

Texas Interventional Pain Care
Arif B. Khan M. D.

Registration Information:

Patient Last Name: _____ First Name: _____ Middle: _____ Date of Birth: ____/____/____
 Home Phone: _____ Cell Phone: _____ Sex: Male /Female Marital Status: _____
 Mailing Address: _____ Email: _____
 City: _____ State: _____ Zip: _____
 Social Security Number: _____ Driver's License Number: _____
 Employer Name: _____ Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Primary/Referring Physician: _____ Phone Number: _____
 Emergency Contact Name: _____ Phone Number: _____

Provider the following information if guarantor is different than patient

Guarantor/Attorney Name: _____
 Phone: _____ Social Security Number: _____
 Mailing Address: _____ Date of Birth: _____
 City: _____ State: _____ Zip: _____ Relationship: _____

Primary Insurance-circle PPO HMO Medicare WC LOP	Secondary Insurance-circle PPO HMO Medicare WC LOP
Company Name: _____	Company Name: _____
Claims Address: _____	Claims Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____	Phone: _____ Fax: _____
Policy/ID: _____ Group: _____	Policy/ID: _____ Group: _____
Insured Name: _____ DOB: _____ Sex: _____	Insured Name: _____ DOB: _____ Sex: _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Employer: _____ Phone: _____	Employer: _____ Phone: _____
Address: _____ State: _____ Zip: _____	Address: _____ State: _____ Zip: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Employer: _____ Phone: _____	Employer: _____ Phone: _____
Address: _____ State: _____ Zip: _____	Address: _____ State: _____ Zip: _____

Authorization for Treatment and Insurance Authorization:

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I permit Dr. Arif Khan to administer necessary and advisable diagnosis and treatment to me.

I hereby authorize **Texas Interventional Pain Care/Princeton Anesthesia** to apply for benefits on my behalf for covered services rendered by him. I request that payment from my insurance company be made directly to Texas Interventional Pain Care/Princeton Anesthesia. Our office files insurance claims as a courtesy and in no way releases the patient from responsibility of his/her bill. By signing below the patient agrees to accept responsibility for his/her bill in the event that insurance denies or partially pays for the claim. I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Thank you for your cooperation, patience, and understanding and for placing your care with us.

Date: _____

Signature: _____

SOAPP Version 1.0-14Q

Name: _____ Date: _____

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = NEVER, 1= SELDOM, 2= SOMETIMES, 3= OFTEN, 4= VERY OFTEN

- | | | | | | | |
|-----|--|---|---|---|---|---|
| 1. | How often you have mood swings? | 0 | 1 | 2 | 3 | 4 |
| 2. | How often do you smoke a cigarette within an hour after you wake up? | 0 | 1 | 2 | 3 | 4 |
| 3. | How often have any of your family members, including parents and grandparents had a problem with alcohol or drugs? | 0 | 1 | 2 | 3 | 4 |
| 4. | How often have any of your close friends had a problem with alcohol and drugs? | 0 | 1 | 2 | 3 | 4 |
| 5. | How often have others suggested that you have a drug or alcohol problem? | 0 | 1 | 2 | 3 | 4 |
| 6. | How often have you taken medication other than the way that it was prescribed? | 0 | 1 | 2 | 3 | 4 |
| 7. | How often have you been treated for an alcohol or drug problem? | 0 | 1 | 2 | 3 | 4 |
| 8. | How often have your medications been lost or stolen? | 0 | 1 | 2 | 3 | 4 |
| 9. | How often have others expressed concern over your use of medications? | 0 | 1 | 2 | 3 | 4 |
| 10. | How often have you felt a craving for medications? | 0 | 1 | 2 | 3 | 4 |
| 11. | How often have you been asked to give a urine screen for substance abuse? | 0 | 1 | 2 | 3 | 4 |
| 12. | How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years? | 0 | 1 | 2 | 3 | 4 |
| 13. | How often, in your lifetime, have you had legal problems or been arrested? | 0 | 1 | 2 | 3 | 4 |

Please include any additional information you wish about the above answers. Thank you.

Texas Interventional Pain Care, PA
2201 N. Central Expressway
Suite 171
Richardson, Texas 75080

Date: _____

Name: _____ Date of Birth: _____

Please List your Current Medications:

Medication Name:	Dosage:	Directions:	Provider Name:

Please List any recently discontinued medications:

Medication Name:	Dosage:	Directions:	Reason Discontinued:

List Any Drug Allergies: If None, then mark the box for None

INITIAL the box below if the following apply:

NOT TAKING ANY PRESCRIBED MEDICATIONS

Texas Interventional Pain Care, PA
2201 N. Central Expressway Ste. 171
Richardson, Texas 75080
972-952-0290

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Date: _____

I have reviewed Texas Interventional Pain Care, PA Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this if requested.

Patient Name (Print)

Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below.

Personal Representative (Print)

Personal Representative Signature

CONSENT TO RELEASE INFORMATION
(People we can speak to on your behalf)

I understand that to disclose my PHI. Texas Interventional Pain Care PA, must have my consent, therefore, I authorize Texas Interventional Pain Care, PA to disclose my PHI as described in the above forms, to the recipients listed below.

Name (s) of the person(s) authorized to obtain medical information, such as procedure, test results, appointment, surgeries, medication refills, or billing questions. (e.g., Physician other than your referring doctor)

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

May we leave a detailed message on your answering machine or voice mail? YES NO Failure to check one of these boxes may delay results.

