INTERVENTIONAL PAIN MANAGEMENT

Dear New Patient

Thank you for choosing our clinic for your pain management needs. It is our pleasure to welcome you as our patient. We look forward to giving you the best possible interventional treatment options available. Greater Houston Interventional Pain Associates offers management for acute and chronic pain along with a wide range of procedures to help control pain. On your first visit, you will be seen by one of Board-Certified Physicians. Once the Doctor has established a treatment plan for you, one of our skilled Nurse Practitioners will monitor your progress for at least 3 follow up visits.

Expect to arrive at least 30 minutes prior to your scheduled appointment time and have your patient information packet filled out completely. YOU MUST HAVE A VALID GOVERNMENT ISSUED PHOTO ID TO BE SEEN. NO EXCEPTIONS! All co-payments will be collected before services are rendered and can be paid by cash or credit cards only.

We take pride in our mission to provide interventional pain management solutions, under the highest standards of patient safety and competent medical care.

Sincerely,

Greater Houston Interventional Pain Associates

4747 BELLAIRE BLVD STE 101 BELLAIRE, TEXAS 77401 (P) 713-622-1700 (F) 713-877-0672

INTERVENTIONAL PAIN MANAGEMENT

URINE DRUG TESTING PROTOCOL

Our staff is committed to providing effective treatment that will alleviate the suffering associated with chronic pain. The treatment of pain may include the use of controlled substances or narcotic medications.

There is an increased incidence of accidental death with prescribed medications that contain opiates, as well as other narcotic drugs. All patients will be subject to random urine/saliva drug testing to ensure the best care to all our patients by monitoring compliance in taking their medication(s) as prescribed.

A urine/saliva specimen are usually obtained at the following visits or at random at the providers discretion:

New Patients: Urine /Saliva Drug Testing

All prospective patients who produce urine are asked to submit a urine sample for drug testing.

Existing Patients Beginning Medication Therapy – Urine Drug Testing

All existing patients who will be receiving a prescription for controlled substances or narcotics may be asked to submit a urine sample for drug testing at random or if on probation every 2 weeks at the providers discretion.

Existing Patients Receiving Injections Only

Patients receiving injections only may be subject to random UDT at any visit and may be required to submit a urine sample for drug testing every 3 months.

Drug Test Based on Texas Board of Pharmacy (TBP) Documentation

The clinic staff may query the name of any patient who is receiving schedule II or III medications through the TBP. If information is found indicating that one of our patients appears to be obtaining similar medications from another provider, then the patient will be requested to provide a sample for a urine drug test.

Refusing to Provide a Urine Sample for Drug Testing:

Any patient who refuses to provide a urine sample for drug testing will be at risk of being discharged. The decision to discharge the patient will be made by the provider.

Print: ____________________________________

Sign: ____________________________________

Date: ____________________________________

INTERVENTIONAL PAIN MANAGEMENT

GREATER HOUSTON INTERVENTIONAL PAIN ASSOCIATES

PHYSICIAN DISCLOSURE

As required by Section 102.006 of the Texas Occupations Code

Texas law requires a physician to disclose to a patient those arrangements permitted under applicable Texas law whereby such physician accepts remuneration to secure or solicit a patient or patronage for a person licensed, certified or registered by a Texas healthcare regulatory agency. The purpose of this Disclosure is to notify you, the patient, that your attending physician{s) may receive remuneration for referring you to any of the following ancillary healthcare providers for certain healthcare services:

BAYOU CITY PAIN CONSULTANTS, LLC
(Anesthesia Services)

I hereby acknowledge that my attending physician{s) have disclosed to me, at the time of my initial contact and at the time of referral; his/her affiliation with the foregoing ancillary healthcare provider(s) for whom, I, the patient am being referred, and that he/she will receive, directly or indirectly, remuneration for the referral to such ancillary healthcare provider. I understand that I, the patient, have the right to choose the providers of my healthcare services and/or products and, as such, I have the option of receiving ancillary healthcare services from any ancillary healthcare provider and/or facility that I choose.

