TEXAS PAIN PHYSICIANS

WELCOME LETTER

We would like to welcome you to Solar Health Pain Management (SHPM) DBA Texas Pain Physicians (TPP). It is our goal to get to know you and be able to provide you with the appropriate care in order to treat you so please read all forms in their entirety.

Our facility offers Pain Management and other medical/health related services. We have a team of pain management that is dedicated to provide you with the most comprehensive and conservative care possible. Based on the clinical findings found in your exam these services might be indicated to benefit you. It is ultimately your right to choose whether you receive these services or not. Our doctors are determined to provide you with the best care possible. We have found that a synergistic team approach has been very effective at attaining optimal results.

Each Clinician is trained to treat conditions related to the Neuro-Musculoskeletal System and some of the doctors have completed advanced training in Pain Management.

We will continue to strive to be able to offer you the best care possible and get you on the journey to live a pain free lifestyle with optimal wellness and preventative care.

I understand that my prescriptions must be obtained at the same pharmacy. I agree to notify the office if the need arises to change pharmacies.

I have received a copy of the office policies for the facility named above.

I have read and understand these documents and agree to follow these policies to the best of my ability.

I understand that if I fail to abide by these policies I may be discharged from treatment.

The clinicians who you will be seeing are the following:

Dr. Whitney Chouteau DO

Paula Trunnell NP

By signing this you agree to be treated at our facility by all the different practitioners.

Sincerely,

_____ _____

Patient Signature of Acknowledgement Date

6750 North MacArthur Blvd #151
Irving, TX 75039
P: 972.559.3501 F: 972.559.3529

PATIENT INFORMATION

First Name _____ MI _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Social Security # _____ Date of Birth _____ Race _____ Sex _____

Marital Status S M D W (Circle One) Language:_____ Ethnic Group:_____

Home Phone _____ Cell Phone _____

Employer _____ Work Address _____

City/State _____ Zip _____ Work Phone _____

Email _____ Driver's License # _____

Emergency Contact _____ Phone _____

How were you referred to this office? _____

Is this injury related to: Auto Accident Work Injury Other Accident Illness Unknown cause

Date of Illness/Injury _____ Date Symptoms Appeared _____

Have you seen another doctor or clinic for this illness/injury? Yes No
If Yes, doctor or clinic's name and specialty _____

INSURANCE INFORMATION

Do you have health insurance? _____ Name of Provider _____

Address _____ Phone _____

Insured's Name _____ Relation to patient _____

Insured's date of birth _____ SS# _____

Require a Referral: Yes/No Copay _____ Subscriber ID_____: Group # _____

Are you covered under any other health plan through yourself or your spouse? _____

IF YOUR INJURY WAS AUTO OR WORK RELATED COMPLETE THE FOLLOWING INFORMATION

Patient's Auto/Work Comp Insurance Co. _____ Policy #_____

Claim # _____ Phone # _____ Adjuster's Name _____

Address _____ Uninsured Motorist Coverage? Yes No

PIP Coverage? Yes No Med Pay Coverage? Yes No

Attorney's Name:_____Attorney's Phone:_____

Comprehensive Intake Form
History and Physical Page 1

Please take a few minutes to complete this worksheet, This Information will help us in providing your care.

Name:_____
Date of Birth:_____ Sex:_____
Height:_____ Weight:_____
Phone Number:_____

Medical History:

Have you ever had or been told you have (Check all that apply)

Cardiovascular:
[ ] Chest Pain or angina
[ ] Heart Disease
[ ] MI, Heart attack, Blocked artery
[ ] Congestive heart failure
[ ] High Blood Pressure
[ ] Peripheral vascular disease
[ ] Abnormal heart beat
[ ] Pacemaker
[ ] Angioplasty or Heart Cath
[ ] Rheumatic fever
[ ] Damaged heart valve

Neurological:
[ ] Epilepsy or seizures
[ ] Fainting spells or dizziness
[ ] Stroke_____
[ ] Headaches/Migraines

Gastrointestinal:
[ ] Ulcers, heartburn, reflux
[ ] Diverticulitis or Colitis
[ ] Other:_____
Cancer:_____

Other:
[ ] Chronic Numbness or pain
[ ] Depression or Anxiety
[ ] Other Nervous problems
[ ] Dentures [ ] Partial Plate

