Advanced Spinal Pain Management

Aldon B. Williams, M.D., PA

(PLEASE PRINT)

Date _____/_____/_____ Home Phone (____) _____

Email Address_____

Patient Information

Name_____ Soc Sec #_____

Last Name First Name Middle

Address_____ Cell Phone (____)_____

City_____ State_____ Zip_____

Gender: ☐Male ☐Female Birth date _____/_____/_____ ☐Married ☐Widowed ☐Single ☐Minor ☐Separated ☐Divorced ☐Partnered for ___ years

Patient Employer/ School_____ Occupation _____

Employer/ School Address _____ Employer/ School Phone (___)_____

In case of emergency who should be notified? _____ Phone (___)_____

Primary Insurance

Person Responsible for Account_____

Last Name First Name Middle Initial

Relation to Patient_____ Birthday _____/_____/_____ Soc Sec # _____

Address (if different from patient's)_____Phone(____)_____

City _____ State _____ Zip _____

Person Responsible Employed by_____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Contact # _____ Group # _____ Subscriber # _____

Additional Insurance

Is patient covered by additional insurance? ☐YES ☐NO

Subscriber Name _____ Relation to Patient _____Birth date _____/_____/_____

Address (if different from patient's)_____Phone(____)_____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (_____)_____

Insurance Company _____ Soc Sec # _____

Contract # _____ Group # _____ Zip _____

Assignment and Release

I certify that I, and/or my dependant(s), have insurance coverage with _____and

(name of insurance company (ies)

Assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above named insurance Company (ies) and their agencies for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name Patient, Parent, Guardian or Personal Representative Date

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Acknowledgement of Review of:

Initials

_____ **1. Notice of Privacy Practices**

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ **2. Patient Rights and Responsibilities**

I have reviewed and signed that I have received a copy of the Patient's Rights and Responsibilities.

_____ **3. Advanced Directives**

The Patient Self-Determination Act became **law** on December 1, 1991. As a result, health care organizations that receive Medicare and Medicaid payments have to provide adult patients with written information about their rights to make decision about medical care.

I have received written information on Advanced Directives and have been given the opportunity to express my intention.

_____ **4. Patient Satisfaction Survey / Contact Number**

I have been informed that I may express my concerns at any time and may complete a Patient Satisfaction Survey for each or any visit to this facility and may request a staff manager to help resolve any concern I may have. In the event that the staff members of the facility are unable to address my concerns, I have been provided the address and telephone number for the Texas Department of Health, Licensing and Compliance Division.

_____ **5. Financial Disclosure and Advanced Beneficiary Notice**

I have reviewed and signed that I have received a copy of the Financial Disclosure and am aware of the Advanced Beneficiary Notice.

_____ 6**. General Patient Letter**

I have reviewed and signed that I have received a copy of the General Patient Letter.

Patient must initial to the left of each number before signing below.

_____
Signature of Patient / Guardian or Personal Representative

_____/_____/_____
Date

_____
Name of Patient / Guardian or Personal Representative

_____
Witness

_____/_____/_____
Date

_____
Description of Personal Representative's Authority

Patient Rights and Responsibilities

Patients shall be treated with respect, consideration, and dignity.

Patients shall be provided appropriate privacy.

Patient records shall be treated confidentially and, except when authorized by law, patients shall be given the opportunity to approve or refuse their release.

Patients shall be provided, to the degree known, appropriate information concerning their diagnosis, treatment, and prognosis. When it is medically advisable to give such information to a patient, the information shall be provided to a person designated by the patient or to a legally authorized person.

Patients shall be given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.

Information shall be available to patients and staff concerning:

- All of the above statements
- Patient conduct and responsibilities
- Services available at Aldon B. Williams, MD, PA
- Provisions for after-hours and emergency care
- Fees for services
- Payment policies
- Patient's right to refuse to participate in experimental research and

You may ask the front desk for additional information or a hand out should you want more information on any of these topics.

Marketing or advertising regarding the competence and / or capabilities of the organization shall not be misleading to patients.

Patient Responsibilities

You have the responsibility to give us as much frank information as you can about your health, past and present, and to tell us about any treatment you may be under or any medications or drugs you may be taking, including **vitamins, herbals, or diet therapies**.

You have a responsibility to keep us informed of any changes in address or phone number where we can reach you.

You have a responsibility to pay as much as you can on the fees on your bill, and to make these payments as soon as you can.

You have a responsibility to follow your surgical procedure discharge instructions including reexamination if required and ask any question about anything you do not fully understand.

You have a responsibility to be on time for every appointment and if you cannot keep an appointment, to cancel it as soon as possible.

Your signature attests to the fact that you understand the above and you accept your responsibilities.

_____ _____ _____

Patient or guardian signature **Witness** **Date**

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Pain Management

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PERSONAL VALUABLES DISCLAIMER FORM

Pain Center Patient:

Please be advised that Advanced Spinal Pain Management **will not** be responsible for the Loss or Damage of Personal belongings or Valuables. These items should be left at home or removed and given to your significant other prior to entering the Pre-Op area.

