Board Certified • Fellowship Trained
Interventional Pain Specialists
DiagnosticPainCenter.com

DPC DIAGNOSTIC PAIN CENTER

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DID YOU KNOW YOU CAN DO ALL OF THIS ONLINE?

REGISTER YOUR FREE PATIENT PORTAL ACCOUNT AT WWW.DIAGNOSTICPAINCENTER.COM TO GET STARTED.

Today's Date ______________

Patient Information

Name: ______________________________ Social Security Number: ______________

Street Address: ______________________________ Date of Birth: ______________ Age: ______

City/State/Zip: ______________________________ Height: ______________ Weight: ______________ lbs

Email: ______________________________ Gender: ☐ Male ☐ Female

Physical Address Same as Mailing? ☐ Yes ☐ No If not: ______________________________

Preferred Phone: ______________________________ ☐ Home ☐ Mobile ☐ Work

Secondary Phone: ______________________________ ☐ Home ☐ Mobile ☐ Work

Email: ______________________________ Driver's License # / State: ______________

Emergency Contact Name: ______________________________ Phone: ______________ Relationship: ______________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other ______________________________

Primary Care Doctor: ______________________________

Race (Question required by Affordable Care Act): ☐ American Indian or Alaskan Native

☐ Asian or Pacific Islander ☐ African American ☐ Caucasian ☐ Refuse to Report

Ethnicity (Question required by Affordable Care Act): ☐ Hispanic ☐ Non-Hispanic ☐ Refuse to Report

Primary Language: ☐ English ☐ Spanish ☐ Other

Authorization to Leave Messages Concerning Your Care

You may leave messages on my answering machine for the following: (Please check all that apply)

☐ Confirming appointments ☐ Scheduling procedure information ☐ Message to return call

Please list (s) of persons you authorize to take a message from our staff regarding your care:

Name: ______________________________ Phone: ______________________

Name: ______________________________ Phone: ______________________

COMMUNICATION / PATIENT PORTAL:
We intend to notify you of upcoming appointments or procedures. If you do not wish for us to contact you by Email or Text message, there are links to the email as well as the text message that allow you to "opt out." We do not share this information, and it is strictly for the purpose of confirmation / communication. These messages also provide access to setup a PATIENT PORTAL account, which can be used for messages and questions to our staff. Portal access is mandatory for all patients of Diagnostic Pain Center ("DPC"), as it is possibly the only modality of communication in extreme events such as lack of staffing/resources due to pandemics.

ASSIGNMENT OF BENEFITS:
I hereby assign to and authorize payment of all benefits due to me under any insurance policy, worker's compensation plan, auto insurance policy, Medicare, Medicaid, or any other 3rd party payor for any and all services provided by DPC or any of its individual practitioners directly to DPC or its individual practitioners. This assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as the original.

FINANCIAL AGREEMENT:
I understand and agree that all payments for services rendered are due at the time they are performed. I further understand and agree that I am financially responsible for all charges, including all fees assessed under this paragraph, whether or not my insurance provider accepts or denies any claim for payment, and agree to pay all sums due to DPC and/or its individual practitioners at the usual and customary charge for DPC. I understand that I am solely responsible for obtaining any/all referrals required by my insurance carrier in order to see Dr. Robert Marks, Dr. Sauman Rafii, Dr. John Gburek, and/or their associate(s) at Diagnostic Pain Center under the coverage of my insurance carrier. I also understand that if I fail to obtain the proper referral and my insurance declines to cover any date of service or if my insurance declines to cover any date of service for any reason, I am financially responsible for that date of service and agree to promptly pay any fees due for those dates of service. I understand and agree that there is a $50 fee for all missed office visits and a $100 fee for all missed surgical procedures that are not cancelled at least 24 hours in advance. I understand and agree that there is a $25 service fee for any returned checks regardless of reason. I further understand that I must leave a credit card on file with DPC if I wish to pay my bill by personal check. I authorize DPC to charge my credit card for the full balance owed plus applicable service charges if my check is returned for any reason whatsoever. I certify that I am the patient and/or I am financially responsible for the services rendered and do hereby unconditionally guarantee the full payment of the amount when and as due.