Respiratory:
[ ] Asthma
[ ] Shortness of breath
[ ] Emphysema
[ ] TB

Metabolic:
[ ] Diabetes _____
[ ] Thyroid disease
[ ] Adrenal gland problem
[ ] Steroid use _____

Liver/Kidney/Blood:
[ ] Kidney disease
[ ] Shunt, graft, fistula
[ ] Dialysis
[ ] Liver disease
[ ] Gallbladder
[ ] Hepatitis (Type_____)
[ ] Anemia
[ ] Easy bruising or bleeding
[ ] Anticoagulants (Blood Thinners)
[ ] Back injury or nerve damage
[ ] Skin Condition_____
[ ] Arthritis, rheumatism
[ ] Glasses [ ] hearing aid

Social/Family History: Marital Status S M D W Separated
Mother: Living/Deceased Cause:_____
Father: Living/Deceased Cause:_____
Alcohol _____Drinks per day Other drug use:_____

Employment Status: [ ] Employed Full time
[ ] Employed Part Time [ ] Retired
[ ] Self Employed [ ] Unemployed due to pain
[ ] unemployed for other reasons [ ] Disability
Occupation: _____

Are there any legal/occupational issues pending in regard to your pain condition?
Yes or No If yes what is it?_____

With whom do you live? [ ] Self [ ] Spouse [ ] Children
[ ] Parents [ ] Friends [ ] Other

Allergies: **Reaction:**

_____
_____
_____
_____

Have you or any of your blood relatives ever Had a reaction to anesthesia? Yes or No
_____

All medication you take at home:
Medication: Dose: How often:

_____
_____
_____
_____
_____
_____
_____

Previous Surgeries (Please include date)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Any problems with surgery or anesthesia?
Yes or No _____
_____

ROS: Please check the box if you are currently having any of the following:
[ ] fever, Weight loss, Sweats
[ ] Cough, Sputum production, wheeze
[ ] Weakness or paralysis of arms and legs
[ ] Headaches How often? _____
[ ] Dizziness, vision change, lightheadedness
[ ] Swelling or rash _____
[ ] Abdominal Pain
[ ] Change in bowel habits, Nausea
[ ] Chest Pain, Palpitations
[ ] Pregnant or possibly pregnant?

Comprehensive Intake Form
History and Physical Page 2

Where is most of your pain? _____
_____

Does it go anywhere else? Yes or No
If so where?:_____
When did your pain start? _____
How long have you had this pain? _____
Did it start _____Gradually _____Suddenly _____Not sure

How often do you experience this pain?
_____Constant _____Comes and Goes

Is your pain getting, ____Better _____Worse
_____Staying the same

Have you had any X-rays or MRIs done? Yes or No
If so, where at? _____
_____

Check what most describes your pain?

[ ] Aching [ ] Cramping [ ] Dull
[ ] Hot/Burning [ ] Numbing [ ] Pins/Needles
[ ] Pressure [ ] Sharp [ ] Shooting
[ ] Stabbing [ ] Throbbing [ ] Tingling

Rate your pain at its worst:
No pain 1 2 3 4 5 6 7 8 9 10 Excruciating

Rate your pain at its Best:
No pain 1 2 3 4 5 6 7 8 9 10 Excruciating

Rate your pain on average:
No pain 1 2 3 4 5 6 7 8 9 10 Excruciating

Rate your pain at the moment:
No pain 1 2 3 4 5 6 7 8 9 10 Excruciating

What makes your pain worse?

[ ] Bending [ ] Changing Position
[ ] Defecation [ ] Going up stairs
[ ] Heat [ ] Going down stairs
[ ] Increased Activity [ ] Lying Flat
[ ] Lifting [ ] Movement
[ ] Sitting long time [ ] Sneezing
[ ] Standing Long [ ] Standing straight
[ ] Turning to the Left [ ] Turning to the Right
[ ] Turning side to side [ ] Walking

What makes your pain better?

[ ] Assistive devices [ ] Changing Position
[ ] Cold [ ] Exercise
[ ] Heat [ ] Injections
[ ] Massage [ ] Lying Flat
[ ] Manipulation [ ] Medication
[ ] Physical Therapy [ ] Rest
[ ] Sitting [ ] Standing
[ ] Walking

What treatments have you tried?