Home# _____

Cell# _____

Patient Signature

Date

Patient Representative Signature

Date

AUTHORIZED FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize: _____

To release to: **Texas Interventional Pain Care, PA**
2201 N. Central Expressway, Ste 171
Richardson, Texas 75080
972-952-0290 Fax: 972-952-0293

The following information from the medical records of:

Patient Name: _____ **Date of Birth:** _____

Information to be released:

All Medical Records EKG/Echo Reports Medication List Physical Therapy Records
Lab Results Reports ER Records Itemized Bills CT/MRI Imaging Reports

The information specified above is being requested for the purposes of:

Patient's Request Attorney's Request Consultation and Treatment
Billing/Claims Social Security Administration Other _____

Drug/Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing records contain any of the above underlined information or any of my other sensitive information, I agree to its release. Check one: Yes No _____ Initial Please.

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at the above address. This authorization will automatically expire 180 days from the date of my signature or unless revoked prior to that time or unless otherwise specified as follows _____.

Re-Disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Information Portability and Accountability Act of 1996. The facility, its employees, officers, and physicians, are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative

I understand that Texas Interventional Pain Care, PA may not condition my treatment whether I sign this authorization form. I authorize Texas Interventional Pain Care, PA to use and disclose the protected health information as specified above. I further understand that a reasonable copy fee may be charged for record copies.

Signature Required: of Patient or Legal Representative

Date

Texas Interventional Pain Care, PA
Arif B. Khan, M.D.
Financial Policies

We are dedicated to providing the best possible care and service to you with the best possible customer service. Your complete understanding of your responsibilities is an essential element of your care and treatment. If you have any questions about the following policies, please do not hesitate to discuss them with us.

Despite a large public misconception, the physician has very little decision-making when it comes to your health insurance and how these services are paid. The ONLY decision this practice makes is whether or not to accept your insurance carrier and become an in network provider. Once the contract is signed, the physician/practice is legally bound to rigidly follow the contract or be subject to criminal (jail time), civil (fines/penalties), or administrative (loss of License) penalties. How the claim/services are paid and how much the fees are paid are NOT determined by the physician/practice but have been predetermined by your insurance carrier and your selected plan. How the claim is coded is set by established rules from your insurance carrier and government, and the physician is required to closely adhere to these rules and regulations.

The patient is responsible for all accounts, regardless of insurance coverage. We make every effort to verify your benefits and coverage but every insurance plan is unique, and despite what information was verified, your insurance carrier makes the final decision. Therefore, we encourage our patients to be pro-active in assuring that claims are paid.

Per our insurance carrier and our contract, you are responsible to pay for all co-payments, deductibles, patient percentages, ect. **at the time of service** with no exceptions. This means you will be responsible for paying your **estimated deductible at the time of service.**

Self-Pay Patients: This office does not accept any payment plans for services rendered on self-pay patients and all balances are due at the time of service.

Outside Services: This office does routinely use outside services (laboratories, imaging centers, physical therapy, etc.) to provide you with the highest level of medical care possible. Please understand that any fees accrued by these outside facilities will fall under your insurance policy, and are not part of this office.

Cancellation Policy: It is the office policy to bill the patient (not the insurance company) a \$25.00 fee for any missed appointment without 24-hour prior cancellation. This amount must be paid in full prior to scheduling another appointment. As a courtesy to the patient, we will make reasonable attempts to confirm appointments. Since this is not always possible, it is the patient's responsibility for keeping track of the appointment. Please call us as early as possible if you need to reschedule your appointment.

Medical Records: A copy of medical records will be furnished to a physician or patient upon written request from the physician or patient. An authorization for Release of Medical Records form must be completed and signed by the patient. A fee will be assessed to the patient of \$25.00 for this request and must be paid in full prior to release of records. Please allow five (5) business days for these copies.

I have read and understand the financial policies of the practice. I hereby authorize any and all insurance benefits be paid directly to the Physician and acknowledge that I am financially responsible **for any unpaid balance.** I also authorize the Physician to release any information required by any insurance company, worker's comp, or Law firms.

Printed Name of Patient

Date:

Signature of Patient or Responsible Party:

Relationship

ARIF B. KHAN, M.D.
TEXAS INTERVENTIONAL PAIN CARE, P.A.
2201 N CENTRAL EXPRESSWAY, SUITE 171
RICHARDSON, TX 75080
TEL: 972-952-0290
FAX: 972-952-0293

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT

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 the word "physician" is defined to include not only my physician but also my physician's authorized associates technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat my condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician (name at bottom of agreement) to treat my condition which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent 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 medication supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction any 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 a vehicle or other machinery while using these medications and I could 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 have the right to express if 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 on 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 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 Drug Administration may not 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 result of any drug therapy or cure of any condition. The long-term use of medication s to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have 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.

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 following guidelines and/or conditions may cause discontinuation of medication(s) and/ or my Discharge from care 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 except to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.
- I will receive my 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 physicians. 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 the 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 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 presents 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 detail 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 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 substances 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 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. After 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. After Dr. Khan clearly and fully explains the benefits and risks of any necessary prescribed medications in the treatment of my chronic pain I agree to the appropriate use and to follow the instructions as prescribed. I understand I must get approval from Dr. Khan if I want to change the instructions of any prescribed medication.

Patient Signature Date

Physician Signature (or Appropriately Authorized Assistant) Date

Name and contact information of your Pharmacy Phone Number