Thank you in advance for your cooperation.
Management

_____ _____/____/____ _____
Patient Signature Date Witness

FORMA DE DESCARGO DE RESPONSABILIDAD SOBRE OBJETOS DE VALOR PERSONALES

Paciente de Pain Center:

Por favor sea aconsejado que Advanced Spinal Pain Management **no será** responsable de la pérdida o el daño de bienes personales u objetos de valor. Estos objetos deben dejarse en casa o se deben entregar a una persona de su confianza antes de entrar al area de Pre-Operatoria.

Gracias de antemano por su cooperacion.
Gerencia

_____ _____/____/____ _____
Firma de paciente Fecha Testigo

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PATIENT CONTACT QUESTIONNAIRE

1) Please list the name of a person whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

Name: _____ Phone: (_____) _____

Relationship: _____

2) Please list the name of a person(s) who we can pick up your prescriptions (with Valid ID):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

3) Please list the name of a person other than the above named whom we may contact about your medical condition **ONLY IN AN EMEREGENCY**:

Name: _____ Phone: (_____) _____

Relationship: _____

4) Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

Attn: _____ Address: _____
_____

5) Please print the telephone number where you want to receive calls about your appointments, labs, x-rays, or other health care information if other than your home number: Phone: (_____)
_____

6) Can appointment reminders be left on your answering machine or voicemail?

_____ YES _____ NO

_____
Print Name

_____ _____
Patient Signature Date

Signature of employee entering information into database: _____

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ELECTRONIC MEDICAL RECORD PERMISSION FORM

Dear Patient;

This letter is to inform you that we have an electronic medical records system in place for all medical documentation. Every time you visit our Center, we access your records by utilizing our computer system. All your visit documentation is stored in one medical records data base. The Department of Health State Services requires that we inform you regarding our systemic process of storing and accessing your medical records in our facilities. At any time, your medical record may be accessed by your physician and his staff.

We are requesting your signature to verify that we have provided you with this information.

Thank you,
Advanced Spinal Pain Management

I have been informed and understand the above explanation as stated:

Patient Signature _____ Date _____/_____/_____

Witness _____ Date _____/_____/_____

FORMA DE PERMISO DE REGISTRO MÉDICA ELECTRÓNICA

Estimado Paciente:

Esta carta es para informarle que tenemos un sistema de archivo médico electrónico en uso para toda la documentación médica. Cada vez que Usted visita nuestro Centro, tomamos sus archivos médicos utilizando nuestro sistema de computadora. Toda la documentación de sus citas es guardada en nuestra base de datos de archivos médicos. El Departamento de Servicios de Estado de Salud requiere que le informemos en cuanto a nuestro proceso sistémico del almacenaje y tener acceso a sus archivos médicos en nuestras instalaciones. En cualquier momento su expediente médico puede ser accesazo por su médico, o alguno de los otros tres doctores en la clínica y de su personal.

Solicitamos que con su firma verifique que le hemos proveído de esta información.

Gracias,
Advanced Spinal Pain Management

He sido informado y entiendo la susodicha explicación como declarada:

Firma de Paciente _____ Fecha _____/_____/_____

Testigo _____ Fecha _____/_____/_____

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PATIENT MEDICAL QUESTIONAIRE

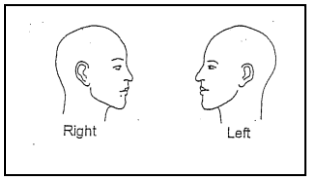
(Please answer **ALL** questions using BLACK ink)

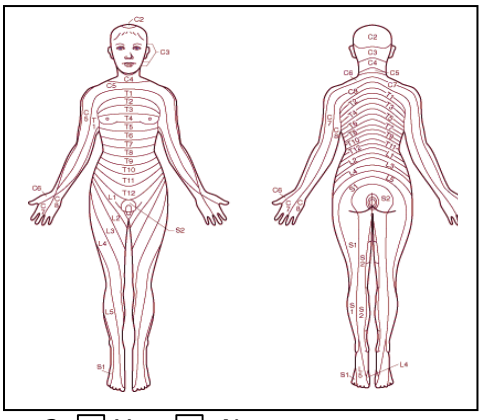
1. Name _____ Date of Birth: _____/_____/_____ Age _____
2. Weight _____ Height _____
3. WHEN did your **PAIN** start? (Month & Year) _____
4. How did your **PAIN** start? ☐ Auto Accident ☐ Following Surgery ☐ Work Injury ☐ Fall ☐ Other (describe) _____
5. PAIN COMPLAINT (be brief & specific) _____