I, the patient has read and understand the information disclosed in my Physician Disclosure.

Print: ________________________________

Sign: ________________________________

Date: ________________________________

INTERVENTIONAL PAIN MANAGEMENT

Patient Rights and Responsibilities

Our Practice is committed to providing quality compassionate health care. We pledge to provide this care with respect and dignity and present the following Patient Rights and Responsibilities:

You have the right to:

- Professional clinicians who will provide competent, considerate and respectful health care, regardless of race, creed, age, sex or sexual orientation.
- A second medical opinion from the clinician of your choice, at your expense.
- An easily understandable explanation of your condition, treatment and chances for recovery.
- A review of your medical records by appointment and in accordance with applicable State and Federal guidelines.
- Confidential management of communication and records pertaining to your medical care.
- Information about the medical consequences of exercising your right to refuse treatment.
- The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency.
- Respectful and humane treatment.
- A treatment plan that will strive to optimize your quality of life.
- Have your pain evaluated and managed.
- Refuse to participate as a subject in research.
- An explanation of your medical bill regardless of your insurance and the opportunity to personally examine your bill.
- To expect we will take reasonable steps to overcome cultural or other communication barriers that may exist between you and the staff.
- To file a complaint should a dispute arise regarding care, treatment or service.
- To select a different clinician.

You are responsible for:

- Knowing your health care clinician's name and title.
- Knowing your health care coverage benefit details
- Providing your clinician with correct and complete health history information, e.g. allergies, past and present illnesses, medications and hospitalizations.
- Providing staff with your correct and complete name, address, telephone and emergency contact information each time you see your clinician, so we can reach you in the event of a schedule change or to give medical instructions.
- Providing staff with current and complete insurance information, including any secondary insurance, each time you see your clinician.
- Signing a "Release of Information" form when asked so your clinician may obtain medical records from other clinicians involved in your care.
- Telling your clinician about all prescription medication(s) (name, dose, route, and frequency), alternative, i.e. herbal or other, therapies, or over-the-counter medications you take. If possible, please bring the bottles to your appointment.
- Telling your clinician about any changes in your condition or reactions to medications or treatment.
- Asking your clinician questions when you do not understand your illness, treatment plan or medication instructions.
- Following your clinician's advice. If you refuse treatment or refuse to follow instructions given by your health care clinician, you are responsible for any medical consequences.
- Keeping your appointments. If you must cancel your appointment, please call the office at least 24 hours in advance.
- Copayments are expected at the time of your office visit. Other bills are due upon receipt.
- Following the office's rules about patient conduct; for example, there is no smoking in our office.
- Respecting the rights and property of our staff and other persons in the office.

Print: ______________________________ **Sign:**______________________________ **Date:** ________________

INTERVENTIONAL PAIN MANAGEMENT

PATIENT INFORMATION SHEET

(PLEASE COMPLETE ALL)

FULL NAME: ________________________________ **DOB:** ____________ **MALE/FEMALE**
(Last, First, Middle)

ADDRESS: ____
(Street) (City) (State) (Zip)

PHONE: __________________ __________________ __________________
(Primary) (Cell) (Work)

SSN: ____________________ **EMAIL:** ______________________________________

MARITAL STATUS: ___**Single** ___**Married** ___**Divorced** ___ **Widowed**

CHIEF COMPLAINT: ____

EMPLOYER INFORMATION:

_________________________ _____________________ ____________________
(Employer Name) (Occupation) (Referring Physician)

EMERGENCY CONTACT INFORMATION:

_________________________ _____________________ ____________________
(Last, First, Middle) (Relationship) (Phone)

IF RESPONSIBLE PARTY IS OTHER THAN PATIENT-PLEASE COMPLETE THIS SECTION

FULL NAME: ______________________________ **DOB:** _____________ **MALE/ FEMALE**
(Last, First, Middle)

