspineandpain.com, and made available to you, upon your request, whenever you subsequently visit our office for care.

File a Complaint**:** If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer using the contact information on the first page of this Notice or with the Office for Civil Rights, U.S. Department of Health and Human Services. Your complaint must be filed within 180 days of when you knew or should have known that the act occurred. The address for the Office of Civil Rights is: Secretary of Health and Human Services, Region VI, Office for Civil Rights, U.S. Department of Health and Human Services, 1301 Young Street, Suite 1169, Dallas, Texas 78202. Or you may call 1-877-696-6775. ***You will not be penalized or retaliated against for filing a complaint.***

ACKNOWLEDGEMENT OF ACCESS TO NOTICE OF PRIVACY PRACTICES

I acknowledge that Freedom Spine & Pain Center's Notice of Privacy Practices is available to me at any time by reviewing it on their website at www.freedomspineandpain.com, by requesting a copy at any of their office locations, by requesting that it be sent to me electronically, or by contacting Freedom Spine & Pain Center's Privacy Officer using the contact information set forth on the first page of the Notice of Privacy Practices. I also acknowledge that before signing this Acknowledgement, Freedom Spine & Pain Center afforded me the opportunity to read and ask questions about the Notice of Privacy Practices.

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Signature of Patient/Guardian/Personal Representative Date

_______________________________________ _______________________________________

Name of Patient/Guardian/Personal Representative Guardian/Personal Representative's Relationship to Patient

OPIOD TREATMENT AGREEMENT

Opioid treatment for chronic pain is used to reduce pain and improve what you are able to do each day. Along with opioid treatment, other medical care may be prescribed to help improve your ability to perform daily activities. This may include exercise, use of non-narcotic analgesics, physical therapy, psychological counseling or other therapies or treatment. Vocational counseling may be provided to assist with your return to work ("RTW") efforts.

I understand that my compliance with the following commitments is a condition of continuing opioid treatment for chronic pain with Freedom Spine & Pain Center.

1. I understand that I have the following responsibilities:
    a. I will take medications only at the dose and frequency prescribed.
    b. I will not increase or change medications without the approval of my treating physician.
    c. I will actively participate in RTW efforts and in any program designed to improve function (including social, physical, psychological and daily or work activities).
    d. I will not request opioids or any other pain medicine from physicians other than my treating physician at Freedom Spine & Pain Center. My treating physician should approve or prescribe all other mind and mood-altering drugs.
    e. I will inform my treating physician of all other medications that I am taking.
    f. I will obtain all medications from one pharmacy, when possible known to Freedom Spine & Pain Center and my treating physician. By signing this Agreement, I give full consent for my treating physician or an authorized representative of Freedom Spine & Pain Center to talk with the pharmacist about all of my medications.
    g. I will protect my prescriptions and medications, and I will keep all medications from children and other household members.
    h. I agree to participate in psychiatric or psychological assessments, as my physician deems necessary.
    i. I understand that if my medications are lost or stolen, they will not be replaced until my next appointment, and they may not be replaced at all.
    j. I will not call between appointments, or at night or on weekends, looking for refills. I understand that prescriptions will be authorized only during scheduled office visits with my treating physician.
    k. I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, opioid or other medication treatment for chronic pain will be terminated.
    l. I will inform Freedom Spine & Pain Center immediately of any change in my mental or physical health status, including any new diagnosis, medical procedure, or course of treatment.

2. I understand that in the event of an emergency, my treating physician, if available, or Freedom Spine & Pain Center should be contacted so my treating physician or an authorized representative of Freedom Spine & Pain Center can discuss my chronic pain treatment with the emergency room or other treating physician. I am responsible for signing a consent to transfer the record of my emergency treatment to Freedom Spine & Pain Center. No more than 3 days of medications may be prescribed by the emergency room or other physician without my treating physician's approval.

3. To the best of my abilities, I will keep and be on time for my scheduled appointments.

4. I understand that my treating physician may stop prescribing opioids or change the treatment plan if:
    a. I do not show any improvement in pain from opioids or my physical activity has not improved.
    b. My behavior is inconsistent with the responsibilities outlined in #1, above.
    c. I give, sell, or misuse the opioid medications.
    d. I develop rapid tolerance or loss of improvement from the treatment.
    e. I obtain opioids from a source other than my treating physician without his or her authorization.
    f. I refuse to cooperate when asked to get a drug screen.

Freedom Spine & Pain Center
OPIOD TREATMENT AGREEMENT (Page 2 of 2)

g. I am identified as having an addiction problem arising from my prescribed treatment or my use of any other addictive substance.
h. I fail to keep follow-up appointments for any reason whatsoever, including any such failure which occurs due to my refusal pay any co-pay, deductible, or charge owed to Freedom Spine & Pain Center.

YOUR SAFETY RISKS WHILE WORKING UNDER THE INFLUENCE OF OPIOIDS:
You should be aware of potential side effects of opioids such as decreased reaction time, clouded judgment, drowsiness, tolerance, and impairment of your ability to operate heavy equipment or drive a motor vehicle.

SIDE EFFECTS OF OPIOIDS:
- Confusion or other change in thinking abilities
- Problems with coordination or balance that may make it unsafe to operate dangerous equipment or motor vehicles
- Breathing too slowly – opioid medication can stop your breathing and lead to death
- Nausea
- Sleepiness or drowsiness
- Vomiting
- Constipation
- Rash
- Aggravation of depression
- Dry mouth
- Itch

THESE SIDE EFFECTS MAY BE MADE WORSE IF YOU MIX OPIOIDS WITH OTHER DRUGS, INCLUDING ALCOHOL OR MUSCLE RELAXERS.