____
PRINT NAME: Patient or Guarantor

______________________________ ______________________________
SIGNATURE: Patient or Guarantor Date

Revised 9/11/2021

EXCHANGE OF INFORMATION:
I authorize DPC to disclose to, or obtain from, to the extent allowed by law, my medical and financial record to: (a) any insurance company, attorney, insurance adjuster, employer, or their representatives, agents, or employees that may be responsible for all or part of the payments due for services rendered to the patient; (b) any physician, clinic, hospital, or other healthcare provider who has provided services for me in the past or who may be providing future services (e.g. a consulting physician or a facility at which a procedure is to be performed); (c) the Centers for Medicare and Medicaid Services or any other government agency as required by local, state, or federal law; (d) any person or entity to provide quality and/or utilization review. This authorization can be revoked by submitting a request in writing to Diagnostic Pain Center, 12176 N. Mopac Expy, Ste D, Austin, Texas 78758.

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. We will not provide your medical information to your family, friends, or others not directly involved in your medical treatment unless specifically authorized by you in writing. We will not provide your name or other information for the purposes of marketing or fund raising. We strive to protect your health information, but there are situations where your medical information can be disclosed to others as determined by the Federal Government. Your health information may be provided to others for what the government calls “Treatment, Payment, and Operations.” This includes sharing information with other physicians, providers, or pharmacists, reporting to your insurance company or worker’s compensation carrier, Legal services, training programs, quality improvement programs, and the like. Your medical bills are sent by mail or by computer to the insurance carriers and may be reviewed by a billing company or clearinghouse before being forwarded to the insurance company. Finally, there are exceptions to the privacy agreement; your medical information may be provided to others without your consent in the following situations, as provided by law: (1) State of Texas reporting requirements, including, but not limited to, duty to warn individuals of a threat from a patient, duty to inform the Department of Public Safety after a seizure, or the duty to prevent a disaster; (2) State of Texas reporting requirements for worker’s compensation claims; (3) State of Texas or local county public health activities; (4) Health oversight activities; (5) Legal proceedings; (6) Police investigations; (7) Any information needed on a deceased patient (i.e. by coroners, etc); (8) Any information needed for organ donation; (9) Certain types of research such as quality improvement initiatives (identity will be protected); (10) Any information needed by the government and not subject to privacy protection under Federal or State law. This notice is printed as required by Federal Law.

CONSENT TO TREAT:
I consent to all examination procedures and/or treatments prescribed by my physician and his/her assistant(s) or designee(s) as is necessary by his/her judgment. I recognize that refill authorizations and requests will not be handled outside of regular business hours or on weekends. A photocopy or scanned copy of this agreement shall be considered effective and valid as the original.

WORKER'S COMPENSATION:
I certify that the condition that I am being treated for is not under a Worker's Compensation Claim, or if it is, I have provided a claim closure letter.

PRINT NAME: Patient or Guarantor

____

SIGNATURE: Patient or Guarantor

______________________________ Date ______________________________

Revised 3/23/2022

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Medical Information Release Form

(HIPAA Release Form)

Name: ____________________________________ Date of Birth: _______________

{ } I authorize the release of information including the diagnosis, records, examination rendered to me, billing and claims information as requested. This information may be released to:
{ } Spouse ____
{ } Child(ren) ____
{ } Other ____
OR
{ } Information is not to be released to anyone.

EFFECTIVE TIME PERIOD. This authorization is valid until permission is withdrawn; or the following specific date (optional):

I understand that I have a right to revoke this authorization by providing written notice to ***Diagnostic Pain Center***. However, this authorization may *not* be revoked if ***Diagnostic Pain Center's*** employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may decline by marking the Information is not to be released to anyone box. This will not affect my services.

Signature: ____________________________________ Date: _______________

Print Name: ____________________________________

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof. {Power of Attorney and/or guardianship papers, etc. MUST BE PROVIDED} I am legally authorized to act on the Patient's behalf with respect to this authorization form.