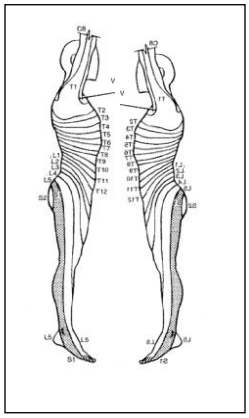
_____

6. Mark where your pain is located and draw where it travels to:

0=No pain	Type of Pain
1-2=Mild	C = Sharp
3-5 = Moderate	D = Stabbing
6-8= Severe	E = Dull
9-10 = Worst	F = Burning
	G = Stinging
	H = Squeezing
	I = Pulsating
	J = Shooting
	K = Throbbing
	L = Numbing
	M = Cramping







7. Does the pain **RADIATE** (shoot or travel) anywhere? ☐ Yes ☐ No
   a. Where does it start? _____
   b. Where does it end? _____
8. When does your **PAIN** occur? (Check ALL that apply)

☐ resting	☐ sitting	☐ walking
☐ lifting	☐ bending	☐ standing
☐ coughing	☐ sneezing	☐ urinate
☐ bowel movement	☐ weather is _____	☐ other _____

9. What relieves your **PAIN**? (Circle ALL that apply)

☐ lying down	☐ sitting	☐ medications	☐ heat	☐ nerve blocks
☐ pulling knee to chest	☐ massage	☐ alcohol	☐ standing	☐ cold
☐ sex	☐ TENS unit	☐ other _____		

10. What makes your **PAIN** worse? (Circle ALL that apply)

☐ lying down	☐ walking	☐ bending	☐ massage	☐ cold	
☐ sex	☐ standing	☐ stress	☐ heat	☐ sitting	☐ other _____

11. Is your **PAIN**: ☐ staying the same ☐ increasing ☐ decreasing
12. Does your **PAIN** wake you up at night? ☐ Yes ☐ No ☐ How many times? _____
13. What diagnostic studies have you had done, when and where? (Please provide actual test &/or reports on your first visit)

Study	Date	Location
☐ X-Ray	___/___/___	_____
☐ CAT Scan	___/___/___	_____

□ MRI ___/___/___ _____
□ Myelogram ___/___/___ _____
□ EMG ___/___/___ _____
□ Bone Scan ___/___/___ _____
□ Other ___/___/___ _____
□ Other ___/___/___ _____

14. Allergies to medication(s)? _____
Other allergies? _____

15. What **MEDICATIONS** are you taking **FOR PAIN** and how often?

Medication, Dose, Frequency	Medication, Dose, Frequency

16. What **OTHER MEDICATIONS** are you taking?

Medication, Dose, Frequency	Medication, Dose, Frequency

17. Are you able to take your pills by yourself? □ Not Applicable □ Yes □ with Assistance

18. Are you Pregnant? □ Yes □ No □ Not Applicable

19. Have you been seen in the Emergency Room for your **Pain**? □ Yes □ No

20. Have you had Physical Therapy for your **PAIN**? □ Yes □ No If yes, how many weeks?
# of weeks _____ When/Where? _____
# of week's _____ When/Where? _____

21. Have you had recent/significant decline in ambulation? □ Yes □ No

22. List all Physicians you have consulted or who have treated you in the past. ***Indicate your primary physician on #1.***
1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

23. Do you receive / have you ever received **Home Health services**? □ Yes □ No
Please list Agency? _____

24. **MEDICAL HISTORY** Please list any past medical problems and the appropriate date of treatment.

Date of Medical Problem	Treatment	Medical Problem	Date of Treatment
□ High Blood Pressure	_____	□ Heart Attack	_____
□ Stroke	_____	□ Cancer Type_____	_____
□ Epilepsy	_____	□ Angina	_____
□ Diabetes	_____	□ Crohns	_____
□ Hepatitis	_____	□ Other _____	_____
□ Asthma	_____	□ Other _____	_____

Comments: _____
_____
_____
_____

25. **PAST MEDICAL HISTORY** (List date & type of surgery)

Surgery & Date	Surgery & Date

26. Have you recently had or do you have now:

	Yes	No		Yes	No
Reading Glasses	□	□	Shortness of Breath	□	□
Change of Vision	□	□	Chills or Fever	□	□
Loss of Hearing	□	□	Heart or Chest Pain	□	□
Ear Pain	□	□	Abnormal Heartbeat	□	□
Hoarseness	□	□	Badly Swollen Ankles	□	□
Difficulty Swallowing	□	□	Calf Cramps with Walking	□	□
Nausea or Vomiting	□	□	Poor Appetite	□	□
Stomach Pain	□	□	Toothache	□	□
Ulcers	□	□	Blood in Bowel Movements	□	□
Frequent Headaches	□	□	Frequent Constipation	□	□
Blackouts	□	□	Frequent Urination	□	□
Seizures	□	□	Nervous Exhaustion	□	□
Frequent Rash	□	□	Insomnia	□	□
Hot or Cold spells	□	□	Depression	□	□
Recent Weight Changes (more than 10lbs.)	□	□	Nervous Tension	□	□

Comments: _____
_____
_____

27. What types of **SURGERY** and/or **NERVE BLOCKS** have you had for your **PAIN** and **WHEN?**

Surgery	Month & Year	Surgery	Month & Year

28. **FAMILY HISTORY** (Do any of the following conditions exist in your family?)

