RPCC PATIENT DEMOGRAPHICS (PD)

Name: _____
Last First MI
Address: _____
City State Zip
Home#: _____ Work#:_____ Cell#:_____

DOB: ____/___/___ SS#: _____Marital Status: S / M / D / W Male/Female (circle)
Race: American Indian____ Alaskan____ Asian____ Black____ Caucasian____

Emergency Contact: _____
Name Number Relation to Patient
Referring Physician: _____
Name Number
Primary Care Physician (Required): _____
Name Number

INSURANCE INFORMATION: (If you are working, Medicare is your Secondary)

Primary Insurance
Insurance Company: _____ Phone#: _____
ID#: _____ GRP#: _____
Subscriber Information if not **SELF**
Name: _____ SS#:_____ DOB: _____
Subscribers' Employer: _____

Secondary Insurance
Insurance Company: _____ Phone#: _____
ID#: _____ GRP#: _____
Subscriber Information if not **SELF**
Name: _____ SS#: _____ DOB: _____
Subscribers' Employer: _____

Acknowledgement of Review of Notice of Privacy Practice
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.

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS:
I hereby authorize the release of any medical information necessary to process my health insurance claims and request payment of benefits to RPCC, where services were provided. I permit a copy of this authorization to be used in place of the original. I understand *I am financially responsible* to the center for charges not covered or that are denied by my insurance company. I further agree in the event of non-payment, to pay the cost of collection and/or court cost and reasonable fees, should this be required.

By signing below I also give permission for **Regional Pain Care Center** to access my pharmacy benefits data electronically through **RelayHealth.** We ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using **RelayHealth**.

_____
Signature of Patient or Personal Representative Date

_____
Name of Guardian/Representative Relation to Patient Date

_____
Witness Date

Regional Pain Care Center

MEDICATION LIST

Patient Name: _____

Doctor you are seeing: _____

Are you here for MRI/CT results ? Yes or No Date of last injection: _____

DID YOU BRING YOUR MEDICATION BOTTLES WITH REMAINING PILLS?

List of Medications (include over the counter) Dosage Times per day

_____
_____
_____
_____
_____
_____
_____

On the average, how severe has your pain been during the last week?

0 1 2 3 4 5 6 7 8 9 10

Not severe at all Extremely severe

In general how much is you pain interfering with day-to-day activities?

0 1 2 3 4 5 6 7 8 9 10

Release of information and assignment of benefits:
I heareby authorize the release of any medical information necessary to process my health insurance claims and request payment of benefits to RPCC, where services were provided. I permit a copy of this authorization to be sed in place of the original. I understan *I am financially responsible* to the center of charges not covered or denied by my insurance compnay. I further agree in the event of non-payment, to pay the cost of collection and/or court cost and reasonable fees, should this be required.

Signature: _____ Date: _____

1111 RAINTREE CIR. STE. 170 ● ALLEN, TX 75013 ● 214-509-9691 ● 214-509-0947

Regional Pain Care Center
OPIOID CONSENT (OC)

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, April 2008 (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.

Additional risks and alternatives (to be filled in by physician as necessary):_____
_____

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 MEDICINE 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. I have read or had read to me the contents of this form.**

I understand the risks and alternatives of this procedure; I have had the opportunity to ask any questions about this treatment.

Signature of Patient_____Date_____

Signature of Physician (or Appropriately Authorized Assistant)_____Date_____