balcones
PAIN CONSULTANTS

Patient Label

ACKNOWLEDGEMENT/CONSENT

____ (initial) **VERIFICATION OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, (print patient name) _____Date of Birth:_____ , acknowledge that I have been given a copy of the Balcones Pain Consultants Notice of Privacy Practices and have read it. I understand that I should ask questions of a Balcones Pain Consultants employee if I need any clarification about anything written in this policy. (This document is available in our waiting room or balconespain.com).

____ (initial) **CANCELLATION POLICY**

If the patient cannot adhere to a scheduled appointment, it is the patient's responsibility to call the office to cancel within 24 hours of the scheduled appointment. Balcones Pain Consultants reserves the right to charge the patient a **$50.00 fee if the patient does not cancel an office visit and a $100 fee if the patient does not cancel an injection/procedure** without the adequate notification.

_____ (initial) **RELEASE OF MEDICAL INFORMATION**

☐ **I do OR** ☐ **do not** (select one) authorize Balcones Pain Consultants and its designated representatives to release medical information to my spouse, parent, guardian, or significant other.

_____ (initial) **PRIMARY CARE PHYSICIAN**

Please write your Primary Care Physician's name and phone number below:

Name _____ **Phone Number** (_____) _____-_____

_____ (initial) **CONTACT PERMISSION**

In the event that Balcones Pain Consultants needs to contact you (patient) regarding an appointment, lab result, medication, or any other reason, it is permissible to: (***Check all that apply)***

- ☐ Leave a message on an answering machine AND/OR
- ☐ Speak with: Name/Contact Number: _____ Relationship: _____
  Name/Contact Number: _____ Relationship: _____

_____ (initial) **CONSENT TO TREATMENT**

I consent to the performance of those diagnostic procedures and urine drug screening with confirmation sometimes using genetic testing for specimen validity as part of medication monitoring policy. I also consent to examinations and rendering of treatment by the medical provider and their designated office staff as deemed necessary in the medical judgment.

_____ (initial) **AUTHORIZATION/ASSIGNMENT/FINANCIAL RESPONSIBILITY**

I authorize the release of any medical information necessary for treatment, payment, and health care operations. I understand that I am financially responsible for all charges and that I am responsible for obtaining any referrals required by my insurance carrier. I request that my medical insurance carrier make any payment directly to Balcones Pain Consultants for services rendered to me. As a courtesy, my charges will be filed with my insurance carrier; however, I will be billed if the claim is denied or is not paid in a timely manner. These services involve medication monitoring: including lab testing involving blood hormone and urine immunoassay testing and chromatographic confirmation of UDT results. For safety and comfort CRNA sedation services during interventional procedures will also be billed to insurance as a courtesy. **Should my account become a collection problem, additional charges may be incurred. Any co-payments/co-insurance amount, plus any deductible is due when services are rendered.** There is a **$30.00 service fee on all returned checks in addition to the amount of the check**. If this happens checks must be redeemed with certified funds (credit card or cash) at or before the next visit.

Notice of Disclosure: Additional Vested Interest by Practice Provider

_____ (initial) Dr. McCarty is an investor and has a financial interest in Genotox Laboratory, Genorite Pharmacy and Water Leaf Surgery Center. This investment allows him/her to have more input into the administration of policies of these facilities. Using these facilities avoids overnight shipping and allows quicker turnaround, while continuing to provide excellent and high quality care to its patients. **You have the option to use an alternative health care facility other than Genotox Laboratory, Genorite Pharmacy and Water Leaf Surgery Center; you will not be treated differently if you choose an alternative health care provider.**

_____(initial) Dr. Lowry is an investor and has a financial interest in Genorite Pharmacy and Water Leaf Surgery Center. This investment allows him/her to have more input into the administration of policies of the facility and that the Pharmacy continues to provide excellent and high quality care to its patients. **You have the option to use an alternative health care facility other than Genorite Pharmacy and Water Leaf Surgery Center; you will not be treated differently if you choose an alternative health care provider.**

My signature below indicates that I have read and am in agreement with all statements that I have initialed above.

_____ _____

Signature of Patient (or guardian) Date

balcones
PAIN CONSULTANTS

Patient Label

Financial Consent Form

We are participating providers with several insurance plans. Balcones Pain Consultants will file all of these insurance claims. A list of these insurance plans is available upon request. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment for your insurer, we will refund any overpayment to you.

If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with you insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejects for the lack of one.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy. You further understand that any out-of-network charges may be your responsibility as determined by your insurance payer.

Thank you for choosing Balcones Pain Consultants for your medical needs.

_____	_____	_____
Print Patient Name	Patient Signature	Date

balcones
PAIN CONSULTANTS

Patient Label

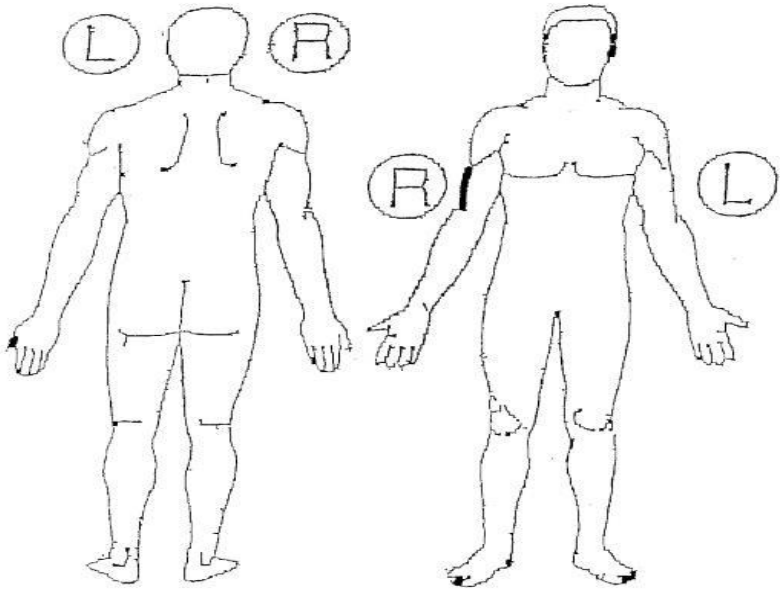
A. CHIEF COMPLAINT (Reason for Visit)/Onset of complaint _____