Yes	**N**o	Condition	**Y**es	**N**o	Condition
		Cardiovascular (heart)			Cancers
		Pulmonary (lungs)			Gastrointestinal (stomach
		Renal/Genitourinary (kidney)			Neurological/Genetics (nerves)
		Endocrine			Hematology (blood)
		Musculoskeletal (bones/muscles)			Immunology (allergy)
		Psychiatric			Other

29. **SOCIAL HISTORY**
    a. Are you employed? □ Yes □ No Where? _____
    b. Are you □ Single □ Married □ Divorced □ Widowed □ other _____
    c. Do you have children? □ Yes □ No # of Children: _____
    d. Please list any hobbies you may have: _____
    e. Do you exercise regularly? □ Yes □ No What Kind? _____
    f. My family role is: □ Care of House □ Care of Kids □ Sole supporter □ Job assist
    g. Before my pain, it was: _____

30. Do you **currently** smoke? □ Yes □ No
YES How many cigarettes? _____ day / week / month
What type (circle)? Cigar Cigarettes Pipe Brand? _____
Have you ever tried to quit? □ Yes □ No How many times? _____
Do you use any smoking cessation aids? □ Yes □ No (such as nicotine gum, spray, patch, etc.)
Please list: _____
Are you willing to quit? □ Yes □ No
NO Do you have a history of smoking □Yes □ No
When did you quit? _____ (Year)

31. Do you drink alcohol? □ Yes □ No Are you a social drinker? □ Yes □ No
How often? _____ day / week / month Type? Beer / Wine / Liquor
How much? _____ glasses / bottles / cans
If you are a heavy drinker, have you ever tried to quit? □ Yes □ No How many times? _____

32. Have you ever had a substance or drug abuse problem? □ Yes □ No
Please be more specific? _____

33. Since the **PAIN** began, what do you worry about? □ Nothing

□ Finances
□ Family and Children
□ Sexual desire, interest, ability
□ Ability to earn income
□ Memory & Concentration
□ Ability to get to sleep, stay asleep or tiredness during the day
□ Loss of social & recreational activities
□ Pain lasting forever
□ Yet to identify medical problems
□ other _____

34. How would you describe the effects of the **PAIN** upon your personality?
□ Normal □ Slight upset □ Moderate upset □ Severe upset □ Total incapacitated

35. Which describes you since your pain began? (Circle ALL that apply)

Alert	Cheerful	Irritable	Get along well	Disagreeable
Moody	Complaining	Dull	Anxious	Desperate
Angry	Bitter	Depressed	Uncooperative	Avoid everyone
Unhappy Panicked	Withdrawn	Severely withdrawn	No reason for living	

36. Have you ever had any of the following disorders? (Write **Y** or **N**)

Y or N	Disorder	Y or N	Disorder
	Anxiety disorder (emotion)		Cognitive disorder (Dementia)
	Eating disorder		Gender Identity disorder
	Impulse control disorder		Disorder beginning in Childhood
	Mood disorder		Obsessive-Compulsive disorder
	Personality disorder		Schizophrenia / Psychosis
	Sexual disorder		Sleep disorder
	Other disorder _____		

37. Have you recently been diagnosed with or ever had any of the following?
(Write **Y** or **N**) If **Y**, next to disease put year

Y or N	Disease	Y or N	Disease
	Chlamydia		AIDS
	Gonorrhea		HIV
	Herpes		Syphilis
	Botulism		Hepatitis A / B / C
	Lyme Disease		Malaria
	Measles		Mumps
	Pertussis		Rubella
	Tuberculosis		Cholera
	Diphtheria		Rabies
	SARS		Tetanus
	Yellow Fever		Other _____

38. Is there anything you would like us to know about your
Home situation? _____
Religion? _____
Culture? _____
Other? _____

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THCIC Demographics Form

The Texas Department of State Health Services is requesting the following information for statistical reasons.

El Departamento de Estado de Tejas de Servicios de Salud solicita la información siguiente para razones estadísticas.