ADDRESS: ____
(Street) (City) (State) (Zip)

PHONE: ____________________ ________________ ____________________
(Primary) (Work) (SSN)

EMPLOYER: __________________________

INSURANCE INFORMATION

PRIMARY INSURANCE:

POLICY HOLDER: ______________________
INSURANCE CO: ______________________
ADDRESS: ___________________________

SECONDARY INSURANCE:

POLICY HOLDER: ______________________
INSURANCE CO: ______________________
ADDRESS: ___________________________

WORKERS' COMPENSATION OR LEGAL CASE-PLEASE COMPLETE THIS SECTION

DATE OF INJURY: ______________ **CLAIM NO.:** _______________________

DOCTOR OF RECORD: ___________________________

ADJUSTER: ______________________ ___________________ __________________
(Name) (Phone) (Fax)

EMPLOYER AT THE TIME OF INJURY: __________________________ __________________
(Name of Employer (Phone)

EMPLOYER ADDRESS: ____
(Street) (City) (State) (Zip)

ATTORNEY: _________________________ ______________________
(Name) (Phone)

ATTORNEY ADDRESS: ____
(Street) (City) (State) (Zip)

INSURANCE AGENT: ____________________________ ________________________
(Name) (Phone)

ORIGINAL DATE OF ACCIDENT: ______________ **CLAIM NO.:** _______________________

I CERTIFY THAT ALL INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

4747 BELLAIRE BLVD STE 101 BELLAIRE, TEXAS 77401 (P) 713-622-1700 (F) 713-877-0672

GREATER HOUSTON

INTERVENTIONAL PAIN MANAGEMENT

MEDICATIONS

Patient Name: ____

Are you allergic to any medications? Yes / No (circle one) if yes; please list

____

____

Medication	Dosage	Frequency (i.e. 2x per day)	Date Started	Prescribed By:

4747 BELLAIRE BLVD STE 101 BELLAIRE, TEXAS 77401 (P) 713-622-1700 (F) 713-877-0672

INTERVENTIONAL PAIN MANAGEMENT

PAIN MEDICINE TREATMENT AGREEMENT & INFORMED CONSENT

My signature to this document indicates that I have read the agreement.

I WILL:

- Only receive opioids from the Provider of GHIPA that I have this agreement with.
- Not ask for opioid medications from any other provider without the knowledge and consent of my provider (this includes dentists). If an acute need occurs (urgent care or emergency room), I will notify my provider within 48 hours. I will provide hospital discharge paperwork at next follow up visit.
- Keep all scheduled appointments and procedures, not just with my provider, but also with other recommended practitioners such as nursing staff, mid-level providers. Three or more missed appointments will be grounds for termination from the clinic.
- Not display aggressive, disruptive, threatening or dishonest behavior. If this occurs, it is grounds for termination from this clinic.
- Agree to provide regular samples of urine and saliva for drug screens. Positive tests for alcohol, any illegal substances, opioids not prescribed by your provider, or absence of the prescribed opioids will result in discontinuing opioid refills and may cause dismissal from the clinic or referral for substance abuse evaluation.
- Please note we are no longer providing opioid medication four times per day. If needed, we will review cases individually to determine the best treatment option.
- Benzodiazepine protocol: GVIPA does not prescribe Benzodiazepines. Patients are not permitted to be prescribed more than 10mg of Diazepam/per day, 1mg of Ativan/per day, 1mg of Clonazepam/per day, 1mg of Xanax/per day and up to 15 dosages of Temazepam/per month by another Physician. If patients are prescribed more than these permitted dosages, it may lead to dismissal from the clinic or referral for substance abuse evaluation. Please note this is only a guideline that is subject to change. GHIPA Providers will utilize this protocol only as a guideline but not as a hard and set rule. Providers will consult on a patient-by-patient basis.
- Sleep Aid protocol: GVIPA does not prescribe Sleep Aids. Patients are not permitted to be prescribed more than 15 dosages/month of 10mgs of Ambien and Lunesta by another Physician. Patients are not permitted to take more than 100- 150mg/per night of Trazadone. If patients are prescribed more than these permitted dosages, it may lead to dismissal from the clinic or referral for substance abuse evaluation Please note this is only a guideline that is subject to change. GVIPA Providers will utilize this protocol only as a guideline but not as a hard and set rule. Providers will consult on a patient-by-patient basis.
- Not get prescription early (you will be allowed one vacation refill per year; at the time of the office visit)
- RX will not be replaced if lost, failed delivery of mail away prescriptions, destructions, or those stolen.
- You will have to file a police or fire department report for lost or stolen medications. You will be required to provide us with a police report number.
- Receive prescriptions refills during regular business office hours. Any medication requests require five working days before they are completed by the clinic.
- Comply fully with all aspects of recommended treatments including behavioral medicine (psychology/psychiatry) and physical therapy. If you do not, this could lead to the discontinuation of opioids.
- Success in managing your pain involves multiple interventions that include active participation in regular physical exercise and the use of psychological coping strategies. If a pattern of passive reliance on medications, resistance to more active physical treatments, and repeated failure to demonstrate the implementation of psychologically based coping strategies that have been taught may lead to discontinuation of prescribed opioid medications and/or referral to another provider.
- I will not share, sell, or divert my medications for illegal use nor permit others (including families and friends) to have access to these medications.
- Comply with requested medication changes such as opioid rotation (shifting to other opioid for improved pain control), Opioid Holiday (to restore opioid potency), Opioid Taper (if not effective, not meeting goals, or if the opioid is potentially causing an increase in pain).
- If arrested or incarcerated in relation to legal or illegal substances-I understand that refills on controlled substances will be denied.
- We understand emergencies can occur-each will be considered on an individual basis.
- I have read the reverse agreement regarding informed Consent for Opioids.

These guidelines have been explained and discussed with me while in full possession of my faculties and not under the influence of any substance(s) that might impair my judgment. All my questions have been answered to my satisfaction and understanding. I also give my provider permission to contact other healthcare providers for sharing information regarding my situation as necessary for coordination of the quality of care that I desire.

Print: ___________________________________

Sign: ___________________________________

Date: ___________________________________

INTERVENTIONAL PAIN MANAGEMENT

A Notice of Privacy Practice (NPP) is provided to all patients.

This Notice of Privacy Practice identifies:

- How medical information about you may be used or disclosed
- Your right to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information
- Your right to complain if you believe your privacy rights have been violated and;
- Our responsibilities for maintaining the privacy of your medical information

Complaints

- Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Compliance Officer. If you are not satisfied with the way the officer handles a complaint, you may file a formal complaint to the Secretary of Human Services.
- We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to PHI. We are also required to abide by the terms of the notice currently in effect.

Other Permitted and Required uses and disclosures
Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. YOU MAY REVOKE THE AUTHORIZATION, at any time, in writing, except to the the extent that your providers' practice has taken an action in reliance on the use or disclosure indicated in the authorization.

The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practice, and is the patient or the patient's personal representative.

Print: ___________________________

Sign: ___________________________

Date: ___________________________

INTERVENTIONAL PAIN MANAGEMENT

Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

Also, over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

Pharmacy Name: ______________________________ **Phone #:** ____-____-____

Address: ____

Print: _____________________________

Sign: _____________________________

Date: _____________________________

INTERVENTIONAL PAIN MANAGEMENT

FINANCIAL DISCLOSURES

You have the right to receive an accounting of certain disclosures.
- You have the right to receive an accounting of all disclosures except for disclosures pursuant to an authorization for the purposes of treatment, payment, healthcare operation required by law that occurred prior to April 14, 2003, or six years prior to the date of the request.

