PATIENT REGISTRATION SHEET

Please complete the ENTIRE form and sign where indicated.
Please provide the receptionist with your insurance card.

MINIVASIVE PAIN SPECIALISTS

Last Name:_____First Name:_____MI: _____

Address:_____City:_____State:_____Zip: _____

Date of Birth:_____/_____/_____Age:_____Social Security #:_____-_____-_____Marital Status: _____

Home #: (_____)_____-_____Cell. #: (_____)_____-_____Email Address: _____

Employer Name:_____Employer Address: _____

Primary Care Physician:_____Phone: (_____)_____- _____

Referring Physician or Chiropractor:_____Phone: (_____)_____- _____

Reason for visit/symptoms: _____

Name of Insurance Company:_____Phone: (_____)_____- _____

Insurance ID Number:_____Group Number: _____

Address:_____City:_____State:_____Zip: _____

Name of Policy Holder:_____Date of Birth:_____/_____/_____

Name of Secondary Insurance:_____Phone: (_____)_____- _____

Insurance ID Number:_____Group Number: _____

Address:_____City:_____State:_____Zip: _____

Name of Policy Holder:_____Date of Birth:_____/_____/_____

Emergency Notification:_____Phone: (_____)_____- _____

Relationship to patient: _____Date of Birth:_____/_____/_____

Phone: (_____)_____- _____

Signature of Responsible Party:_____**Date**: _____

MINIVASIVE
PAIN SPECIALISTS

3301 Spring Stuebner Rd. Suite# 110
Spring, Texas 77389
Phone: 346-800-6001
Fax: 346-800-6002
www.MinivasivePain.com

CONSENT TO TREAT: I consent to the administration of health care by MINIVASIVE Pain Specialists (MPS). I understand that I may set conditions or limitations on my treatment and care and that if I wish to provide such conditions, I will be given the opportunity to write those in a separate document. I have been informed and acknowledge that I may withdraw my consent at any time upon written notice to MPS. I am giving my consent to the administration of health care by MPS voluntarily, and that hereby knowingly and voluntarily enter into this Health Care Consent for Treatment. MPS is an interventional Pain Management clinic only. MPS encourages all patients to obtain a Primary Care Physician.

AGREEMENT FOR BENEFIT ASSIGNMENT AND FINANCIAL RESPONSIBILTY: I agree to pay for all services rendered to me by a MPS physician and/or other qualified healthcare provider employed by MPS. I agree that I am responsible to provide timely information about my insurance coverage and changes in coverage as they occur. **I am responsible for keeping any required insurance referrals current and up to date**. I agree to respond promptly to requests for information from my insurance company as they occur. I assign MPS benefits due to me or become due to me as a result of the medical services I shall receive from a MPS physician or other qualified healthcare provider. I further authorize the payments to be paid directly to MPS. I also understand that I am responsible to MPS for any payments made directly to me for services MPS provided to me. If this account is not paid in accordance with MPS' policies, I agree and guarantee to pay collection costs, including reasonable attorney fees, collection agency fees and interest from the date of demand. We also can arrange payment plans.

IF MEDICARE or other similar government program should determine that I am not eligible for coverage or that the treatment is not covered, I will be responsible for payment, unless prohibited by law.

IF NO INSURANCE, THIRD-PARTY INSURANCE, or MOTOR VEHICLE ACCIDENTS you will be responsible for all charges associated with your care. We can file insurance claims to third-parties or insurance carriers on your behalf. You will be responsible for all charges as well as billing appropriate carriers as you like.

ACKNOWLEDGEMENT OF PRIVACY POLICIES / HIPAA: I have been offered a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the notice may be changes at any time and I have the right to request new copies at any MPS location during regular business hours.

☐ ACCEPTED ☐ DECLINED _____Patient's Initials

By my signature below, I am acknowledging receipt of this document and agree to the terms under all sections of this document. Agreement Consent to Treat, Benefit Assignment and Financial Responsibility and receipt of Privacy Policies / HIPAA.