Name of Legal Representative: ______________________________ Date: _______________

Signature of Legal Representative: ________________________________

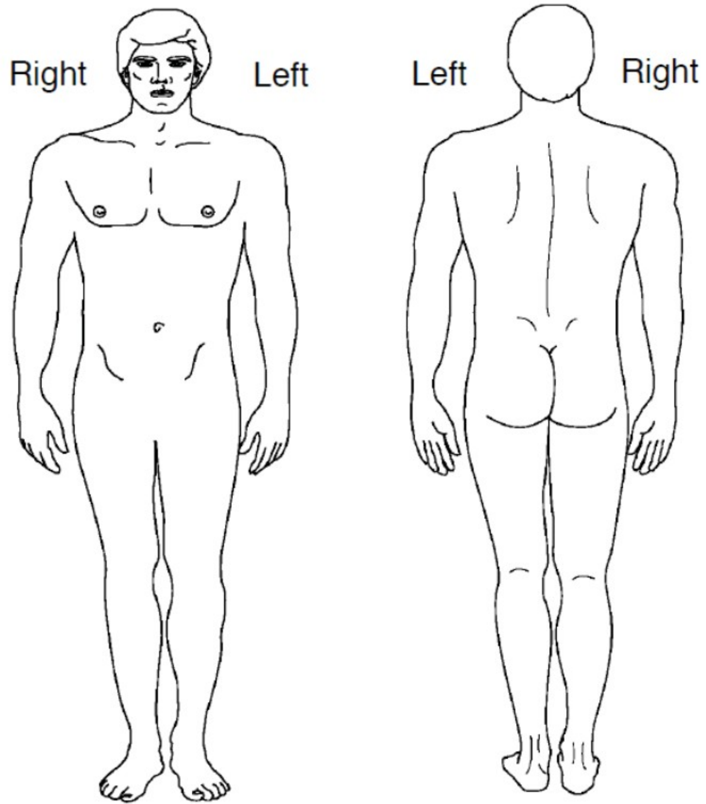
Name of Witness: ________________________________ Date: _______________

Signature of Witness: ________________________________

DIAGNOSTIC PAIN CENTER PATIENT INTAKE **NAME**: ______________________________ **DOB**: ____________

Use this diagram to indicate the location of your pain. Mark the drawing with the following letters that best describe your symptoms:

"N" = Numbness
"S" = Stabbing
"B" = Burning
"P" = Pins and needles
"A" = Aching



Where is your worst pain located? ____

Does this pain radiate? If so, where?____

Please list any additional areas of pain: ____

Onset of Symptoms

Approximately when did this pain begin? ____

What caused your current pain episode? ____

Is your pain the result of a Motor Vehicle Accident or Personal Injury (legal term describing injury sustained to your person by negligence of another) □ Yes □No

How did your current pain episode begin? □ Gradually □Suddenly

Since your pain began, how has it changed? □ Decreased □ Increased □Stayed the same

In the past three months have you developed any new:

□ Balance Problems □ Bladder incontinence □ Bowel incontinence □ Chills

□ Difficulty Walking □ Fevers □ Nausea □ Vomiting

□ Loss of Sensation – Where?________________________□ Loss of Strength – Where? ______________________

□ I HAVE <u>NOT</u> RECENTLY DEVELOPED ANY OF THE ABOVE CONDITIONS.

What aspects of your life are affected by your pain? (Check All That Apply)?

□ Performing activities of daily living □ Engaging in a normal lifestyle

□ Performing work-related activities □ Achieving adequate sleep

Pain Description

Check all of the following that describe of your pain:

□ Aching	□ Hot/Burning	□ Shooting	□ Stabbing/Sharp
□ Cramping	□ Numbness	□ Spasms	□ Throbbing
□ Dull	□ Shock-like	□ Squeezing	□ Tingling
□ Pins & Needles	□ Constant dull/aching background pain with exacerbations as checked above		

What word best describes the frequency of your pain? □ Constant □ Intermittent

When is your pain at its worst? □ Mornings □ During the day □ Evenings □ Middle of the night
□ Progressively worsens throughout the day □ No changes – it's inconsistent or always the same

Use the pain scale described below to rate your pain for the questions below:

