HOUSTON
PAIN & SPINE

Patient Information

Patient Name: _____ DOB: _____

Social Security Number: _____

Address: _____

City, State, Zip _____

Phone (1): _____ Type: _____

Phone (2): _____ Type: _____

Email: _____ What is the best way to contact you? _____

Ethnicity: _____ Race: _____ Preferred Language: _____

How were you referred? ☐ Physician: _____ Phone: _____

☐ Magazine, which one? _____

☐ Online

☐ Friend

Preferred Pharmacy

Preferred Pharmacy _____

Address _____

City, State Zip _____

Phone _____

Insurance Information

☐ Insurance ☐ Legal (Please indicate attorney below) ☐ Self Pay ☐ Worker's Comp

Primary Insurance Carrier _____

Policy Holder _____ Holder's DOB _____

Policy Number _____ Group Number _____

Secondary Insurance Carrier _____

Policy Holder _____ Holder's DOB _____

Policy Number _____ Group Number _____

_____ _____

Patient Signature Date

The information provided above is correct as to the best of my knowledge.

HOUSTON
PAIN & SPINE

832.436.4040 I 832.436.4050 I www.houstonpainandspine.com

Name _____ Date _____ Age _____ Male Female

MRN _____ Referring Physician _____

Physician Use Only

A. History of Present Illness

When did your pain start? _____

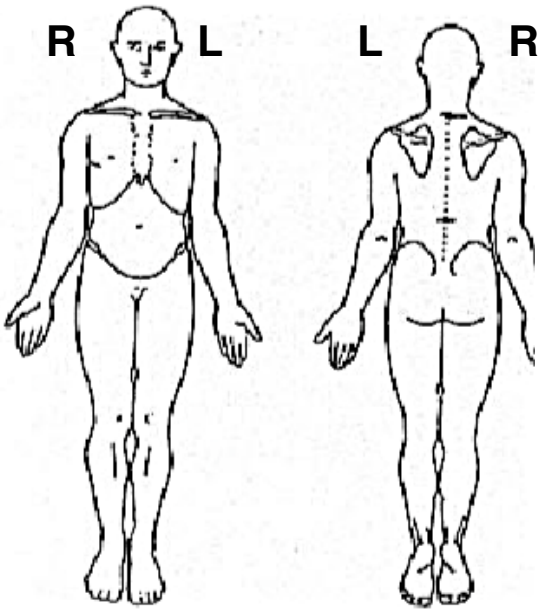
What caused your pain? Motor vehicle accident On it's own Job Injury Other

Please give details: _____

Please indicate the following: 0 1 2 3 4 5 6 7 8 9 10
On a scale of 1-10, your current pain level I—I—I—I—I—I—I—I—I—I—I

0 1 2 3 4 5 6 7 8 9 10
On a scale of 1-10, your average pain level I—I—I—I—I—I—I—I—I—I—I

Please complete the following pain diagram indicating where your current pain is. If your pain radiates to your legs or arms, please note that on the diagram.



Please circle the types of pain that you have:
- Deep (inside)
- Superficial (on the skin)
- Constant (all the time)
- Intermittent (starts & stops) - Aching
- Burning
- Shooting
- Stabbing
- Pins & needles
- Electrical
- Other (Please describe)

_____

_____

What makes your pain worse? Sitting Standing Walking Bending Cough/Sneeze Lying Down Other _____

What makes your pain better? Standing Sitting Walking Lying Down TENS Nothing Other _____

What type of treatments have you tried for your pain, how long did you try it for, and did it

work?

Treatment	For How Long Did You Try	Was it effective?
Exercises, Home Exercises		
Physical Therapy, How Many Sessions		
NSAIDs		
Muscle Relaxers		
Pain Injections		
TENs Unit		

What medications have you tried for your pain?