(PLEASE PRINT)

(EN BLOK POR FAVOR)

Date / *Fecha* _____/_____/_____

Patient Information */ Informacion de Paciente*

Name / Nombre

_____

Last Name / *Apellido* | First Name / *Primer Nombre* | Middle / *Segundo*

Date of Birth / *Fecha de Nacimiento* _____/_____/_____

Home Phone / *Telefono en casa* (____)_____

Cell Phone / *Telefono cellular* (____)_____

Address / *Direccion* _____

City / *Cuidad* _____ State / *Estado* _____

Zip / *Clave Postal* _____

Race / *Raza*:

- ☐ American Indian / Eskimo / Aleut *(Nativo Americano / Eskimal / Aluet*)
- ☐ Asian or Pacific Islander (*Asiático o Isleño Pacífico)*
- ☐ Black (*Africano Americano)*
- ☐ White (*Blanco)*
- ☐ Other / Multiracial / Mixed Race (*Multirracial)*

Ethnic Background / *Etnia*:

- ☐ Hispanic / Latino (*Hispano* / *Latino*)
- ☐ Not Hispanic / Not Latino (*No Hispano / No Latino*)

Patient Signature / Firma de Paciente: _____

Initials of Staff: _____

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INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT

AS REQUIRED BY THE TEXAS MEDICAL BOARD

REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9, CHAPTER 170

3Rd Edition: Developed by the Texas Pain Society, April2008 (www.texaspain.org)

NAME OF PATIENT: _____ DATE: _____/_____/_____

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to use the drug(s) recommended to you by me, as your physician. For the purpose of this agreement the use of the word "physician" is defined to include not only my physician but also my physician's authorized associates, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat my condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician (name at bottom of agreement) to treat my condition which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent for my physician to administer or write prescription(s) for dangerous and/or controlled drugs (medications) as an element in the treatment of my chronic pain.

It has been explained to me that these medication(s) include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT HAVE BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT (THIS IS SOMETIMES REFERRED TO AS "OFF-LABEL" PRESCRIBING). MY DOCTOR WILL EXPLAIN HIS TREATMENT PLAN(S) FOR ME AND DOCUMENT IT IN MY MEDICAL CHART.

I HAVE BEEN INFORMED AND understand that I will undergo medical tests and examinations before and during my treatment. Those tests include random unannounced checks for drugs and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances may result in my being discharged from your care.

For female patients only:

To the best of my knowledge **I am NOT pregnant.**

If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment. I accept that it is **MY responsibility** to inform my physician immediately if I become pregnant.

If I am pregnant or am uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY.

All of the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo/ fetus / baby.

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension(low blood pressure), arrhythmias(irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medication(s) for the treatment of my chronic pain.

The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and active life. I realize that I may have a chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored specifically for me. I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time and that I will notify my physician of any discontinued use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

I understand that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of medications to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

PAIN MANAGEMENT AGREEMENT:

I UNDERSTAND AND AGREE TO THE FOLLOWING:
That this pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called 'narcotics, painkillers', and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). **Therefore, medication(s) will only be provided so long as I follow the rules specified in this Agreement.**

My physician may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior:

- My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the **medication(s) may be discontinued**.
- I will **disclose** to my physician **all medication(s)** that I take at any time, prescribed by any physician.
- I will use the medication(s) **exactly as directed by my physician**.
- I agree **not to** share, sell or otherwise permit others, including my family and friends, to have access to these medications.
- I will **not allow or assist in the misuse/diversion of my medication**; **nor will I give or sell them** to anyone else.
- All medication(s) must be obtained at **one pharmacy, where possible**. Should the need arise to change pharmacies, my physician must be informed. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my physician to release my medical records to my pharmacist as needed.
- I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money**. If either are lost or stolen, they may NOT BE REPLACED.**
- Refill(s) **will not be ordered before the scheduled refill date**. However, early refill(s) are allowed when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.
- I will receive medication(s) **only from ONE physician** unless it is for an emergency **or** the medication(s) that is being prescribed by another physician is approved by my physician. Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.
- If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then **my physician may try alternative medication(s) or may taper me off all medication(s**). I will not hold my physician liable for problems caused by the discontinuance of medication(s).
- I **agree to submit to urine and/or blood screens** to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), such as marijuana, speed, cocaine, etc., treatment for chronic pain may be terminated. Also, a consult with, or referral to, an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an addictionologist or a physician who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.
- I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize **that my active participation** in the management of my pain is extremely important. I agree to **actively participate in all aspects of the pain management program** recommended by my physician to achieve increased function and improved quality of life.
- I agree that I **shall inform any doctor** who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.

- I hereby give my physician **permission to** discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).
- I must take the medication(s) as instructed by my physician. **Any unauthorized increase** in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.
- I must **keep all follow-up appointments** as recommended by my physician or my treatment may be discontinued.

I certify and agree to the following:

1) I am **not currently using illegal drugs or abusing prescription medication**(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

2) I have **never been involved** in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.)

3) **No guarantee or assurance has been made** as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life.

4) I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain. **I fully understand the explanations regarding the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.**

E-prescribing/Medication History Consent

E-prescribing is way for doctors to electronically send an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The e-prescribe program also includes:

• **Formulary and benefit transactions** - Gives the prescriber information about which drugs are covered by the drug benefit plan.

• **Medication history transactions** - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality of your medical care. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

• **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

The medication history information would include medications prescribed by your health care provider at The Headache and Pain Center as well as other health care providers involved in your care.