0 – Pain-free
1 – Very minor annoyance, occasional minor twinges
2 – Minor annoyance, occasional strong twinges
3 – Annoying enough to be distracting
4 – Can be ignored if you are really involved in your work/task, but still distracting
5 – Cannot be ignored for more than 30 minutes
6 – Cannot be ignored for any length of time, but you can still go to work and participate in social activities
7 – Makes it difficult to concentrate, interferes with sleep, but you can still function with effort
8 – Physical activity is severely limited. You can read and talk with effort. Pain causes Nausea and dizziness
9 – Unable to speak, crying out or moaning uncontrollably, near delirium
10 – Unconscious, pain makes you pass out

0 ← 1 2 3 4 5 6 7 8 9 → 10

______ What number on the pain scale (0-10) best describes your **CURRENT pain**?
______ What number on the pain scale (0-10) best describes your **LEAST pain**?
______ What number on the pain scale (0-10) best describes your **WORST pain**?
______ What number on the pain scale (0-10) best describes your **AVERAGE pain**?

What Makes Your Pain Worse? (Check All That Apply)

□ Bending/Stooping	□ Coughing/Sneezing	□ Driving	□ Lifting
□ Lying FLAT	□ Lying SIDEWAYS	□ Physical Activity	□ Sexual Intercourse
□ Prolonged Sitting	□ Prolonged Standing	□ Straining	□ Stress/Anxiety
□ Twisting	□ Walking	□ Walking UP Stairs	□ Walking DOWN Stairs
□ Looking UP	□ Looking DOWN	□ Looking LEFT	□ Looking RIGHT

□ Other: ____

Diagnostic Tests and Imaging

Mark all of the following tests you have had that are related to your current pain complaints:

□ MRI of the_______________________________ Date:________________ Facility: ___________________
□ X-ray of the______________________________ Date:________________ Facility: ___________________
□ CT scan of the____________________________ Date:________________ Facility: ___________________
□ EMG/NCV study of the______________________ Date:________________ Facility: ___________________
□ Other diagnostic testing: ____
□ I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS.

Past Medication Treatments: Which medications have you tried? (Check all that apply)

Anti-Inflammatories:

□ Aspirin □ Naproxen (Aleve, Naprosyn) □ Ibuprofen (Advil, Motrin) □ Meloxicam (Mobic)
□ Celecoxib (Celebrex) □ Rofecoxib (Vioxx) □ Valdecoxib (Bextra) □ Sulindac (Clinoril)
□ Diclofenac (Arthrotec, Voltaren Gel, Pennsaid) □ Etodolac (Lodine) □ Flector patch □ Ketorolac (Toradol)
□ Indomethacin (Indocin) □ Nabumetone (Relafen) □ Oxaprozin (Daypro) □ Jacabimad (Robama)
□ ORAL Steroids (Medrol Dose-Pak, Prednisone, Methylprednisolone) □ Other: ____________________________

Antidepressants/Anxiolytics:

□ Amitriptyline (Elavil) □ Nortriptyline (Pamelor, Aventyl) □ Duloxetine (Cymbalta)
□ Bupropion (Wellbutrin) □ Citalopram (Celexa) □ Effexor □ Imipramine □ Escitalopram (Lexapro)
□ Fluoxetine (Prozac) □ Paxil □ Pristiq □ Remeron □ Sertraline (Zoloft) □ Serzone □ Trazodone
□ Other: ____________________________

Beta Blockers (For Pain/Headache Purposes):

□ Blocadren (Timolol) □ Inderal (Propranolol) □ Tenormin (Atenolol) □ Toprol (Metoprolol)
□ Corgard (Nadolol) □ Other: ____________________________

Calcium Channel Blockers (For Pain/Headache Purposes):

□ Verapamil □ Other: ____________________________

Muscle Relaxants:

□ Baclofen □ Carisoprodol (Soma) □ Cyclobenzaprine (Flexeril, Amrix) □ Metaxalone (Skelaxin)
□ Methocarbamol (Robaxin) □ Tizanidine (Zanaflex) □ Other: ____________________________

Opioids:

□ Buprenorphine (Butrans Patch, Suboxone, Subutex, Belbuca) □ Codeine (Tylenol #3/#4) □ Zipreant
□ Fentanyl (Actiq, Duragesic Patch, Fentora) □ Hydrocodone (Lortab, Norco, Vicodin, Vicoprofen, Zohydro)
□ Hydromorphone (Dilaudid, Exalgo) □ Methadone □ Morphine (Avinza, Embeda, Kadian, MS Contin)
□ Oxycodone (Oxycontin, Percocet) □ Oxymorphone (Opana, Opana ER) □ Propoxyphene (Darvocet, Darvon)
□ Tapentadol (Nucynta) □ Tramadol (Ultram, Ultram ER) □ Demerol □ Other: _________________________

Triptans:

□ Axert (Almotriptan) □ Frova (Frovatriptan) □ Imitrex (Sumatriptan) □ Maxalt (Rizatriptan)
□ Relpax (Eletriptan) □ Zomig (Zolmitriptan) □ Other: ____________________________

Other:

□ Acetaminophen (Tylenol) □ Depakote (Divalproex) □ Depakene (Valproic Acid) □ Gabapentin (Neurontin)
□ Lidocaine Patch (Lidoderm) □ Lyrica (Pregabalin) □ Tegretol (Carbamazepine) □ Topamax (Topiramate)
□ Fioricet

□ Topical Pain Cream (which one, if known?): ____

□ Other: ____

Pain Treatment History

HOW DO THE FOLLOWING TREATMENTS IMPACT YOUR PAIN?

*** IF YOU HAVEN'T TRIED IT, LEAVE THE ROW BLANK ***

TREATMENT	No Relief	Temporary Relief	Excellent Relief	DATE(S)? (ok to approximate)
Acupuncture				
Physical Therapy				
Chiropractic				
Traction				
TENS Unit				
Heat (Heating Pad; Hot Bath)				
Ice Packs				
Psychotherapy				
Stretching / Yoga				
Massage				
Podiatrist Treatment				
Botox Injections				
Vertebroplasty/Kyphoplasty				
Joint Injections: Which Joint(s):____________________________				
Surgery: Details: ________________________________				
Spinal Cord Stimulator: Circle: Trial / Permanent Implant				
Radiofrequency Ablation (AKA "nerve burning"): Location: ________________________________				
Facet Joint Injection / Medial Branch Block: Circle: Cervical / Thoracic / Lumbar				
Epidural Steroid Injection: Circle: Cervical / Thoracic / Lumbar				
Trigger Point Injections: Where: __________________________________				
Other Nerve Blocks: Which nerve(s):____________________________				

Please describe any further details regarding previous pain treatments: ________________________________

____

____

What **positions** make your pain **better** (i.e., sitting in a recliner, bending forward, etc.): ____________________

What other specialists have you seen regarding your pain? ____

□ I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS.

Anesthesia History

Have **you** ever had any adverse reactions to anesthesia? □ Yes □No

If yes, which type of anesthesia did you have problems with? (Please check all that apply)

□ Local anesthesia □ Epidural □ General Anesthesia □IV Sedation

Has a **family member** ever had any adverse reactions to anesthesia? □ Yes □No

If yes, which type of anesthesia did they have problems with? (Please check all that apply)

□ Local anesthesia □ Epidural □ General Anesthesia □IV Sedation

Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the date, type, and any pertinent details.

Abdominal Surgery

- ◻ Gallbladder removal ________________________
- ◻ Appendectomy ________________________
- ◻ Other ________________________

Female Surgeries

- ◻ Caesarean section ________________________
- ◻ Hysterectomy ________________________
- ◻ Laparoscopy ________________________
- ◻ Ovarian ________________________
- ◻ Other ________________________

Heart Surgery

- ◻ Valve replacement ________________________
- ◻ Aneurysm repair ________________________
- ◻ Stent placement ________________________
- ◻ Other ________________________

Joint Surgery

- ◻ Shoulder ________________________
- ◻ Hip ________________________
- ◻ Knee ________________________

Spine/Back Surgery

- ◻ Discectomy (levels)________________________
- ◻ Laminectomy ________________________
- ◻ Spinal fusion (levels) ________________________

Other Common Surgeries

- ◻ Hemorrhoid surgery ________________________
- ◻ Hernia repair ________________________
- ◻ Thyroidectomy ________________________
- ◻ Tonsillectomy ________________________
- ◻ Vascular surgery ________________________

Please list any other surgeries and dates (attach an additional sheet if necessary):

◻ I HAVE NEVER HAD ANY SURGICAL PROCEDURES.

