PERSONAL INFORMATION

Patient Name _____

Social Security # _____ Date of Birth _____/_____/_____ Age _____ ▢ Male ▢ Female

Address _____ Apt # _____ City _____ State _____ Zip _____ Phone #

_____ Cell # _____ Email _____ Marital Status ▢ Married ▢ Divorced ▢

Widowed ▢ Other # of Children _____ Spouse's Name_____ Emergency Contact & Phone

#_____ Occupation _____

Employer _____ Family Physician _____

How did you hear about our office? ▢ Doctor Referral ▢ Online Search/Google ▢ Online Ad ▢ Facebook ▢ Instagram ▢ Yelp

▢ Zocdoc ▢ Family Member/Friend Referral ▢ Insurance ▢ Magazine ▢ Letter/Postcard ▢ Other _____

INSURANCE

Please provide a copy of your insurance card. If your plan requires a referral, please provide a copy.

Primary Insurance_____ Subscriber Name _____ Date of Birth _____/_____/

_____ ID# _____ Group # _____

HISTORY OF CONDITION

Date of Onset _____ Areas injured/affected _____

How did the symptoms occur? _____

Were you evaluated at an ER or other doctor for your injuries? ▢ Yes ▢ No If yes, where? _____

Taken by ambulance? ▢ Yes ▢ No Were X-rays or diagnostic imaging taken? ▢ Yes ▢ No

Were medications prescribed? ▢ Yes ▢ No Are you taking those medications? ▢ Yes ▢ No

Did you lose consciousness when these injuries occurred? ▢ Yes ▢ No

Did you have any *(circle all that apply)* Cuts / Scratches / Bruises / Fractures

Were you the *(circle one)* Driver / Front seat passenger / Back seat passenger

SYMPTOM SPECIFIC INFORMATION

Overall, would you describe your symptoms as *(circle one)* Mild / Mild to Moderate / Moderate to Severe / Severe

How often do you experience these symptoms *(circle one)* Occasionally / Occasional to Frequent / Frequently / Frequent to Constant / Constantly Since onset, have your symptoms *(circle one)* Improved / Gotten Worse / Stayed about the same / Changes daily

Describe your symptoms *(circle all that apply)* Tingling / Numbness / Sharp / Burning / Dull / Shooting / Cramping / Other _____ Have you missed work due to these symptoms? ▢ Yes ▢ No Are you ***currently*** off of work due to these symptoms? ▢ Yes ▢ No

AUTHORIZATION TO RELEASE MEDICAL RECORDS

- I hereby authorize the release of all my medical records to Houston Spine & Rehabilitation Affiliates where necessary or as required for the purposes of my examination and/or treatment
- I further authorize payment be made directly to Houston Spine & Rehabilitation Affiliates, as an assignment of my benefits, for services rendered that would otherwise be payable to me.
- I agree that in the event my outstanding bills are unpaid by a third-party source, I am responsible for payment of all services performed. I have read and understand the above statements and attest that the information I have provided is correct.

TREATMENT COMPLIANCE POLICY

- The outcome of your treatment could be negatively affected by your inability or unwillingness to abide by and/or maintain the proposed course of treatment. Just as you expect our office to be considerate of your time, we ask for the same courtesy. If you are unable to make a scheduled appointment, please contact our office so that we may provide another patient with that time slot. Success with your treatment in our office is our primary concern and compliance with our treatment plan is essential.
- The undersigned patient hereby acknowledges that he/she is seeking care and treatment from Houston Spine & Rehabilitation Affiliates and that the doctor(s) will rely on the patient for giving truthful statements regarding the facts and circumstances surrounding his/her illness and/or injury. Any untruthful statements can possibly lead to the rendering of an improper diagnosis and/or unnecessary treatment. I, the patient, therefore attest that the questions responded to above and throughout my paperwork are truthful and accurate.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

Printed Name of Patient or Guardian _____

PATIENT HISTORY

MEDICAL HISTORY - Do you have a history of?