Assignment of Insurance Benefits
- In the event the patient is entitled to medical benefits arising out of any policy of insurance insuring the patient or any other party liable to the patient, said benefits are hereby assigned to the provider for application on the patient's bill. It is agreed that the provider may accept any such payment and shall discharge the said insurance of any and all obligations under the policy to the extent of such payment. I am responsible for charges not covered by this assignment.

Financial Responsibility
- I agree (as the patient or responsible party) that in consideration of the services to be rendered to the patient, I obligate myself to pay all charges by the physician incurred in connection with treatment of thew patient or costs related thereof. It is further agreed that the undersigned shall be liable for actual charged billed. Any charges estimated at the time of treatment are subject to change. It is also my responsibility to be aware of my healthcare benefits at the time of service.

Cancellation/No Show
-There is a 10-minute grace period for scheduled appointments, **EXCEPTION:** There is no grace period for appointments set for 11:30am or 3:30pm. Any minute past the grace period is considered a no show and there will be a $25 no show fee that will be added for office visits that fail to show or cancel an appointment within 24 hours of the scheduled appointment. There will be a $100 no show fee added for scheduled procedure appointments that fail to show or cancel within 24 hours of the scheduled time. Three (3) no show appointments may result in discharge from the practice.

ALL NO SHOW FEES MUST BE PAID IN FULL ON YOUR FOLLOWING VISIT OR YOU WILL BE ASKED TO RESCHEDULE

If you have any questions about this policy, please speak with a member of our staff before signing.

Print: ___________________________

Sign: ___________________________

Date: ___________________________

INTERVENTIONAL PAIN MANAGEMENT

CONSENT TO RELEASE TO FAMILY MEMBER/FRIEND
Consent to release information orally to family or friends for the purposes of treatment, payment, and health operations.

I direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

GREATER HOUSTON INTERVENTIONAL PAIN ASSOCIATES

Health Information to be disclosed upon the request of the person{s) named below (Circle either A or B):

A. Disclose my complete health record (including but not limited to diagnosis, lab tests, prognosis, treatment, and billing for all conditions)

OR

B. Disclose my health record, as above, **BUT DO NOT DISCLOSE** the following {circle as appropriate)

Mental health records

Communicable diseases {including HIV and AIDS)

Alcohol/drug abuse treatment

Other (please specify) ____

____

Individuals who may receive confidential health information		**Relationship**	**Phone**
______________________________	A / B	______________	______________
______________________________	A / B	______________	______________
______________________________	A / B	______________	______________

I understand that I have the right to revoke this permission, in writing, at any time and that disclosures made in good faith may have already occurred and that the withdrawal of permission cannot be retroactively.

Print: ______________________________ **Sign:** __________________________ **Date:** ______________

4747 BELLAIRE BLVD STE 101 BELLAIRE, TEXAS 77401 (P) 713-622-1700 (F) 713-877-0672

INTERVENTIONAL PAIN MANAGEMENT

CHRONIC PAIN NARCOTIC CONTRACT

Our policy regarding, narcotic use for CHRONIC NON-MALIGNANT (non-cancerous) pain is based on medical research as well as clinical experience. Narcotics should be used as deemed medically necessary and ideally as an adjuvant to other therapies. The clinician will provide you with resources to improve your function, as well as medical therapies and injections. Our goal is to minimize narcotic use and maximize your quality of life.

The guidelines regarding narcotic use are outlined below. These guidelines were developed with the patient's welfare in mind. If these guidelines are unacceptable or at odds with your medical goals, we will honor your request, or we may choose to refer you to another pain management physician.