[ ] Exercise [ ] Massage
[ ] Chiropractic [ ] Acupuncture
[ ] Brace [ ] Physical Therapy
[ ] Heat [ ] Ice
[ ] Nerve Block [ ] Biofeedback
[ ] TENS unit [ ] Traction
[ ] Psychologist [ ] Psychiatrist
[ ] Surgery

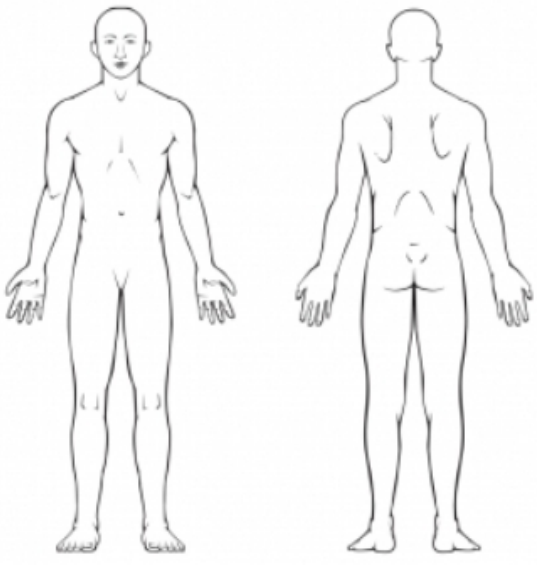
What medications have you tried (Circle)
NSAIDS: Aspirin, Ibuprofen, Advil, Motrin
Relaxants: Flexeril, Valium, Xanax, Ativan
Sleep Medicines: Ambien ,Restoril, Benadryl
Antidepressants: Elavil, Amitriptyline, Prozac, Effexor, Zoloft, Deseryl, Paxil, Pamelor
Narcotics: Vicodin, Darvocet, Tylenol 3, Tylon-Codeine, Percocet, Percoden, MS Contin, Oxy, Demerol, Morphine, Dilaudid, Methadone
Neuropathic Medication: Neurontin, Klonopin Tegretol, Dilantin, Baclofen, Ultram

[ ] Smoking: Now or Past
_____packs per day

On the Diagram, Please shade in the areas

Where you have pain?

Right Left Left Right



ASSIGNMENT OF BENEFITS

SOLAR HEALTH PAIN MANAGEMENT (SHPM) DBA TEXAS PAIN PHYSICIANS (TPP),

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to the physician or facilities named above the following rights, power and authority.

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjuster, for purposes of processing my claims for benefits and payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy including the exclusive irrevocable right to collect payment for such services, make demand in my name for payment and prosecute and receive penalties, interest, court costs or other legally compensable amounts owed by an insurance company in accordance with Article 21:55 of the Texas Insurance Code or other applicable insurance or state statute. I, as the patient and/or responsible party, further agree to cooperate, provide information as needed and appear as needed wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above, you are hereby tendered demand to pay in full the bill for serviced rendered by the physician/facility named above within 60 days following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy for benefits, less any amount which I/we personally owe which are not payable under the terms of the policy. This demand specifically conforms with Article 21:55 of the Texas Insurance Code, providing attorney fees, 18% penalty, court costs and interest from judgment upon violation.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to dispense a separate draft to pay in full all services rendered payable directly to the physician/facilities named above.

STATUTE OF LIMITATIONS: I waive my rights to claim statute of limitations regarding claims for services rendered or to be rendered by the physician/facilities named above, in addition to reasonable costs of collection, including attorney fees and court costs if incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facilities named above the power to endorse my name upon any checks, drafts or other negotiable instrument representing payment from any insurance company representing payment for treatment and health care rendered by physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our address upon request in writing to the physician/facility named above.

TERMINATION OF CARE WAIVER: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic or facilities, he/she has the full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If, during the course of care, my insurance company requires me to take an examination from any other doctor, I will notify this physician/facility immediately. I understand that failure to do so may jeopardize my case.

A photocopy of this instrument will serve as the original.

Print Name:_____ Date:_____

Signature of Patient:_____

Witness Signature:_____ Date:_____
(For Office Staff only)

6750 North MacArthur Blvd #151
Irving, TX 75039
P: 972.559.3501 F: 972.559.3529

Member Authorization form for Designated Representative to Appeal a Determination

Date:_____

Member Name:_____

Member #:_____

I hereby authorize **my provider** to appeal the determination concerning adjudication of claims billed out for services provided to me on my behalf, as my Designated Representative, and, as part of the claim appeal process.