		Resolved	Treating
Diabetes	Y / N	▢	▢
High Blood Pressure	Y / N	▢	▢
Heart Disease	Y / N	▢	▢
Stroke	Y / N	▢	▢
Cancer (type) _____	Y / N	▢	▢
Thyroid Disease	Y / N	▢	▢
AIDS/HIV	Y / N	▢	▢
Hepatitis (type) _____	Y / N	▢	▢
Arthritis	Y / N	▢	▢
Rheumatoid Arthritis	Y / N	▢	▢
Asthma	Y / N	▢	▢
Osteoporosis	Y / N	▢	▢
Osteopenia	Y / N	▢	▢
COPD	Y / N	▢	▢
Pacemaker	Y / N	▢	▢
Defibrillator	Y / N	▢	▢
Kidney Stones	Y / N	▢	▢
Kidney Infections	Y / N	▢	▢
Urinary Tract Infection	Y / N	▢	▢
Ulcers	Y / N	▢	▢
GI Problems	Y / N	▢	▢
Alcoholism	Y / N	▢	▢
Bowel Problems	Y / N	▢	▢
Stroke	Y / N	▢	▢
Diabetes	Y / N	▢	▢
Hypertension	Y / N	▢	▢

FAMILY HISTORY - Has anyone in your family had any of the following?

Diabetes	Y / N	
Heart Disease	Y / N	
Stroke	Y / N	
Cancer	Y / N	(type)_____

SOCIAL HISTORY - Do you use….

Tobacco products	Y / N
Alcohol	Y / N
Recreational Drugs	Y / N

What is your current activity/exercise level?
Sedentary / Moderate / Very Active

Are you pregnant? Y / N / Maybe

CURRENT MEDICATIONS

Please list the medications you are currently taking and the reason:_____

_____

_____

_____

DRUG ALLERGIES

Please list:

_____

_____

REVIEW OF SYMPTOMS - Do you have any of the following symptoms?

Depression	Y / N	Sinus Pressure	Y / N
Anxiety	Y / N	Stomach / Abdominal Pain	Y / N
Fever	Y / N	Change in bowel or bladder function	Y / N
Unexplained Weight Loss	Y / N	Nausea	Y / N
Chest Pain	Y / N	Vomiting	Y / N
Irregular Heart Beat	Y / N	Dizziness	Y / N
Poor Circulation	Y / N	Tingling	Y / N
Blood in Urine	Y / N	Numbness	Y / N
Difficulty with Urination	Y / N	Joint Swelling	Y / N
Headaches	Y / N	Neck Pain	Y / N
Radiating Pain	Y / N	Back Pain	Y / N
Decreased / Blurred Vision	Y / N	Pain with Movement	Y / N
Shortness of Breath	Y / N	Trouble sleeping due to pain	Y / N
Persistent Cough	Y / N	**Are you currently being treated or have you recently been**	
Ringing in your Ears	Y / N	**treated by another physician for any of these symptoms? Y / N**	
Hearing Loss	Y / N	If yes, who? _____	
Throat Pain	Y / N	What is the nature of that treatment? _____	
		_____	

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

Printed Name of Patient or Guardian _____

PATIENT HISTORY

Date _____

Patient Name _____

Please help us to provide you with the best comprehensive care by completing the following questionnaire.