Consent

By signing this consent form you are agreeing that Advanced Spinal Pain Management can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to Advanced Spinal Pain Management to enroll me in this e-prescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____

Patient Signature

_____

Physician Signature (or appropriately authorized assistant)

_____

Staff Member Witness

_____

Name and contact information for pharmacy

Advanced Spinal
Pain Management

Aldon B. Williams, M.D., PA

Patient Satisfaction Survey

Your satisfaction is important to us. We strive to provide services that meet your individual needs in a caring and safe environment. We need your help in answering these few questions so that we can continuously evaluate our services and make changes when necessary to provide the highest quality care and meet your needs.

Thank you for being a part of our performance improvement and patient safety team.

Please rate the following:		**Yes**	**No**	***Comments***
1.	The front desk receptionist(s) were polite and helpful; answered your questions			
2.	The waiting room was clean and comfortable.			
3.	Payment requirements and benefits were explained			
4.	The waiting time before being seen by the doctor was appropriate			
5.	Employees took time to verify your name and birthday with your record			
6.	You were given information about your condition / procedure			
7.	Employees verified and marked the site of the procedure to be done (when applicable)			
8.	Procedures were explained before they were performed			
9.	Employees respected and provided appropriate privacy for you during you stay			
10.	Procedure discharge instructions were given to you prior to leaving			
11.	*Overall, were you satisfied with your care?*			

11. Were there any unexpected problems with your procedure? Yes No
Please explain: _____

_____

12. Did you observe anything that you think was unsafe? Yes No
Please explain: _____

_____

If you would like for us to contact you regarding any dissatisfaction that you may have experienced, please give us your name and a telephone number and a member of our staff will call you.

_____

If you have any concern or complaint, please tell us. Please mail this questionnaire to us at the top address or you may return it to the receptionist on your next visit.

Advanced Directives

This is an important medical document that you need to know about which can have a profound impact on the delivery of medical care that you receive. The document is called "***An Advanced Directive".***

The Patient Self-Determination Act became **law** on December 1, 1991. As a result, health care organizations that receive Medicare or Medicaid payments have to provide adult patient with written information about their rights to make decisions about medical care.

What is an Advanced Directive?

An Advanced Directive is a document that provides a person the ***opportunity to give directions about future medical care.***

An advanced directive tells your doctor what kind of care you would like to have if you become unable to make medical decisions (if you are in a coma, for example). If you are admitted to any medical facility, the facility is required by law to inform you of Advanced Directives.

A good advance directive describes the kind of treatment you would want depending on how sick you are. For example, the directives would describe what kind of care you want if you have an illness that you are unlikely to recover from, or if you are permanently unconscious. Advanced directives usually tell you doctor that you want a certain treatment no matter how ill you are.

An Advanced Directive ***can also serve as a legal document*** designating another individual to make decisions for you if you are unable to make those decisions yourself.
This document will speak for you if you become incapacitated.

As a perspective patient, you can complete an Advanced Directive document if you are 18 years or older, and of sound mind. You do not need a lawyer to complete an Advanced Directive form.

Remember that Advanced Directive forms can be modified or even revoked at any time as long as you make your wishes clearly known.

What is a living will?

A living will is one type of advance directive. It only comes into effect when you are terminally ill. Being terminally ill generally means that you have less than six months to live. In a living will, you can describe the kind of treatment you want in certain situations. A living will does not let you select someone to make decisions for you.

What is a durable power of attorney for health care?

A durable power of attorney (DPA) for health care is another kind of advance directive. DPA states whom you have chosen to make health care decisions for you. It becomes active any time you are unconscious or unable to make medical decisions. A DPA is generally more useful than a living will. But a DPA may not be a good choice if you don't have another person you trust to make these decisions for you.

What is a do not resuscitate order?

A do not resuscitate order is another kind of advance directive. A DNR is a request not to have cardiopulmonary resuscitation (CPR) if your heart stops or if you stop breathing. (Unless given other instructions, medical staff will try to help all patients whose heart has stopped or who have stopped

breathing.) You can use an advanced directive form or tell your doctor that you don't want to be resuscitated. In this case, a DNR order is put in your medical chart by your doctor. DNR orders are accepted by doctors and hospitals in all states.

Most patients who die in a hospital have had a DNR order written for them. Patients who are not likely to benefit from CPR include people who have cancer that has spread, people whose kidneys don't work well, people who need a lot of help with daily activities, or people who have severe infections such as pneumonia that require hospitalization. If you already have one or more of these conditions, you should discuss your wishes about CPR with your doctor, whether in the doctor's office or when you go to the hospital. It's best to do this early, before you are very sick and considered unable to make your own decisions.

Should I have an advance directive?