I hereby allow my health insurance carrier, in its decision letter and in connection with the processing of my appeal, to communicate with my Designated Representative in all aspects of the appeal.

I understand this information is privileged and confidential and will only be released as specified in this authorization, or as required or permitted by law. This authorization is valid for the entire period of 1 year form the last date of service.

_____

Signature of Member or Legal Guardian

Solar Health Pain Management (SHPM) DBA Texas Pain Physicians (TPP)
6750 North MacArthur Blvd #151
Irving, TX 75039
P: 972.559.3501 F: 972.559.3529

OUT – OF –NETWORK ADVANCED PATIENT NOTICE

We welcome you to our medical practice and facilities. Solar Health Pain Management (SHPM)) DBA Texas Pain Physicians (TPP), has some services that are out of network for your insurance.

Your health insurance provides you with out of network benefits which allows you to receive full medical care by a non-participating physician or facility. If you would like to locate a participating provider, please contact your health insurance company.

TO BE COMPLETED BY PATIENT OR PATIENTS LEGAL GUARDIAN.

By placing my signature on this form, I acknowledge the following:

1. I was made aware that any medical services provided such as Anesthesia, or injections performed at different surgery centers are covered by my Out of network Benefits provided by my health insurance and will be billed out as Out of Network Claims.

2. I understand that I may be responsible for costs for services provided as specified in my out of network benefit plan and that absent financial hardship, the provider is prohibited from waiving deductibles, co-pays and co-insurances.

3. I was given an opportunity to contact my health insurance plan before obtaining services.

4. I am voluntarily choosing to obtain services and procedures from Integrated Hospital Specialists and affiliated Out of Network facilities.

Print Patient Name: _____ Date: _____

Patient Signature/Legal Guardian: _____

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MEDICAL OFFICE
FINANCIAL POLICY

We believe that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy. This policy applies to the following clinics or facilities; Texas Pain Physicians, Solar Health Pain Management and Integrated Hospital Specialists.

1. PAYMENT is expected at the time of your visit. We will accept cash, certified check and credit/debit card payments. Effective September 1, 2016 we will no longer accept personal checks. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause or grace period, payment in full is expected at the time of your visit. We do ask for a copy of an ID card or license due to the many cases of identity theft in the news lately. (Please do not be offended!)

2. INSURANCE We are participating providers with many insurance plans. We will file insurance claims on your behalf as a courtesy.

Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you may be billed.

If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage though we will make every effort to do so. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. You are responsible for obtaining a properly dated referral if required by your insurer and will be responsible for payment if your claim rejects for the lack of one.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

Patients who insist on "day of" urgent/emergent scheduling or care after hours or on days the clinic is closed will be assessed an additional urgent care or after hours' fee. These fees will be billed to your insurance carrier or collected as part of the office charges for self-pay patients.

3. FORMS FEES: completing insurance forms, copying medical records, etc. Requires office staff time and time away from patient care for our doctors. We require pre-payment for completing forms, copying medical records, notarizing, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. Base form charges are $10 per occurrence plus and applicable postage or notary fees. Postage is additional and payment is required in advance. Fees for Medical Records is $25 for the first twenty (20) pages and $0.50 per page in excess of twenty. The office asks to allow 5-7 business days in which to copy records before making them available for patient to pick up, and these 5-7 days will commence after payment has been received and after patient has signed this form authorizing records' release.

4. CANCELLATIONS OR MISSED APPOINTMENTS: If you do not cancel your appointment at least 24 hours before, or if you no-show, we will assess a $25 missed appointment fee for Office Visits and a $50 missed appointment fee for Injections or Procedures.

5. RESPONSIBILITY FOR PAYMENT: I understand that I, personally, am financially responsible for charges not covered by the assignment of insurance benefits.

6. INSURANCES WE WON'T BILL/PATIENTS WE WON'T ACCEPT INTO THE PRACTICE: I am not currently eligible for, Medicaid, I will notify the office in writing immediately if I become eligible for any of these payors, thus terminating my care from the office, who WILL NOT accept new patients with Medicaid, nor bill these payors if patients switch after becoming established with the office.

7. RELEASE OF INFORMATION: I hereby authorize and direct the office to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

8. INSURANCE ASSIGNMENT: I hereby authorize payment to be made directly to my provider by my insurance company for any charges for services covered by the terms of my policy. I agree to cooperate, aid and assist the facility in procuring all possible insurance benefits initiation and fulfillment of all policy provisions such insurance companies may require for payment.