Current Medications

Please indicate which (if any) of the following blood-thinners you are taking:

◻ Aggrenox ◻ Coumadin / Warfarin ◻ Effient ◻ Lovenox ◻ Plavix ◻ Pletal ◻ Pradaxa ◻ Prasugrel ◻ Ticlid ◻ Aspirin ◻ Other ___________

Please list *all* medications you are currently taking. Attach an additional sheet, if required.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

Allergies

Do you have any known drug allergies? ☐ Yes ☐ No

If so, please list all medications you are allergic to.

Medication Name **Allergic Reaction Type**

____

____

____

____

Topical Allergies: ☐ Iodine ☐ Latex ☐ Tape Are you allergic to shellfish? ☐ Yes ☐ No

Family History

Mark all appropriate diagnoses as they pertain to your biological *MOTHER AND FATHER* only.

	Arthritis	Cancer	Diabetes	Headaches	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Problems	Liver Problems	Osteoporosis	Rheumatoid Arthritis	Seizure	Stroke
Mother													
Father													

Other medical problems: ____

☐ I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY. ☐ I AM ADOPTED (No Medical History Available).

Social History

Are you capable of becoming pregnant? ☐ Yes ☐ No *If so*, are you currently pregnant? ☐ Yes ☐ No

Highest level of education: ☐ Grammar school ☐ High School ☐ College ☐ Post-graduate

Alcohol Use: ☐ Never Drinks Alcohol ☐ Daily Use ☐ Social Use (not daily) ☐ History of Alcoholism ☐ Current / Alcoholic

Tobacco Use: ☐ Current Tobacco User ☐ Former Tobacco User ☐ Has Never Used Tobacco

Illegal Drug Use: ☐ Denies Any Illegal Drug Use ☐ Currently Using Illegal Drugs (Which:________________)
☐ Formerly Used Illegal Drugs (not currently using) (Which:__________________________)
☐ Currently Using Someone Else's Prescription Medications

Have you ever abused narcotic or prescription medications? ☐ Yes ☐ No (Which:___________________)

Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

General Medical

- □ Cancer – Type ______________
- □ Diabetes – Type ____________
- □ HIV/AIDS

Head/Eyes/Ears/Nose/Throat

- □ Headaches
- □ Migraines
- □ Head Injury
- □ Hyperthyroidism
- □ Hypothyroidism
- □ Glaucoma

Cardiovascular/Hematologic

- □ Anemia
- □ Bleeding Disorders
- □ Heart Attack
- □ High Blood Pressure
- □ High Cholesterol
- □ Mitral Valve Prolapse
- □ Murmur
- □ Phlebitis
- □ Poor Circulation
- □ Stroke
- □ Coronary Artery Disease

Respiratory

- □ Asthma
- □ Bronchitis
- □ Emphysema/COPD
- □ Pneumonia
- □ Tuberculosis
- □ Valley Fever

Gastrointestinal

- □ Bowel Incontinence
- □ GERD (Acid Reflux)
- □ Gastrointestinal Bleeding
- □ Constipation

Musculoskeletal

- □ Amputation
- □ Bursitis
- □ Carpal Tunnel Syndrome
- □ Chronic Low Back Pain
- □ Chronic Neck Pain
- □ Chronic Joint Pain
- □ Fibromyalgia
- □ Joint Injury
- □ Osteoarthritis
- □ Osteoporosis
- □ Phantom Limb Pain
- □ Rheumatoid arthritis
- □ Tennis Elbow
- □ Vertebral Compression Fracture

Genitourinary/Nephrology

- □ Bladder Infection(s)
- □ Dialysis
- □ Kidney Infection(s)
- □ Kidney Stones
- □ Urinary Incontinence

Hepatic

- □ Hepatitis A (active/inactive/unsure)
- □ Hepatitis B (active/inactive/unsure)
- □ Hepatitis C (active/inactive/unsure)