Avinza	MS Cotin	Advil	Naproxen	Zanaflex
Darvocet	Norco	Aleve	Gabapentin	_____
Duragesic	Oromorph	Arthrotec	Neurotin	_____
Hydrocodone	Oxycodone	Bextra	Topamax	_____
Kadian	Oxycontin	Celebrex	Flexeril	_____
Lorcet	Percocet	Mobic	Methcarbamol	
Methadone	Tylenol #3	Motrin	Skelaxin	
Morphine	Ultram	Naprosyn	Soma	

B. Medical History

Have you ever had back or neck surgery? Yes No If yes, What type? _____

Past Medical History**:** High Blood Pressure Stroke Diabetes Depression Seizures DVT

Have you have a previous heart attack? YES NO If yes, when was it? _____

Cirrhosis Gastritis HIV/AIDS Other: _____

Is there any chance you might be pregnant? YES NO Are you breastfeeding? YES NO

Are there any current law suits regarding your pain? YES NO

Does anyone in your family have a history of: chronic pain depression substance abuse

Current Medications, Please list medications, dosage and frequency. (If there are additional medications, please ask for an extra medication list.

Medication	*Dosage*	*Frequency*

Pain Injections

Type: _____

Doctor: _____

Location: _____

DOS: _____

Relief: _____

Previous Spine Surgery

Type: _____

Location: _____

DOS: _____

Doctor: _____

Do you take any of the following blood thinners? YES NO (ex: Aspirin, coumadin, plavix) If yes, Which ones? _____

Are you allergic to any medications? YES NO If yes, please list them: _____

_____

Are you allergic to any of the following: Latex IV Dye Shellfish

Review of Symptoms: Have you had any of the following in the past six months?

General	**ENT**	**Cardiovascular**	**Skin**
Weight Loss	Tearing	Chest Pain	Rashes
Weakness	Hearing Loss	Palpitations	
Fatigue	Dizziness	Shortness of Breath	**Endocrine**
Fever	Lightheadedness		Sweating
			Thirsty
Respiratory	**Psychological**	**Genitourinary**	Always Cold
Cough	Depression	Bloody Urine	Always Hot
Coughing up Blood	Anxiety	Urgency Incontinence	
	Mood Swings	Pain with urination	**Hematological**
			Bleeding
GI	**Musculoskeletal**	**Neurological**	Bleeding Clot
Vomiting	Joint Pain	Seizure	
Heartburn	Stiffness	Paralysis	
Constipation	Limp	Numbness	
Diarrhea	Spasms	Tingling	
Bloody Stool	Muscle Pain	Headaches	
Abdominal pain	Muscular Weakness		

C. Social History

Marital Status Single Married Widowed Divorced

Job Status Employed Unemployed Disability Retired

Alcohol Use Yes No How much: _____ **Tobacco Use** Yes No

Marijuana Use Yes No **Drug Use** Yes No

I certify that the above information is correct to best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature Date

HOUSTON
PAIN & SPINE

Financial Policy

Patient Name: _____

We are committed to providing the best possible medical care and experience in our clinic. The intent of this policy is to avoid any misunderstandings or disagreements concerning the prompt payment for services rendered to you.

General Information

- For your convenience, we accept all major credit cards, cash and personal checks.
- We will assist you with insurance questions, however, any specific coverage issues you may have can only be addressed by your insurance company.
- Any outstanding balances are required to be paid before additional treatment can be rendered.

Managed Care Patients

- Our office contracts with a number of insurance companies and for our patients who are participating in these plans, we will submit a claim to your insurance carrier for services rendered. All necessary insurance information and appropriate completed forms must be presented to and verified by our staff prior to your appointment.
- Current insurance information (copy of your card) and identification (driver's license) may be requested/obtained at each visit.
- Payments for co-pays, deductibles and/or any percentage of the charges as specified by an insurance carrier will be collected at the time of service. Co-pays will be collected upon arrival.
    - ***For deductibles and coinsurance, we will do our best to calculate your portion due according to our contract with your insurance. After your insurance company processes your claim you may receive a statement for the remaining amount due.***
    - Payment is expected at time of service for procedures as well as office visits. You may refuse to have the procedure performed for financial reasons. However, refusing the procedure, may impact our ability to provide you the level of health care expected of board certified specialist.
- Your managed care plan may require a referral from your PCP in order to pay for your specialist visit. Please make sure we have received your PCP referral prior to your appointment to ensure that your claim is processed with your insurance company.