I have read and understand the practice's financial policy and I agree to be bound by its terms.
I also understand and agree that such terms may be amended by the practice from time to time.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Date
Witness Signature	Date

Patient Authorization

Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed - The information covered by this authorization includes:

_____

_____

Persons Authorized to Use or Disclose Information - Information listed above will be used or disclosed by:

_____
Name of Person Organization

_____
Name of Person Organization

Expiration Date of Authorization - This authorization is effective through _____ unless revoked or terminated by the patient or patient's personal representative.

Patient Rights

Right to Terminate or Revoke Authorization - You may revoke or terminate this authorization by submitting a written revocation to this office and contact the Privacy Officer.

Potential for Re-disclosure - Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations. I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

If you understand and agree with all of the above policies, please sign your name below.

_____ _____
Patient Signature Date

_____ _____
Print Patient's Full Name Time

_____ _____
Witness Signature Date

Notice to Patient

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment, if you wish.

_____ _____
Patient or Legally Authorized Individual Signature Date

_____ _____
Print Patient's Full Name Time

For Staff Use Only

[ ] The Patient refused to sign
[ ] Due to an emergency situation it was not possible to obtain a signature
[ ] We weren't able to communicate with the patient
[ ] Other (Please provide specific details)

_____ _____
Employee Signature Date

6750 North MacArthur Blvd #151
Irving, TX 75039
P: 972.559.3501 F: 972.559.3529

REQUEST FOR MEDICAL RECORDS

TO: _____
ATTN:_____
FAX #: _____

Hello, we are requesting records for the following Patient;

Name:_____

DOB:_____ SS#: _____

- ☐ Dictation Note DOS: _____
- ☐ MRI Report
- ☐ X-Ray Report
- ☐ CT Report
- ☐ All Medical Records
- ☐ All Radiology Reports
- ☐ All Dictation Notes

I hereby request that my medical records be released to;

6750 North MacArthur Blvd #151
Irving, TX 75039
PH: ____-_____-_____
FAX: ____-_____-_____

Patient Signature: _____ Date: _____

TEXAS PAIN
PHYSICIANS

INFORMED CONSENT AND PAIN

MANAGEMENT AGREEMENT AS REQUIRED BY

THE TEXAS MEDICAL BOARD

REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9, CHAPTER 170
4th Edition: Developed by the Texas Pain Society, August 2017
(www.texaspain.org)

PATIENT NAME:_____ **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(s) after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to use the drug(s) recommended to you by me, as your physician. For the purpose of this agreement the use of the word "physician" is defined to include not only my physician but also my physician's authorized associates, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat my condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician (name at bottom of agreement) to treat my condition which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent for my physician to administer or write prescription(s) for dangerous and/or controlled drugs (medications) as an element in the treatment of my chronic pain.

It has been explained to me that these medication(s) include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

TEXAS PAIN
PHYSICIANS

THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT HAVE BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT (THIS IS SOMETIMES REFERRED TO AS "OFF-LABEL" PRESCRIBING). MY DOCTOR WILL EXPLAIN HIS TREATMENT PLAN(S) FOR ME AND DOCUMENT IT IN MY MEDICAL CHART.

I **HAVE BEEN INFORMED AND** understand that I will undergo medical tests and examinations before and during my treatment. Those tests include random unannounced checks (urine, blood, saliva or any other testing indicated and deemed necessary by my physician at any time) 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 or absence of authorized 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 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(children). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo/ fetus / baby.

TEXAS PAIN
PHYSICIANS

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 will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction times might still be slowed. Such activities include but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself.

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 functional life. I realize that I may have a chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored specifically for me. I understand that I may withdraw from this
treatment plan and discontinue the use of the medication(s) at any time and that I will notify my physician of any discontinued use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

I understand that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of medications to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be

used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

TEXAS PAIN
PHYSICIANS

PAIN MANAGEMENT AGREEMENT:

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:

I am aware that all controlled substance prescriptions are now being monitored by the Texas State Board of Pharmacy and that information will be accessed by my physician each time a prescription is written.

____ My progress will be periodically reviewed and, if the medication(s) are not improving my function and 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.

TEXAS PAIN
PHYSICIANS

____ My pain management physician will manage the chronic pain symptoms, all other health related issues must be managed by my primary care Physician.