Neuropsychological

- □ Alcohol Abuse
- □ Alzheimer Disease
- □ Bipolar Disorder
- □ Depression
- □ Epilepsy
- □ Prescription Drug Abuse
- □ Multiple Sclerosis
- □ Paralysis
- □ Peripheral Neuropathy
- □ Schizophrenia
- □ Seizures
- □ Reflex Sympathetic Dystrophy/CRPS
- □ Other Diagnosed Conditions

____

Review of Systems

Mark the following symptoms that you currently suffer from. *Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.*

Constitutional:

- □ Chills
- □ Difficulty Sleeping
- □ Easy Bruising
- □ Excessive Sweating
- □ Excessive Thirst
- □ Fatigue
- □ Fevers
- □ Insomnia
- □ Low Sex Drive
- □ Night Sweats
- □ Tremors
- □ Unexplained Weight Gain
- □ Unexplained Weight Loss

Eyes:

- □ Recent Visual Changes
- □ Vision Loss

Ears/Nose/Throat/Neck:

- □ Dental Problems
- □ Earaches
- □ Hearing Problems
- □ Nosebleeds
- □ Recurrent Sore Throats
- □ Ringing in the Ears
- □ Sinus Problems

Cardiovascular:
□ Bleeding Disorder
□ Chest Pain
□ Deep Vein Thrombosis
□ Fainting
□ High Blood Pressure
□ Irregular Heartbeat
□ Lightheadedness
□ Shortness of Breath During Sleep
□ Swelling in the Feet

Respiratory:
□ Cough
□ Wheezing
□ Pulmonary Embolism
□ Shortness of Breath on Exertion/Effort
□ Shortness of Breath at Rest

Gastrointestinal:
□ Abdominal Cramps
□ Acid Reflux
□ Constipation
□ Coffee Ground Appearance in Vomit
□ Dark and Tarry Stools
□ Diarrhea
□ Hernia
□ Vomiting

Musculoskeletal:
□ Back Pain
□ Joint Pain
□ Joint Stiffness
□ Joint Swelling
□ Muscle Spasms
□ Neck Pain

Genitourinary/Nephrology:
□ Blood in Urine
□ Painful Urination
□ Decreased Urine Flow/Frequency/Volume
□ Flank Pain

Neurological:
□ Tremors
□ Dizziness
□ Headaches
□ Numbness/Tingling
□ Seizures

Psychiatric:
□ Depressed Mood
□ Feeling Anxious
□ Stress Problems
□ Suicidal Thoughts
□ Suicidal Planning

I certify that the information that I provided in this document is accurate, complete and true.

Signed:____ Date: _______________________

OPIOID RISK TOOL

Circle YES or NO

1. **Family History of Substance Abuse**

Alcohol	YES	NO
Illegal Drugs	YES	NO
Prescription Drugs	YES	NO

2. **Personal History of Substance Abuse**

Alcohol	YES	NO
Illegal Drugs	YES	NO
Prescription Drugs	YES	NO

3. **Age** (Mark box if 16 – 45) Age_____

4. **History of Preadolescent Sexual Abuse** YES NO

5. **Psychological Disease**

Attention Deficit Disorder	YES	NO
Obsessive Compulsive	YES	NO
Bipolar	YES	NO
Schizophrenia	YES	NO
Depression	YES	NO

I certify that the above information is correct to the best of my knowledge.

Name: ____ Date of Birth: _______________

Signature: ____ Date: _______________

CTRL#: FiABD-MiCCD-BiiCDE-BiiiA-iVFCM0-BVBBB-A / MOD#:47 Rev 9/2021

Diagnostic Pain Center, Austin, TX

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT

AS REQUIRED BY THE TEXAS MEDICAL BOARD

REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9, CHAPTER 170

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 to treat my condition which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent to administer or prescribe the 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).

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.

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 have been informed that the drug therapy that my physician may prescribe for me may involve using a drug that the Federal Food and Drug Administration may not have been asked by the manufacturer to review for safety for effectiveness for my condition. Current medical literature shows that such "off label" use may be beneficial to some patients and I understand that recommended dosages for treating chronic pain are often exceeded in order to balance the benefit and risk to the patient.

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 MANAGEMENT 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), 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.**

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Patient Signature

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Physician Signature (or Appropriately Authorized Assistant)

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Name and contact information for pharmacy