Medicare Patients

Your physician accepts Medicare assignments on covered Medicare charges. Payment for the 20% Medicare Co-Insurance amount is expected at the time of service, unless you have supplemental insurance. Medicare may not pay for certain services it determines to be medically unnecessary.

Worker's Compensation Insurance

Validated worker's compensation services are billed either to the employer or the employer's carrier, depending on the company's policy. In the absence of validation by the employer of a work-related injury, the patient will be held responsible for payment for

Financial Policy

Patient Name: _____

services rendered. Should the employer or carrier subsequently deny a validated worker's compensation service such charges will be the financial responsibility of the patient.

Personal Injury Claims
Validated personal injury claims are billed to the attorney or auto insurance on file. Should the carrier subsequently deny a previously validated personal injury claim such charges will be the financial responsibility of the patient.

Self Pay Patients
Self Pay Patients: Houston Pain and Spine welcomes self-paying patients when no insurance coverage is available for our services. Patients who have no insurance are asked to pay full at the time of service. As a self pay patient, you are receiving a discount for paying on the date of service. If for any reason, you may be unable to pay in full at the time of service, speak with the office manager in advance of the visit to determine if reasonable payment arrangements can be established with Houston Pain and Spine.

I have read the above policy that applies to my financial relationship with Houston Pain and Spine. I authorize **Houston Pain and Spine** to file insurance claims on my behalf and to accept assignment of benefits for services rendered to me. I give permission to release the necessary medical information as required by my insurance company for payment purposes.

_____ _____
Patient Signature Date

HOUSTON
PAIN & SPINE

Consent for Treatment

By signing this consent, I am authorizing my physician and/or other individuals, as he or she, deems appropriate to perform and/or order exams, tests, procedures, infusions, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Dr. Asif Chaudhry unless revoked by me orally or in writing.

_____	_____
Patient's Printed Name	Date of Birth
_____	_____
Patient's Legal Representative	Date
_____	_____
Relationship to Patient	Date
_____	_____
Witness	Date

Houston l 2100 West Loop South Suite 400 Houston, TX 77027
Woodlands l 3117 College Park Dr. Suite 210 The Woodlands, TX 77384
P 832.436.4040 **F** 832.436.4050 **W** www.houstonpainandspine.com

HOUSTON
PAIN & SPINE

2100 West Loop South Suite 400 Houston, TX 77027 | 3117 College Park Drive Suite 210 The Woodlands, TX 77374
Phone: 832.436.4040 | Fax: 832.436.4050 | www.houstonpainandspine.com

Disclosure of Ownership

State and federal guidelines may require physicians that may have an ownership interest in a facility to which the physician refers patients disclose the information listed below. In the interest of providing our patients with complete information, we are providing the names of the outside facilities where the physicians of Houston Pain and Spine may have an ownership interest.

Houston Metro Ortho and Spine Surgery Center 4219 Richmond #200 Houston, TX 77027

New Trails Surgical Center	9303 New Trails Dr #175 The Woodlands, TX 77381
Hospital for Surgical Excellence at Oakbend	1211 Hwy 6 Sugar Land, TX 77478

You have the right to choose the provider of your healthcare services. Therefore, you have the option to use a health care facility other than the ones listed above. You will not be treated differently by your physician if you choose to obtain services at a facility other than the ones listed above.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician may have an ownership interest in the facilities listed above.

If you have any questions about this, please contact 832.436.4040 and ask for the practice administrator.