- Prescriptions are to be used as prescribed. The use of an increased amount of medication, without the consent of the provider may result in discharge from the practice.
- Prescription refills occur on a monthly (30 day) basis. Your prescriptions will be refilled at your regular follow up visit. We do not call in routine refills after hours or on holidays. If you call and request a refill after hours, you will be instructed by the answering service to go to the emergency room of your choice.
- We utilize long and short acting medications in treating chronic pain. We strive to prescribe the amount of medication that will decrease your pain, so you may have an improved quality of life and increased function.
- You have or will sign a contract agreeing not to receive prescriptions for narcotics (including tramadol or codeine) from any other physicians including dentists; if taking opioids concomitantly with benzodiazepines please refer to **PAIN MEDICINE TREATMENT AGREEMENT & INFORMED CONSENT** form for dosages that are acceptable. Exceptions may be made in extraordinary circumstances and only after consulting with a provider.
- Any evidence of other prescriptions, forged prescriptions, substance abuse, or aberrant behavior (including verbal abuse to the office staff) may result in the termination of our patient physician relationship. Lost or stolen prescriptions will not be replaced. We suggest you protect your medications. Exceptions may be made for extraordinary circumstances and a police report is generally required.
- If you are discharged from the practice you will receive a written letter notifying you of your discharge. We will forward your medical records to a new physician of your choice. You may or may not receive narcotic prescriptions for one month after the date of termination. You may be presented with the option, in lieu of termination, to receive an evaluation for drug dependency, and if appropriate, be referred for detoxification.
- Please provide us with a reliable contact phone number.
- You may be asked to respond within 24 hours to a physician's request to bring your medication to the office for a pill count.
- You may be asked to respond immediately to a physician's/provider's request for drug screening. Inconsistent results will be addressed and may be cause for immediate termination.
- Any violations of this contract may result in immediate termination from our practice.
- You will need to select one pharmacy to fill your medications.

We want to empower you to take charge of your pain. Making appointments for medication refills is part of that empowerment. Our providers will be your guide and support in our common goal to minimize your pain. We asked you make an earnest effort to improve SLEEP HABITS, NUTRITION, BODY, WEIGHT, CONDITIONING, and PSYCHOLOGICAL STATE**.** Narcotics are not the answer to chronic pain. They can be used as a part of a multimodal approach to effectively to reduce your pain. We are committed to minimalizing narcotic dependence.

Print: ________________________________

Sign: ________________________________

Date: ________________________________

INTERVENTIONAL PAIN MANAGEMENT

By signing this form, I authorize you to release confidential health in about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below. I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), genetic testing or screening, behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

Limitations on the information you may release subject to this Release Form are:

- Last three office visits (if applicable)
- Radiological reports
- Lab reports

Release my protected health information to the following person(s) / entity:

Greater Houston Interventional Pain Associates
4747 Bellaire Blvd Ste 300
Bellaire, Texas 77401
Phone: 713-622-1700 Fax: 713-877-0672

The reasons or purposes for this release of information are as follows:

- For evaluation and treatment of patient
- For continuity of care

Print: ______________________________

Sign: ______________________________

Date: ______________________________

INTERVENTIONAL PAIN MANAGEMENT

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PLEASE READ CAREFULLY

I consent to the use of or disclosure of my protected health information by GHIPA for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the physician's office and any other use required by law. I understand that diagnosis or treatment of me by GHIPA, may be conditioned upon my consent as evidenced by my signature on this document.

- I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment of healthcare operations of the practice. GHIPA, is not required to any restrictions that I may request. However, if GHIPA, agrees to a restriction I request, the restriction is binding to the providers of Greater Houston Interventional Pain Associates. I have the right to revoke this consent, in writing, at any time, except to the extent that the GHIPA provider has acted in reliance on this consent.
- We will use and disclose your PHI to provide coordinated care or to manage your healthcare and any related services. This includes the coordination or management of your health care with a third party. For example, your PHI may be provided to a physician to whom you have been referred to ensure the physician has the necessary information to diagnose or treat you.
- My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or healthcare clearinghouse. This protected health information related to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis the information may identify me.
- I understand that I have a right to review GHIPA'S Notice of Privacy Practices prior to signing this document. The GHIPA's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills or in the performance of health care operations of GHIPA. The Notice of Privacy Practices also describes my rights, the providers rights, and is also posted in the lobby. This Notice of Privacy Practices also describes my rights and GHIPA's duties with respect to my protected health information.
- The doctor is authorized to furnish format the patient's record requested information or excerpts to the primary care or referring physician, if any, and to any insurance company or third-party payer for the purpose of obtaining payment of the account of the physician for services provided to the patient. The provider is authorized to release information from my medical record to any healthcare facility or provider for continuation of care.
- We may use or disclose, as needed, your PHI in order to support the business activities of your provider's practice. The activities include, but are not limited to, quality assessment, employee review, training of medical students, fundraising, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and provide the name of your provider. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your PHI, as necessary to contact you to remind you of your appointment and inform you about treatment alternatives or other health-related benefits and services.
- We may use or disclose your PHI in the following situation without your authorization. These situations include, as required by law, public health issues as required by law, communicable diseases, health oversight abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity, national security, workers' compensation, inmates and other required uses and disclosures. Under the law we must make disclosures to you on your request required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Greater Houston Interventional Pain Associates reserves the right to change the privacy practices that are described in Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, email, or by asking for one at the time of my next appointment.