CHIEF COMPLAINT

What is the reason for your visit today?_____

Please mark the severity of your complaint **right now**:

▢ No Symptoms ▢ Discomfort - Does not affect activity ▢ Prevents Personal Activities

▢ Limits Work ▢ Prevents all activity ▢ Keeps me bedridden

Please mark the severity of your complaint on average:

▢ No Symptoms ▢ Discomfort - Does not affect activity ▢ Prevents Personal Activities

▢ Limits Work ▢ Prevents all activity ▢ Keeps me bedridden

Please mark the severity of your complaint **at its best:**

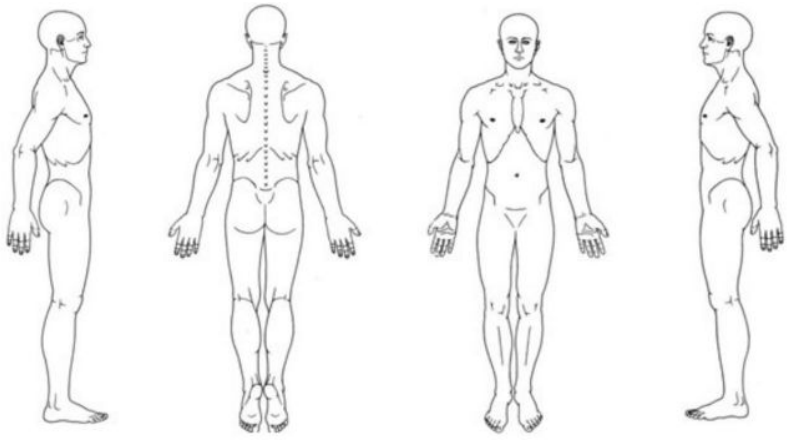
▢ No Symptoms ▢ Discomfort - Does not affect activity ▢ Prevents Personal Activities

▢ Limits Work ▢ Prevents all activity ▢ Keeps me bedridden

Please mark the severity of your complaining at its worst:

▢ No Symptoms ▢ Discomfort - Does not affect activity ▢ Prevents Personal Activities

▢ Limits Work ▢ Prevents all activity ▢ Keeps me bedridden



Mark the areas of your complaint on the diagrams to the left. Please include any descriptions or comments that you feel are important.

If your symptoms travel to other areas of your body, mark the diagram to reflect how the symptoms seem to move.

AUTHORIZATION FOR TELEPHONE CONTACT

I authorize the team of Houston Spine & Rehabilitation Affiliates to contact me at my home, cell, or any other alternate phone number that I have listed. ▢ Home ▢ Work ▢ Cell

_____ (Initial) I authorize Houston Spine & Rehabilitation Affiliates to leave a voicemail on the above phone in reference to any items that assist the practice in carrying our Treatment, Payments and Healthcare Operations (TPO), such as appointment reminders, insurance items, and any other calls pertaining to my clinical care, including lab results among others.

AUTHORIZATION FOR U.S. MAIL AND EMAIL

Consent for Houston Spine & Rehabilitation Affiliates to mail to my home or email any item is that assist the practice in carrying out TPO, such as appointment reminders, documentation to refer out for services, documentation requested by myself and patient statements. I understand that as with any Internet service, there is a risk sending information through email. All records are kept in our Electronic Medical Record.

▢ I acknowledge and consent to receive paper mail ▢ I acknowledge and consent to receive email

NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be Involved in that treatment directly and indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I agree to receive an electronic copy of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request In writing that you restrict how my private Information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, that you are bound to abide by such restrictions.

By acknowledging below I give my consent for Houston Spine & Rehabilitation Affiliates to use and disclose my protected health information (PH) in the ways described in the Notification and to carry out treatment, payment, and healthcare operations (TPO).

_____ (Initial) I have read or been given the opportunity to read the Notification of Privacy Practices and agree as indicated above.

Due to the privacy laws mentioned above, we are unable to discuss your PHI (Including appointment information) with any family member without your expressed consent. If you would like us to be able to discuss any aspect of your PHI with a spouse, parent or other family member please list them below. For minor children we will follow any applicable state or federal laws regarding release of information.

I authorize Houston Spine & Rehabilitation Affiliates and all of its healthcare providers to discuss issues regarding my visits, any lab or test results, my appointments or insurance with the following people and understand that this authorization will remain In effect until I notify the office in writing of any changes.