_____ _____

Patient Signature Date

HOUSTON
PAIN & SPINE

Privacy Policy Acknowledgement

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

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative Authority

Houston l 2100 West Loop South Suite 400 Houston, TX 77027
Woodlands l 3117 College Park Dr. Suite 210 The Woodlands, TX 77384
P 832.436.4040 **F** 832.436.4050 **W** www.houstonpainandspine.com

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.
This notice describes our privacy practices. You can request a copy of this notice at any time. For more information about this notice or our privacy practices and policies, please contact the current Privacy Officer at Houston Pain and Spine.

Treatment, Payment, Health Care Operations

Treatment
We are permitted to use and disclose your medical information to those involved in your treatment. For example, the physician in this practice is a specialist. When we provide treatment, we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.

Payment
We are permitted to use and disclose your medical information to bill and collect payment for the services provide to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. The form will contain medical information, such as a description of the medical service provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations
We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we may engage the services of a professional to aid this practice in its compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law.

Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.
Public Health, Abuse or Neglect, and Health Oversight
We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.
We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled.
We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement
We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.
If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided that the information:

- Is released pursuant to legal process, such as a warrant or subpoena;
- Pertains to a victim of crime and you are incapacitated;
- Pertains to a person who has died under circumstances that may be related to criminal conduct;

- Is about a victim of crime and we are unable to obtain the person's agreement;
- Is released because of a crime that has occurred on these premises; or
- Is released to locate a fugitive, missing person, or suspect.

We may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Workers' Compensation

We may disclose medical information as required by the Texas workers' compensation law.

Military, National Security and Intelligence Activities, Protection of the President

We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors

When a research project and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased or a cause of death. Further, we may release your medical information to a funeral director where such a disclosure is necessary for the director to carry out his duties.

Required by Law

We may release your medical information where the disclosure is required by law.

<u>Your Rights Under Federal Privacy Regulations</u>

The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their HIPAA rights.

Requested Restrictions

You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

To request a restriction, submit the following in writing: (a) The information to be restricted, (b) what kind of restriction you are requesting (i.e. on the use of information, disclosure of information or both), and (c) to whom the limits apply. Please send the request to the address and person listed below.

You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

Receiving Confidential Communications by Alternative Means

You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information

You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed below.

We can refuse to provide some of the information you ask to inspect or ask to be copied if the information:

- Includes psychotherapy notes.
- Includes the identity of a person who provided information if it was obtained under a promise of confidentiality.
- Is subject to the Clinical Laboratory Improvements Amendments of 1988.
- Has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make any such review.

Texas law requires that we are ready to provide copies or a narrative within 15 days of your request. We will inform you of when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.
HIPAA permits us to charge a reasonable cost based fee. The Texas State Board of Medical Examiners (TSBME) has set limits on fees for copies of medical records that under some circumstances may be lower than the charges permitted by HIPAA. In any event, the *lower* of the fee permitted by HIPAA or the fee permitted by the TSBME will be charged.

Amendment of Medical Information
You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed below. We will respond within 60 days of your request. We may refuse to allow an amendment if the information:

- Wasn't created by this practice or the physicians here in this practice.
- Is not part of the Designated Record Set?
- Is not available for inspection because of an appropriate denial.
- If the information is accurate and complete.

Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know have the incorrect information.

Accounting of Certain Disclosures
The HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person listed below. Your first accounting of disclosures (within a 12 month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you and you may choose to withdraw or modify your request *before* any costs are incurred.

Appointment Reminders, Treatment Alternatives, and Other Health-related Benefits
We may contact you by both telephone and mail to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

Complaints
If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us. The contact information for the United States Department of Health and Human Services is:
U.S. Department of Health and Human Services
HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

Our Promise to You
We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

Questions and Contact Person for Requests
If you have any questions or want to make a request pursuant to the rights described above, please contact:
Houston Pain and Spine.
Attn Privacy
5420 West Loop South, #2100
Bellaire, Texas 77401

This notice is effective on March 1, 2011

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.