____ 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, earl 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 controlled substance medication(s) **only from ONE physician** unless it is for an emergency or the medication(s) that is being prescribed by another physician is approved by my physician. Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.

____ If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then **my physician may try alternative medication(s) or may taper me off all medication(s).** I will not hold my physician liable for problems caused by the discontinuance of medication(s).

____ I **agree to submit to urine and/or blood screens** to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), such as marijuana, speed, cocaine, etc., treatment for chronic pain may be terminated. Also, a consult with,

TEXAS PAIN
PHYSICIANS

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 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 give my pain physician permission to obtain any and all medical records necessary to diagnose and treat my painful conditions.

____ 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 understand many prescription medications for chronic pain produce serious side effects including drowsiness, dizziness, and confusion. Alcohol will enhance all of these side effects and should be discontinued before starting these medications.

TEXAS PAIN
PHYSICIANS

I certify and agree to the following:

____ l) 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.**

____ 5) If I become a patient in this clinic and receive controlled substances to control my pain, this pain management agreement supersedes any other agreement that I may have signed in the past.

Name and contact information for pharmacy

Patient Signature

Physician Signature
(or Appropriately Authorized Assistant)

MEDICAL OFFICE POLICIES

PLEASE RETAIN OFFICE POLICIES FOR FUTURE REFERENCE

OFFICE HOURS: The office is open Monday through Friday 9:00 am to 5:00 pm.

APPOINTMENTS: You must schedule an appointment to be seen by the doctors at the clinics of Solar Health Pain Management (SHPM) DBA Texas Pain Physicians (TPP). Please contact the office during business hours to schedule appointments. As a courtesy we will call/text to confirm your appointment: however, it is your responsibility to maintain your schedule and be on time for appointments.

Contact us immediately if you are going to be late. If you are unable to attend your appointment, we ask that you give at least 24 hours notice so that we can attend to other patients. Without a 24 hour notice you may be charged a $25 missed appointment fee and $50 for injection appointments, payment will be required prior to your next appointment.

CHANGES TO PERSONAL INFORMATION: You must contact the office with any change to your personal information including: phone numbers, address, name change, new or cancelled insurance.

PRESCRIPTIONS & REFILLS: Due to the nature and addictive properties of OPIOIDS prescribed for pain management it is necessary that we evaluate your treatment plan on a regular basis. It is our policy to prescribe no more than 30 day supply of medication. You are required to be present for your follow up appointment. You may be required to provide a urine sample for drug screening during your appointment. Requests made by phone or through your pharmacy will not be filled. THERE ARE NO EXCEPTIONS TO THIS POLICY.

FORMS & MEDICAL RECORDS: There is a $15 charge for completion of all forms such as; FMLA, Disability Request, Daycare, Gym Membership, Credit Card and Insurance Forms. There is a $35 charge for medical records being released to anyone other than a licensed health care provider. A release form must be signed by the patient or legal guardian. Payment is required and you must allow 5-7 business days for completion from the date any of our clinics receive payment.

PHONE CALLS: Keep in mind that the office receives a large volume of phone calls daily, please make calls brief and to the point by clearly identifying yourself and the reason for your call. Keep in mind that the staff cannot answer questions pertaining to your condition or treatment. Those questions need to be addressed with the doctor during your appointment.

PERSONAL BEHAVIOR: Profanity, rude or discourteous behavior will not be tolerated. Inappropriate or threatening behavior will result in you being discharged from care at any of our clinics.

PAYMENT: Payment is required at the time of service unless other arrangements have been made. For insurance patients; you will need to bring your insurance card to all appointments in the event we need to re-verify your benefits.

INSURANCE: We will work with your insurance carrier to verify your benefits and get your claims paid; however the contract is between you and your carrier. It is your responsibility to make sure that we have current information on file all times and that you respond in a timely manner if your carrier requests information from you. If you have questions about your benefits you will need to contact your carrier directly. If a claim is denied because you have not provided requested information you may be responsible for the insurance.

MEDICARE: We will accept Medicare assignment and file claims with Medicare as a primary or secondary carrier. You are responsible for your deductible and co-insurance if you do not have supplemental insurance.

HMO PATIENTS: You will need to provide your PCP's contact information. You may also be asked to contact your PCP to obtain a referral.

TEST RESULTS & SCHEDULING: The office will make arrangements for diagnostic testing. Test results will be reviewed with you at your next schedule visit. You need to call the office within 72 hours of your procedure to schedule an appointment to discuss test results.