Most advance directives are written by older or seriously ill people. For example, someone with terminal cancer might write that he/she does not want to be put on a respirator if he/she stops breathing. This action can reduce his/her suffering, increase her peace of mind and increase his/her control over his/her death. However, even if you are in good health, you might want to consider writing an advance directive. An accident or serious illness can happen suddenly, and if you already have a signed advance directive, your wishes are more likely to be followed.

How can I write an advance directive?

You can write an advance directive in several ways:

Use a form provided by a medical facility
Write your wishes down by yourself
Call your state senator or state representative to get a form
Call a lawyer
Use a computer software package for a legal document

Advance directive and living wills do not have to be complicated legal documents. They can be short, simple statements about what you want done or not done if you can't speak for yourself. Remember, anything you write by yourself or with a computer software package should follow your state laws. You may also want to have what you have written reviewed by your doctor or a lawyer to make sure your directives are understood exactly as you intended. When you are satisfied with your directives, the orders should be notarized if possible, and copies should be given to your family and your doctor.

Can I change my advance directive?

You may change your advance directives at any time, as long as you are considered of sound mind to do so. Being of sound mind means that you are still able to think rationally and communicate your wishes in a clear manner. Again, your changes must be made, signed and notarized according to the laws in your state. Make sure that your doctor and any family members who knew about your directives are also aware that you have changed them.

If you do not have time to put your changes in writing, you can make them known while you are in a medical facility. Tell your doctor and family or friends present exactly what you want to happen. Usually, wishes that are made in person will be followed in place of the ones made earlier in writing. Be sure your instructions are clearly understood by everyone you have told.

To All of Our Patients

Your satisfaction is important to us. And, because we care, we are continuously evaluating our services and making improvements. We review patient comments from our patient satisfaction questionnaires. Thank you for your in-put.

One area that we monitor is patient waiting time because we know that your time and your family's time are valuable to you. We know that patients with pain feel the waiting time even more than a regular check up.

No matter how well we plan our patient schedules, many unexpected events may cause us to have to change your scheduled day or time:

- Our **patients have many different needs** and from time to time we may spend more time with a patient than was scheduled. One day, you may have this same need and take longer than was scheduled and someone else may be delayed. Please understand that we want to provide quality care first and then see patients as close to their scheduled time as possible.

- We want patients to schedule visits rather than call for work-ins; however, we do attempt to **work in patients** that are having severe pain. This of course means that the patient that has been worked into the schedule may wait longer than if scheduled. Also, this causes every patient visit after the work-in to be delayed and makes waiting time longer.
  Please help us decrease waiting time for all patients by scheduling your appointments before coming to the facility.

- Patients are sometimes **late for appointments.** This may also cause a delay and increase the waiting time for other patients.

- Please notify us immediately if you will be **unable to make a scheduled appointment.** Other patients that are experiencing pain may have a later appointment and can be moved into your vacancy. Please help us to help all of our patients receive timely and needed care.

For prescription refills, please allow 3-5 business days to process your request. Please be advised that requests made on evenings and on weekends will not begin process until the next business day.

Thank you for your cooperation and in-put in helping us help you.

HIPAA & Your Privacy Rights

We strongly believe in doing everything we possibly can to safeguard the privacy and security of your health information and records.

As a result, we have made some changes in our office management procedures to make sure we follow the Health Information Portability and Accountability Act into law in 1996, HIPPA sets federal standards for the privacy and security of patient information for all healthcare providers, plans, insurance companies and anyone they do business with.

HIPAA gives you additional rights regarding control and use of your health information, meaning you have more access and control than ever. Please take a few minutes to review these new rights. We're happy to answer any questions you might have.

Control Over Your Health Information

All healthcare providers (and health plans) are now required to give you a written explanation of how they use and disclose your personal health information before they can treat you. This way, you can decide if a provider is doing everything they should to protect your privacy before you chose them as your caregiver.

We must, by law, post a Notice of Privacy Practices, which outlines how we secure the privacy of patient information, in a place where you can easily see it.

We must get your signature for non-routine uses and disclosures of your information. A non-routine use is any situation not directly related to treatment, payment or operations. For example, if your child is going to summer camp and the camp needs a medical history, you will be asked to authorize us to release it before we can send the information. You have the right to say no, and you don't have to tell anyone why.

Authorizations of non-routine information are one-time only, case by case, for the use defined by you.

Access To Your Health Information

You can get copies of your medical records simply by asking for them. Healthcare providers are required to get you a copy of your record within 60 days of your request. There may be a cost for this service.

Providers also must give you a history of non-routine disclosures if you ask for it. All you need to do is ask for the record and it is provided to you-no justification is needed.

You can also amend your medical records. You cannot change the existing record, but you can add notes or comment on any procedures, treatments, payments or operations.

The provider then has the right to respond to your amendment. This way you can be sure your records reflect your side of the story about treatment and payment issues.

Patient Recourse If Privacy Protections Are Violated

Every healthcare provider must also inform you of grievance procedures. If your privacy is violated, report the incident to our Privacy Officer immediately. You also have the right to the Department of Health and Human Services, Office of Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201

If you decide to file a grievance either with us or with the Department of Health and Human Services, we are not allowed to discriminate or retaliate against you in any way.