Name of Individual to release Information to: _____ OR Relationship: _____

_____ (Initial) I do not wish to designate anyone to have access to my information.

STATE-REQUIRED ETHNICITY AND RACE QUESTIONS

You may choose not to disclose. If you do choose not to identify your own race & ethnicity, our team will use their best judgment to make the identification for reporting purposes. The state uses this data to assist researchers in determining whether or not all citizens are receiving adequate health care.

ETHNICITY: ▢ Hispanic/Latino ▢ Not Hispanic/Latino ▢ Choose not to disclose

RACE: ▢ American Indian/Eskimo/Aleut ▢ Asian or Pacific Islander ▢ Black ▢ White ▢ Choose not to disclose
▢ Other (*including all responses not listed above. Patients who consider themselves as multiracial or mixed should choose this category)*

PATIENT/GUARDIAN SIGNATURE _____ DATE _____ Printed Name of Patient or Guardian _____

PATIENT ACKNOWLEDGEMENT OF BILLING PRACTICES

Houston Spine & Rehabilitation Affiliates have many facets to care for patients and their healthcare needs.

A patient may be treating with the professionals and clinicians in one or more of the facets of Houston Spine & Rehabilitation Affiliates /Houston Spine & Rehabilitation Centers. The treating doctors, physical therapists and clinicians include, but are not

limited to:

Mark Yezak, DC	**Scott Neuburger, DC**	**Jerry Gentry, MD**
Reid Amedee, DC	**Shanna Lee, DC**	**Lenny Jue, MD**
Michael Crone, DC	**Brett Baer, DPT**	**Jennifer Barton, DPT**

Due to the multiple disciplines utilized for patient care, Houston Spine & Rehabilitation Affiliates are under the direction of our Medical Director, **MEDICAL DIRECTOR**.

- ✓ **All claims for patient care are submitted to insurance companies under the direction of our Medical Director.**
- ✓ **Our medical director is in-network with most major medical insurance plans and their name will appear on all explanation of benefits and correspondence from the insurance company.**
- ✓ **During patient care, the benefit levels that will be utilized on insurance plans are the specialist and physical therapy benefits.**

By signing this acknowledgment, the patient understands the billing practices of Houston Spine & Rehabilitation Centers and Houston Spine & Rehabilitation Affiliates. If there are any questions, please contact our office.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____ Printed Name of Patient or Guardian _____

DISCLOSURE OF PHYSICIAN OWNERSHIP INTEREST NOTICE TO PATIENTS

Dear Patient, Please carefully review this notice.

In order to allow you to make a fully-informed decision about your healthcare, the physicians of Houston Spine & Rehabilitation Affiliates (the "Practice") would like to inform you that at some point during the course of your treatment, the providers may refer you to laboratories, diagnostic imaging centers, surgical centers or hospitals to perform diagnostic studies or surgical procedures. The practice wishes to advise you that some or all of the doctors of Houston Spine & Rehabilitation Affiliates have a direct ownership interest in:

Spring Imaging
26406 IH 45 N
Spring, Texas 77386

Gallaria MRI
3391 West Park
Houston,Texas 77005

All of the practice's physicians will make referrals to laboratories, diagnostic imaging centers, surgical centers or hospitals, based upon the best interest of a patient's health and any other factors that a patient would like his or her physicians to consider, regardless of any ownership, interest or compensation arrangement that a physician may have with a particular laboratory or other facility.

You, as a patient, have the right to choose the provider of your healthcare services and the diagnostic facilities where you receive services or treatment.

If you have any questions concerning this notice, please feel free to ask your physician or any member of our staff. We welcome you as a patient and value our relationship with you.

By signing below, you acknowledge that you have read and fully understand this notice.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

Printed Name of Patient or Guardian _____

TO: PATIENTS OF Houston Spine & Rehabilitation Affiliates

Houston Spine & Rehabilitation Affiliates specializes in the treatment of the spine and associated pain. We perform various treatments consisting of passive modalities, therapeutic interventions and spinal manipulation. The goal of our services is to reduce and/or eliminate your pain, however, with any chiropractic and/or physical medicine services there are risks associated with the services we provide.