PROCEDURES RESCHEDULE AT A SURGERY CENTER OR HOSPITAL: If you are unable to keep your scheduled appointment, we ask that you give at least 2 hours' notice. Without a 24 hour notice you may be charged a $150 facility fee for your missed appointment. Payment will be required prior to your next appointment.

HANDGUNS PROHIBITED: Pursuant to section 30.07, penal code (trespass by license holderwith an openly carried handgun), a person license under Subchapter H, Chapter 411, government code (handgun licensing law), may not enter this property with a handgun that is carried openly. Pursuant to section 30.06, penal code (trespass by holder of license to carry a concealed handgun), a person license under Subchapter H, Chapter 411, government code (concealed handgun law), may not enter this property with a concealed handgun.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND ENCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

OUR PLEDGE REGARDING YOUR MEDICAL INFORMATION

We are committed to protecting medical information about you. We create a record of the care and services you receive for use in your care and treatment.

We are required by law to:

- Make sure that your medical information is protected;
- Give you opportunity to review this Notice describing our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, or other health system personnel who are involved in your care. We may also share medical information about you with other personnel, agencies or facilities in order to provide or coordinate the different things you need, such as prescriptions, lab work and x-rays.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party.

For Health Care Operations. We may use and disclose medical information about you for purpose of quality of care. Your medical information may also be used or disclosed to comply with law and regulation, for contractual obligations, patient' claims, grievances or lawsuits, health care contracting, legal services, business management and administration, underwriting and other insurance activities.

Individuals Involved in Your Care or Payment for Your Care. We may release medical information to anyone involved in your medical, e.g., a friend, family member, personal representative, or may individual you identify. We may also give information to someone who helps pay for your care.

As Required By Law. We will disclose medical information about you when required to do so by federal or state law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent or lessen a serious and imminent threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to someone able to help stop or reduce the threat.

Workers' Compensation. We may use or disclose medical information about you for Workers' Compensation or similar programs as authorized or required by law.

Public Health Disclosures. We may disclose medical information about you for public health purpose. These purposes generally include the following:

- Preventing or controlled disease (such as cancer and tuberculosis), injury or disability;
- Notifying a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition;
- Reporting to the employer findings concerning a work-related illness or injury or workplace-related medical surveillance;
- Notifying the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence and make this disclosure as authorized or required by law.

Health Oversight Activities. We may disclose medical information to governmental, licensing, auditing, and accrediting agencies as authorized or required by law.

Lawsuits and Other Legal Actions. In connection with lawsuits or other legal proceedings, we may disclose medical information about you in response to a court or administrative order, or in response to a subpoena, discovery request, warrant, summons or other lawful process.

Law Enforcement. If asked to do so by law enforcement, and as authorized or required by law, we may release medical information about criminal conduct.

National Security and Intelligence Activities. As authorized or required by law, we may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

Your medical information is our property. You have the following rights, however, regarding medical information we maintain about you:

Right to Inspect and Copy. With certain exceptions, you have the right to inspect and/or received a copy of your medical information. To inspect and/or to receive a copy of your medical information, you must submit your request in writing. If you request a copy of the information, there is a fee for these services. We may deny your request to inspect and/or to receive a copy in certain limited circumstances. If you are denied access to medical information, in most cases, you may have the denial reviewed.

Right to Request an Amendment or Addendum. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information or add an addendum. You have the right to request an amendment or addendum for as long as the information is kept by or for us. To request an amendment, your request must be made in writing. In addition, you must provide a reason that supports your request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us;
- Is not part of the medical information kept by or for us;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete in the record.

Right to an Accounting of Disclosures. You have the right to receive a list of the disclosures we have made of your medical information. To request this accounting of disclosures, you must submit your request in writing. Your request must state a time period that may not be longer than the six previous years. You are entitled to one accounting within any 12-month period at no cost. If you request a second accounting within that 12-month period, there will be a charge for the cost of compiling the accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any cost are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. To request a restriction, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, only to you and your spouse. We are not required to agree to your request. If we do agree, our agreement must be in writing, and we will comply with your request unless the information is needed to provide you emergency treatment.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time.

CHANGES TO PRIVACY PRACTICES AND THIS NOTICE

We reserve the right to change our privacy practice and this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we received in the future.