RISKS:
1. **Physical dependence.** This means that abrupt stopping of the drug may lead to withdrawal symptoms characterized by one or more of the following:
   - Runny nose
   - Difficulty sleeping for several days
   - Diarrhea
   - Abdominal cramping
   - Sweating
   - 'Goose bumps'
   - Rapid heart rate
   - Nervousness
2. **Psychological dependence.** This means it is possible that stopping the drug will cause you to miss or crave it.
3. **Tolerance.** This means you may need more and more drug to get the same effect.
4. **Addiction.** There is the potential for the development of addiction or addiction behaviors. This likelihood may be increased in the presence of genetic or other factors.
5. **Problems with pregnancy.** If you are pregnant or contemplating pregnancy, discuss this with your treating physician.

RECOMMENDATIONS TO MANAGE YOUR MEDICATIONS:
- Keep a diary of the pain medications you are taking, the doses, the time of day you are taking them, their effectiveness, and any side-effects you may be having.
- Use a medication sorting box that you can purchase at your pharmacy that is divided by the days of the week and times of the day so it is easier to remember when to take your medications.
- Use a medication lock box that you can purchase at your pharmacy to lock your medications out of the reach of others and prevent anyone but you from obtaining access to it.
- Take only the amount you need with you when leaving home to reduce the risk of losing all your medications at the same time.

I have read, understand, and hereby make the commitments set forth in this Opioid Treatment Agreement. I will comply with these commitments to the best of my ability, and I hereby consent to opioid treatment for chronic pain in accordance with their terms and conditions.

____

Patient Signature | Printed Name | Date

DISCLOSURE OF HEALTH INFORMATION

Freedom Spine & Pain Center will not disclose any of your health information to family (including your spouse), friends, or third parties that fall outside of the Notice of Privacy Practices guidelines, unless you authorize us to do so in writing. If there are any persons and/or facilities that you do not authorize to have access to your personal health information, please ask to complete a request for restriction form.

CONTACT AUTHORIZATION

Notwithstanding Freedom Spine & Pain Center's right under Texas and federal laws and our Notice of Privacy Practices to provide your medical information to certain persons who in our reasonable judgment are involved in your medical care or payment therefor, we would like for you to give us guidance concerning third parties with whom we might share your medical information and the means of doing so. Accordingly, we inquire, if Freedom Spine & Pain Center needs to contact you about your medical care but is unable to reach you directly, would you like for us to attempt any of the following commonly requested alternatives?

Before you check one or more of the options below, please take into consideration that these messages could include information about your medication(s), test results, insurance coverage, appointment details, benefit payments, account status, or other personal information regarding your care at Freedom Spine & Pain Center.

If unable to contact me directly, I authorize Freedom Spine & Pain Center to (please check the applicable boxes):

- ☐ Leave a voice mail message at this phone number ____
- ☐ Speak to my spouse or significant other whose name is ____
- ☐ Speak to or leave a message with the family members/friends listed below:

Name: __________________________________ Relationship to Patient: __________________________

Contact Number: ___________________________________

Name: __________________________________ Relationship to Patient: __________________________

Contact Number: ___________________________________

I understand that if I want to withdraw authorization for Freedom Spine & Pain Center to share information regarding my care with any of the individuals or by any of the means listed above, or if I wish to designate different individuals or means of leaving a message, it is my responsibility to notify Freedom Spine & Pain Center in writing.

____

Signature of Patient/Guardian/Personal Representative Date

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

TO: ____
Name of Healthcare Provider

____
Street Address Phone Number

____
City State Zip Code

RE: Patient Name: ____
Last First Middle

Date of Birth: __________________________ Social Security Number: _____________________________

Patient authorizes and requests that Healthcare Provider disclose Patient's medical information as described below for the purpose of review, evaluation, and presentation in connection with Patient's further medical evaluation, diagnosis, and treatment. Patient requests that Healthcare Provider's Custodian of Records disclose Patient's medical information to include the following:

- Any and all hospital and medical records or reports of any sort, charts, notes, x-rays, other radiographic studies, lab reports, and prescription information, including the right to inspect and copy such records; and
- Any and all other information pertaining to any confinement, examination, treatment or condition of Patient, including medical, dental, psychological or other treatment, examinations, or counseling for any medical condition.

Healthcare Provider may disclose Patient's medical information ***for all times*** when Patient received Healthcare Provider's medical attention.

Disclosure to be made to: Freedom Spine & Pain Center
1580 S. Main Street, Suite 101
Boerne, TX 78006
Fax: 210-944-0919
Attn: _________________________

Patient understands that this authorization allows disclosure and use of medical information of Patient, which is protected under federal and state law. Patient also understands that any disclosure of medical information carries the potential for re-disclosure where the information might no longer be protected by law.

Patient understands that Patient has a right to revoke this authorization at any time. Revocation must be in writing and should be directed to Healthcare Provider's Custodian or Records/Privacy Officer at Healthcare Provider's address listed above. Patient further understands, however, that Patient's revocation will not be valid as to any actions Healthcare Provider make take in reliance on this authorization before it receives Patient's revocation and that Healthcare Provider will have no obligation to retrieve information it disclosed while this authorization was still in effect. **This authorization will expire two (2) years after the date it is signed.**

____
Signature of Patient/Guardian/Personal Representative Date

_______________________________________ _______________________________________
Name of Patient/Guardian/Personal Representative Guardian/Personal Representative's Relationship to Patient