Aside from these new rights to access and control your medical information under HIPAA, there are also clear limits on all healthcare providers regarding how they disclose medical information. Here are some of the key aspects of these boundaries:

Providers must ensure that health information is not used for non-health purposes. Health information (*covered by the privacy rules*) generally may not be used for non purposes not related to health care- such as disclosures to employers to make personnel decisions, or to financial institutions- without your explicit authorization.

There are clear, strong protections against using health information for marketing. The privacy rules set new definitions, restrictions and limits on the use of patient information for certain marketing purposes. Providers must get your specific authorization before sending you any materials other than those related to treatment.

Use only the minimum amount of information necessary. In general uses or disclosures of information will be limited to the minimum necessary. This does not apply to disclosure of records for treatment purposes, because physicians, specialists and other providers may need to access the record to provide quality care.

Exceptions

There are situations where healthcare providers may not have to follow these privacy rules. They include: emergency circumstances; identification of a body or the cause of death; public health needs; judicial and administrative proceedings; limited law enforcement activities; and activities related to national defense and security.

We understand your right to have your medical information kept confidential. Our compliance with the Health Information Portability and Accountability Act is one example of our advocacy and leadership on issues of to improve patient's rights and privacy of information we encourage you to ask questions and look forward to working together to improve the quality of your healthcare experience.

Advanced Spinal
Pain Management

Aldon B. Williams, M.D., PA

FINANCIAL DISCLOSURE FORM

Please be advised that the physician at this pain clinic is Aldon B. Williams, M.D. You have the right to be advised of this financial disclosure and that if you desire treatment elsewhere, you have that right as well, although you will need to seek the care of another physician in another clinic.

Our current practice is that we coordinate with Arc Fluoro for the use of their facility for interventional procedures.

The importance from a billing perspective is that you may receive two statements:

- one from your pain physician for the consultation or interventional procedure
- one from Arc Fluoro for the use of their facility

If you have insurance, we will help you receive maximum benefits by filing for you; however, we will expect payment of co-pays, co-insurance, and deductibles at the time of service. The undersigned individual guarantees prompt payment of all charges if the insurance carrier rejects the claim of any charges related to this account. There may be a time where a service ordered by the physician may not be covered by your insurance policy. For these services/supplies we will require you to fill out an Advanced Beneficiary Notice (ABN) to accept or deny financial responsibility for services/supplies rendered. If charges remain unpaid, it may become necessary to turn the account over to a collection agency.

If at any time, you do not understand or have a question regarding a statement, please contact a member of the collection staff.

Our ultimate goal is to become a “Center of Excellence” in providing management services. We appreciate your help and support. Informing us of what we do well, and what we do not do so well is helpful. As you visit the clinic, please take the time to complete our patient satisfaction questionnaires as often as you would like. If you want a response to a complaint, please let us know by leaving your name and contact number.

Sincerely,

Aldon B. Williams, M.D., PA
Arc Fluoro

Advanced Spinal
Pain Management

Aldon B. Williams, M.D., PA

Patient Rights and Responsibilities

Patients shall be treated with respect, consideration, and dignity.

Patients shall be provided appropriate privacy.

Patient records shall be treated confidentially and, except when authorized by law, patients shall be given the opportunity to approve or refuse their release.

Patients shall be provided, to the degree known, appropriate information concerning their diagnosis, treatment, and prognosis. When it is medically advisable to give such information to a patient, the information shall be provided to a person designated by the patient or to a legally authorized person.

Patients shall be given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.

Information shall be available to patients and staff concerning:

- All of the above statements
- Patient conduct and responsibilities
- Services available at the Pain Center
- Provisions for after-hours and emergency care
- Fees for services
- Payment policies
- Patient's right to refuse to participate in experimental research and
- Methods for expressing complaints and suggestions to the ASC

You may ask the front desk for additional information or a hand out should you want more information on any of these topics.

Marketing or advertising regarding the competence and / or capabilities of the organization shall not be misleading to patients.

Patient Responsibilities

You have the responsibility to give us as much frank information as you can about your health, past and present, and to tell us about any treatment you may be under or any medications or drugs you may be taking, including **vitamins, herbals, or diet therapies**.

You have a responsibility to keep us informed of any changes in address or phone number where we can reach you.

You have a responsibility to pay as much as you can on the fees on your bill, and to make these payments as soon as you can.

You have a responsibility to follow your surgical procedure discharge instructions including reexamination if required and ask any question about anything you do not fully understand.

You have a responsibility to be on time for every appointment and if you cannot keep an appointment, to cancel it as soon as possible.

Your signature attests to the fact that you understand the above and you accept your responsibilities.

***** YOU WERE ASKED TO SIGN THE ORIGINAL**
SO THAT WE CAN KEEP ON FILE **