A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

Name of Patient/Guardian Date

_____ _____

Signature of Patient/Guardian Date

_____ _____

Relationship to Patient if signed by someone other than patient Date

MINIVASIVE
PAIN SPECIALISTS

Patient Name: _____

Date of Birth: _____

HIPAA Policy

Minivasive Pain Specialists
3301 Spring Stuebner #110
Spring, Texas 77389
(Phone)346-800-6001
(Fax)346-800-6002

According to the Texas State Law and per HIPPA policy, our practice is not allowed to release any of your information without your permission. Please list any individuals that you are giving permission to receive or to pick up any scripts written by the doctor. Please list any individuals that you are giving permission to receive information in regards to you as a patient at our practice.

Name:_____D.O.B.___/___/___
Phone:_____Relationship: _____

Name:_____D.O.B.___/___/___
Phone:_____Relationship: _____

CHECK ALL THAT APPLY

Home Phone

- □ Okay to leave a message with detailed information
- □ Leave message with call back number only

Cellular Phone

- □ Okay to leave a message with detailed information
- □ Leave message with call back number only

Email

- □ Okay to send email with detailed information

Print Patient Name	Patient/Guardian Signature	Date

Patient Name: _____

Date of Birth: _____

MINIVASIVE
PAIN SPECIALISTS

Meaningful Use Patient Questionnaire

In an effort to improve the quality of care or patients receive, Minivasive Pain Specialists has implemented an electronic health record and is participating in the Meaningful Use Initiative. The data we are collecting below will help MPS efficiently and safely care for you, reduce health disparities, and improve care coordination between MPS, your primary care physician and local hospitals. Please take a moment to answer the following very important questions regarding you and your overall healthcare. Thank you for choosing MPS.

Please circle your race:

American Indian or Alaska Native Asian Native Hawaiian or Other Pacific Islander

Black or African American White Hispanic Other Race Other Pacific Islander

Refuse to Report

Please circle your ethnic background:

Hispanic or Latino Not Hispanic or Latino Refuse to Report

What is your preferred language? _____

Patient/Guardian Signature_____ **Date:** _____

MINIVASIVE
PAIN SPECIALISTS

Patient Name: _____

Date of Birth: _____

Therapeutic Agreement for Controlled Substance Medication Prescriptions

Both Minivasive Pain Specialists (MPS) and I (the "Patient") have a common treatment goal: to improve my ability to function and/or work. In consideration of that goal, I will be treated with potent medications. I understand that some of the medications will be narcotics, tranquilizers and/or barbiturates. I understand that these medications are considered controlled substance medications and their use is closely controlled and monitored by the local, state and federal agencies. I have been informed that these medications are highly effective when taken as directed under medical supervision, but they also have potential for misuse and abuse. I also understand that these medications have the potential for various side effects and the side effects will be explained to me prior to treatment.

I have been fully informed by MPS' physicians and staff about psychological dependence (addiction) to controlled substances. If this happens to me, I agree that I will promptly notify MPS of my addiction and I agree to follow the MPS physician's guidance and participate in any treatment program prescribed which may include detoxification, psychological counseling, and medical treatment. I understand that my failure to comply with the MPS physician's guidance and recommendations may result in the termination of my relationship with MPS.

In light of the foregoing, and as a condition to MPS prescribing controlled substance medications to me, I agree to abide by the following:

1. A baseline drug screen may be obtained and completed on the first and/or subsequent clinic visits.
2. I agree that all controlled substance medications and prescriptions shall be prescribed only by MPS.
3. I understand that obtaining and taking controlled substance medications from any individual or physician other than MPS will be considered a violation of this agreement. The only exception is medications prescribed while I am admitted to the hospital.
4. I agree that in the event I obtain and take controlled substance medications from any individual or physician other than MPS, I will promptly (no later than my next clinic visit) inform MPS of the details.
5. I will take the medications as prescribed by MPS as directed, no more and no less. If I use up my medications sooner than prescribed, I understand that they will not be replaced.
6. I understand that if I have any unused medication, the medication needs to be brought into the office for the purpose of supervised disposal.
7. I understand that some patients may develop a tolerance, which is the need to increase the dose of the medication to achieve the same effect in terms of pain relief. I also understand that as a result of other treatment modalities or the natural course of my disease process, my pain may decrease. Therefore, I recognize that my medication doses will have to be adjusted (increased or decreased) as deemed appropriate by my MPS physician. I agree that I will not adjust the medications by myself.
8. I understand that if I stop taking the medications abruptly this may be dangerous and lead to withdrawal symptoms. I agree that if the medications need to be discontinued, I will do so gradually and only under medical supervision.
9. I acknowledge that I am responsible for my controlled substance medications. I agree that is my medications or prescriptions are lost, misplaced, stolen or disappear for any reason, they will not be replaced. I further agree that in such an event, I must promptly contact and notify the MPS staff regarding the loss of my prescriptions or medication immediately. I understand that a police report is required for replacement of lost or stolen medications.

10. I understand that I am responsible for keeping track of the amount of the medications left and for scheduling an appointment in advance for the refill of my prescriptions so I will not run out of medications.

11. I agree to use:

    _____ pharmacy, located at_____phone number

    _____ for all my pain medications. I further understand that:

    a. Request for refills will be addressed at monthly office visits. **Refills will not be made at night, on holidays, or weekends.** I understand that refill requests after regular office hours will not be prescribed or refilled because such requests could suggest inappropriate opioid usage.

    b. Refills may be delayed as a result of drug screen results.

12. I understand that MPS may perform random drug screens on me at any time, in the sole discretion of MPS, and that I may be financially responsible for the costs associated with the random drug screens. Failure to complete random drug screen within 24 hours will be presumed positive and the doctor may choose to terminate the relationship at that time.

13. I understand that MPS reserves the right to obtain my external prescription history.

14. I realize that it is my responsibility to keep others and myself from harm, including the safety of my driving. If there is any question of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have not used my medication for at least four days.

15. I agree that I will not, at any time, use any illegal controlled substances, including marijuana, cocaine, etc.

16. I agree to help myself by trying to change my behavior towards a healthier lifestyle including: stop smoking, use of alcohol only in moderation as permitted by my physician, diet and weight control and exercise. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treatment.

I understand that if I violate any of the above conditions, my relationship with MPS (including my right to receive controlled substance prescriptions) may be terminated.

Patient Name (signed): _____

Patient Name (printed): _____

Witness: _____

Date: _____

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Authorization to Release Medical Records

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the release of your Medical Records.

Patient Name: _____ DOB: _____
Phone Number: _____ EMAIL: _____

RELEASE INFO TO:
Name:_____
Address:_____
City, State:_____Zip:_____
Phone:_____
Fax:_____

OBTAIN INFO FROM:
Name:_____
Address:_____
City, State:_____Zip:_____
Phone:_____
Fax: _____

Reason for Disclosure (Please circle one):

Treatment/Continuing Care | Personal Use | Billing/Claims
Insurance | Legal Purposes | Other: _____

What information can be disclosed? *Complete the following by indicating those items that you want disclosed. If entire Medical Record is to be released, then check only the first line.*

☐ **Entire Record** ☐ Operations Reports
☐ Lab Results ☐ Consultations
☐ Imaging Results ☐ Diagnostic Test Reports

Your initials are required to NOT release the following information:

___Mental Health Records (Excluding Psychotherapy Notes) ___Genetic Information/results
___Drug, Alcohol, or Substance Abuse Records __HIV/AIDS test results/treatment

RIGHT TO REVOKE: *I understand that I can withdraw at any time by giving written notice stating my intent to TERMINATE this authorization to **Minivasive Pain Specialists 3301 Spring Stuebner #110, Spring, Tx 77389.** I understand that prior actions taken in reliance on this authorization by entities that had permission to access my Medical Record will not be affected.*

SIGNATURE AUTHORIZATION: *I have read this form and agree to the uses and disclosures of the information as described. I understand that*
refusing to sign this form does not stop release of Medical Record that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code 181.154(c) and/or 45 C.F.R. 164.502(a)(1). I understand that information released pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

_____ _____
Patient Signature Date

_____ _____
Legally Authorized Representative Relationship to Patient

_____ _____
Witness Signature Date

MINIVASIVE
PAIN SPECIALISTS

PRIVACY NOTICE ACKNOWLEDGMENT FORM

I hereby acknowledge that I have been given the opportunity to read and review our Notice of Privacy Practices, located on our web site and in the lobby of our office. I understand that a copy of this Notice will be made available to me, for my personal use, if requested.