_____

1. Please describe your pain. (Circle all that apply)

* Sharp	* Numbness	* Constant
* Dull	* Tingling	* Cramping
* Aching	* Radiating	* Burning
* Pressure	* Stabbing	* Other_____

B. PAIN DIAGRAM: Please shade the areas on the diagrams where your pain is located



On a scale from 0-10, 0 being no pain and 10 worst pain:

1. What is your current pain level? _____
2. What is your level of pain *without* medication?_____
3. What is your level of pain *with* medication?_____

C. PAST MEDICAL HISTORY (please check all that apply):

☐ High Blood Pressure	☐ Vascular Problems	☐ Shingles	☐ Epilepsy
☐ Diabetes	☐ Tuberculosis	☐ Low Thyroid	☐ Heart Disease
☐ Lupus	☐ Stroke	☐ Kidney Problems	☐ Asthma
☐ Emphysema	☐ AIDS	☐ Rheumatoid Arthritis	☐ Hepatitis
☐ Other: _____		☐ Osteoarthritis	

All current physicians_____

_____

_____

Patient Label

D. PAST SURGICAL HISTORY:

Surgery	Details (including side performed on)	Date & Doctor
Back Surgery		
Neck Surgery		
Shoulder Surgery		
Knee Surgery		
Hip Surgery		
Hysterectomy/Ovaries		
Other		
Other		

E. CURRENT MEDICATIONS (Include over the counter & herbal products):

Name	Dose & Frequency	Condition Being Treated	Duration

F. ALLERGIES TO MEDICATION (List all medications & reactions): _____

_____

G. SOCIAL HISTORY:

*Tobacco Use: No / Yes (Circle) Packs per Day _____ # of Years_____ Previous Use? _____

*Alcohol Use: No / Yes (Circle) Drinks per Week_____# of Years_____ Previous Use? _____

*Recreational Drug Use: No / Yes (Circle) Drugs Used _____

H. FAMILY HISTORY (Include age of family member):

History	Type	Father/Mother	Brother/Sister	Other Relatives
Cancer				
Diabetes				
Heart Disease				
Hypertension				
Other				

Patient Label

I. RADIOLOGY:

Have you had an X-ray or MRI? _____Where? _____

J. PRIOR PAIN MANAGEMENT HISTORY:

Have you been treated for pain management before? Y N

If yes, please write the Doctor's name _____

K. PSYCHOLOGICAL TREATMENT:

Have you ever had psychiatric, psychological, or social work treatments/evaluations for any diagnosis/problem, including your current pain? Y N

a. If yes, for what diagnosis or problem were you treated? _____
b. Therapist's name? _____

Have you considered suicide? Y N Date: _____

Have you ever attempted suicide? Y N Date: _____

L. REVIEW OF SYSTEMS:

GENERAL

Y	N	Weight Gain
Y	N	Weight Loss
Y	N	Dry Mouth
Y	N	Fatigue
Y	N	Fever

NECK

Y	N	Neck Pain
Y	N	Neck Stiffness

NEUROLOGIC

Y	N	Paresthesia
Y	N	Weakness
Y	N	Dizziness
Y	N	Unusual Sensation

MUSCULOSKELATAL

Y	N	Leg Cramps
Y	N	Back Pain
Y	N	Calf Pain
Y	N	Decreased ROM
Y	N	Joint Pain
Y	N	Joint Redness
Y	N	Joint Stiffness
Y	N	Joint Swelling
Y	N	Muscle Atrophy
Y	N	Muscle Cramps
Y	N	Muscle Pain
Y	N	Muscle Weakness
Y	N	Swelling of Extremities

GASTROINTESTINAL

Y	N	Abdominal Pain
Y	N	Bloody Stool
Y	N	Constipation
Y	N	Diarrhea
Y	N	Nausea
Y	N	Vomiting

PSYCHIATRIC

Y	N	Depression
Y	N	Mood Changes
Y	N	Suicidal Ideation
Y	N	Suicidal Planning
Y	N	Previous Suicide Attempts
Y	N	Anxiety
Y	N	Insomnia

ENDOCRINE

Y	N	Cold Intolerance
Y	N	Heat Intolerance
Y	N	Libido Change
Y	N	Thyroid Problem

Patient Label

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

Scale = 0 Never, 1 Seldom, 2 Sometimes, 3 Often, and 4 Very Often

	0	1	2	3	4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

Please include any additional information you wish about the above answers. Thank you.

Patient Label

FOR MEANINGFUL USE PURPOSES ONLY

Race/Ethnicity (please circle one):

- American Indian or Alaska Native
- Asian
- Black or African American
- More than one race
- Native Hawaiian
- Other Pacific Islander
- Refuse to report
- White

Ethnicity (please circle one):

- Hispanic or Latino
- Non-Hispanic or Latino
- Refuse to report

Marital Status (please circle one):

- Single
- Married
- Divorced
- Widowed
- Separated
- Partnered
- Refuse to report

Employment (please circle one):

- Full-time
- Part-time
- Not employed
- Self-employed
- Retired
- Military Duty

Student (please circle one):

- Full time
- Part time
- Not a student

Preferred Language (please circle one):

- English
- Spanish
- Other:_____