Print: ____________________________ **Sign:** ___________________________ **Date:** ___________________

INTERVENTIONAL PAIN MANAGEMENT

Patient Name: ____________________________ **Date of Service**_________________

Reviewed By: _____________________________

REVIEW OF SYSTEMS: Please indicate any personal history below:

GENERAL			Back Pain	No	Yes
Do you take the following blood thinners?	No	Yes	Generalized osteoarthritis	No	Yes
Aspirin	No	Yes	Rheumatoid arthritis	No	Yes
other NSAIDSs(Ibuprofen,					
celebrex,etc	No	Yes	Cold extremities	No	Yes
Plavix	No	Yes	Difficulty in walking	No	Yes
Coumadin, warfarin, Pradaxa	No	Yes	Other:	No	Yes
heparin, Lovenox	No	Yes		No	Yes
Aggrenox	No	Yes	**NEUROLOGICAL**	No	Yes
Other:	No	Yes	Frequent or recurring headaches	No	Yes
Could you be pregnant today?	No	Yes	Light headed or dizzy	No	Yes
Do you have any allergies to					
mediations?	No	Yes	Stroke or TIA	No	Yes
If yes list all medications you are					
allergic to:	No	Yes	Paralysis	No	Yes
	No	Yes	numbness or tingling sensations	No	Yes
	No	Yes	Convulsions	No	Yes
CONSTITUTIONAL SYSPTOMS	No	Yes	Seizures	No	Yes
Good general health lately	No	Yes	Tremors	No	Yes
recent weight change	No	Yes	Head Injury	No	Yes
Loss of appetite	No	Yes	Other:	No	Yes
Fever	No	Yes		No	Yes
Sweating	No	Yes	**PSYCHIATRIC**	No	Yes
Night Sweats	No	Yes	Anxiety	No	Yes
Fatigue	No	Yes	Depression	No	Yes
Headaches	No	Yes	Insomnia	No	Yes
	No	Yes	Memory loss or confusion	No	Yes
EYES	No	Yes	Nervousness	No	Yes
Eye disease or injury	No	Yes	bipolar Disorder	No	Yes
Wear glasses/ contact lenses	No	Yes	Other:	No	Yes
Cataract surgery	No	Yes		No	Yes
Blurred or double vision	No	Yes	**ENDOCRINE**	No	Yes
Glaucoma	No	Yes	Glandular or hormone problem	No	Yes
Other:	No	Yes	Diabetes(insulin or non-insulin)	No	Yes
			Excessive thirst or urination	No	Yes
EARS/NOSE/MOUTH/ THROAT	No	Yes	thyroid disease	No	Yes
Chronic sinus problem or rhinitis	No	Yes	Heat or cold intolerance	No	Yes