_____ _____

Patient's Name (Please Print) Date of Birth

_____ _____

Patient/Representative Signature Date of Signature

_____

Representative's Relation to Patient, If Applicable

Documentation of Good Faith Effort (To be completed by our staff if a signature is not obtained by patient or representative) A good faith effort has been made to obtain a written acknowledgement of the Notice of Privacy Practices made available to the patient, provided in the lobby of our office. An Acknowledgement has not been obtained because:

___ Patient refused to sign the Acknowledgement despite having opportunity to read and review.

___ Other: Patient was unable to sign the acknowledgement because:_____
_____

_____ _____

Employee Signature Date

MINIVASIVE
PAIN SPECIALISTS

PHYSICIAN DISCLOSURE OF FINANCIAL INTEREST

MINIVASIVE PAIN SPECIALISTS

Texas law requires that your physician disclose to you any financial interest he or she may have in another healthcare entity to which you may be referred, so that you may address any concerns you may have directly with your physician. Your referring physician is a contractor and/or owner of Minivasive Pain Specialists (the "Group"). The physician members of the Group are NOT owners of any of the Ambulatory Surgical Centers, Hospitals, Laboratories, or Imaging facilities to which you have been referred for therapeutic and/or diagnostic services. By signing the below, you acknowledge your receipt of this Physician Disclosure of Financial Interest.

Print Patient Name: _____

Patient Signature (or legal representative): _____

Date: _____

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NEW PATIENT FORM

Patient's Name: Date of Birth:

Date of Visit: Occupation:

Please fill out this medical intake to facilitate your appointment today.

About Your Pain:

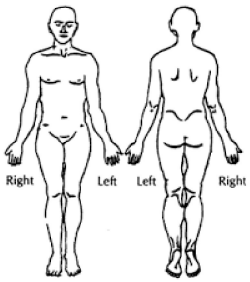
Chief Complaint (Reason for visit) :_____

_____

How long have you experienced this problem? ____Days /____ Weeks / ____ Months /____ Years

If Injured - Date of Loss: / / Type (circle): Car Accident / Work Accident / Slip and Fall

Describe the inciting event that caused pain: Driver or Passenger _____



Please shade where it hurts

_____

Describe your pain (Circle): Shooting / Throbbing / Aching / Burning / Sharp / Dull / Cramping / Other:_____

Is the pain constant? ☐ Yes | ☐ No If not, how often and how long does the pain last?_____

Does your pain radiate anywhere? _____ Numbness / Weakness/ Other: _____

Rate your pain: Mild Moderate Moderately Severe Severe

What makes your pain WORST?_____BETTER?_____

What medications have you tried or currently using?_____

Have you tried Chiropractic or Physical Therapy? ☐ Yes | ☐ No When and with who?_____

What previous treatments (acupuncture, injections, surgeries) have you tried?_____

Have you been treated by a previous Pain Specialist? ☐ Yes | ☐ No When?_____By who?_____

Has the pain affected your Activities of Daily Living (ADLs) ☐Yes | ☐No. If yes, describe _____

_____

Has pain affected your: PHYSICAL FUNCTION e.g. grooming, dressing, bathing, transfers: ☐Yes | ☐No
FAMILY & SOCIAL LIFE: ☐Yes | ☐No SLEEP PATTERNS: ☐Yes | ☐No WORK: ☐Yes | ☐No HOBBIES ☐Yes | ☐No
QUALITY OF LIFE ☐Yes | ☐No OTHER: _____