Item	No	Yes
Earaches or drainage	No	Yes
Hearing loss or ringing	No	Yes
Nose bleeds	No	Yes
Bleeding gums	No	Yes
Mouth sores	No	Yes
Swollen glands in neck	No	Yes
Sore throat or voice change	No	Yes
Other:	No	Yes
	No	Yes
MUSCULOSKELETAL	No	Yes
Joint Pain	No	Yes
Joint stiffness or swelling	No	Yes
Morning stiffness	No	Yes
Weakness of muscles or joints	No	Yes
Muscle Pain or cramps	No	Yes
GASTROINTESTINAL continued….	No	Yes
Other:	No	Yes
	No	Yes
CARDIOVASCULAR	No	Yes
High blood pressure (HTN)	No	Yes
Chest pain or angina pectoris	No	Yes
heart attach(MI) If yes when:	No	Yes
	No	Yes
Short of breath with walking? Or	No	Yes
Lying flat?	No	Yes
Swelling of feet, ankles or hands	No	Yes
Heart trouble	No	Yes
Palpitation	No	Yes
Pacemaker	No	Yes
coronary bypass(heart surgery)	No	Yes
Heart Stent placement	No	Yes
heart valve replacement	No	Yes
Mitral valve prolapse	No	Yes
Heart murmur	No	Yes
Hardening of arteries (PVD)	No	Yes
Other:	No	Yes
	No	Yes
HEMATOLOGIC/ LYMPHATIC	No	Yes
Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Slow to heal after cuts	No	Yes
Phlebitis or blood clots	No	Yes
Past transfusion	No	Yes
HIV positive/ AIDS	No	Yes
Enlarged glands	No	Yes
sickle cell disease	No	Yes
Other:	No	Yes
	No	Yes

Item	No	Yes
Change in hat or glove size	No	Yes
Other:	No	Yes
GASTROINTESTINAL	No	Yes
Nausea or vomiting	No	Yes
Change in bowel movements	No	Yes
Constipation	No	Yes
Frequent diarrhea	No	Yes
abdominal pain	No	Yes
Rectal bleeding	No	Yes
Blood in stool?	No	Yes
Peptic Ulcer (stomach or duodenal?	No	Yes
Heartburn (GERD)	No	Yes
Hepatitis or jaundice	No	Yes
Hepatitis C	No	Yes
kidney stones	No	Yes
Chronic renal failure	No	Yes
Dialysis	No	Yes
Sexual difficulty	No	Yes
Male - testicle pain	No	Yes
Female - do you see a gynecologist?	No	Yes
Other:	No	Yes
	No	Yes
RESPIRATORY	No	Yes
Chronic or frequent coughs	No	Yes
Shortness of breath	No	Yes
Spitting up blood	No	Yes
Asthma or wheezing	No	Yes
Chronic bronchitis	No	Yes
COPD	No	Yes
EMPHYSEMA	No	Yes
ASBESTOS LUNG DISEASE	No	Yes
Tuberculosis	No	Yes
Other:	No	Yes
	No	Yes
ALLERGIC/IMMUNOLOGIC	No	Yes
History of skin reaction or	No	Yes
other reaction to:	No	Yes
Penicillin or other antibiotics	No	Yes
Morphine	No	Yes
Demerol	No	Yes
Or other narcotics?	No	Yes
Novocain or other	No	Yes
Anesthetics	No	Yes
Aspirin or other pain remedies	No	Yes
Tetanus antitoxin or other	No	Yes
Serums?	No	Yes
Lodine or other antiseptic	No	Yes

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INTEGUMENTARY (skin, breast)	No	Yes
Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Varicose Veins	No	Yes
Breast pain	No	Yes
Breast Lump	No	Yes
Breast discharge	No	Yes
Other:	No	Yes
	No	Yes
GENITOURINARY	No	Yes
Frequent urination	No	Yes
Incontinence or dribbling	No	Yes
Change in force of strain when urinating	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes

Known food allergies:	No	Yes
	No	Yes
Environmental allergies:	No	Yes
Other:		

Please mark the location(s) of your pain on the diagram below with an "x", You may shade in whole areas of pain such as an arm or leg if needed.