As your healthcare provider, we feel that it is crucial that you understand these risks. By informing you of these risks, we are striving to more actively involve you in our care, as well as further assist you in making well informed decisions regarding your treatment options.

PASSIVE MODALITIES

Passive modalities consist of the following treatments: hot packs, cold packs, ultrasound, electrical stimulation, massage, traction and cold laser. The primary risks associated with passive modalities include skin irritation or electrical burns due to exposure to heat, cold or agents used in application or modalities (i.e. lotions and pads). If you have experienced skin sensitivity to heat, cold temperatures and/or lotions or similar products in the past, or are aware of any skin allergies, please inform our staff prior to treatment so proper precautions can be made prior to initiating treatment.

THERAPEUTIC INTERVENTIONS

Therapeutic interventions consist of the following types of treatments: stretching, flexibility exercises, strengthening exercises, joint mobilizations and myofascial release. Therapeutic interventions are generally quite safe, though there are risks associated with each of these procedures. The primary risk is potential aggravation of your current condition and/or underlying condition. As with any physical activity and/or exercise, there is also the risk of injury. Though this risk is minimal, as you are under the direct supervision of experienced clinical staff, it may still exist. Some responses to therapeutic interventions are muscle soreness, muscle fatigue, increased discomfort, overall tiredness and/or joint stiffness and/or pain. It is important that you inform your treating staff member of any of these responses following your treatment and more importantly, it is crucial that you continue to attend your appointments as scheduled so your condition can be documented and your symptoms effectively managed.

SPINAL MANIPULATION

Spinal Manipulation consists of adjustments that seek to restore normal function to the spine and other joints. Typically, this involves applying a specific, highly controlled treatment directly to a joint or muscle. This treatment often reduces or eliminates both local and referred pain, allows muscle spasms to relax and may even release the irritation from the nervous system, which may result in other health benefits. As with any healthcare service, there are potential reactions and risks, however as with any healthcare intervention, it is hoped that the expected benefits of spinal manipulation exceed the expected risks. These are unavoidable risks of spinal manipulation which, though rare, can occur.

DISK HERNIATION

The occurrence of disk herniation during spinal manipulation is highly unlikely. In fact, averaged disks withstand an average of 23 degrees or rotation and degenerated disks an average of 14 degrees of rotation before failure occurs. Furthermore, given the fact that during manipulation posterior facet joints limit rotation to a maximum of 23 degrees, this joint would have to fracture to allow any further rotation to occur.

CAUDA EQUINA SYNDROME

It is estimated that the rate of occurrence of the Cauda Equina Syndrome as a complication of lumbar spinal manipulation is about one case per 100 million manipulations. It Is probably higher in patients with a herniated nucleus pulposus and lower in patients without this anatomic abnormality.

VERTEBROBASILAR ARTERY COMPROMISE

Serious complications of cervical spine manipulation are also rare (none have been reported in any of the clinical trials), but appear to be more common and severe than complication of lumbar manipulation. The most serious complication of the cervical spine manipulation is related to compromise of the vertebrobasilar artery, leading to stroke or death. The risk Is higher for manipulation involving rotation plus extension of the vertical spine than for other types of manipulation and those persons who have suffered manipulation related vertebrobasilar artery compromise due to atherosclerotic disease. The best estimate of the incidence of vertebrobasilar artery compromise related to cervical spine manipulation is that it occurs one in a million manipulations (Hurwitz, 1996; McGregor, 1955).

PATIENT UNDERSTANDING AND ACCEPTANCE OF RISKS ASSOCIATED WITH TREATMENT

As your doctor, it is our responsibility to inform you of the potential risks and benefits of your treatment, but we also want to assure you that we strive to minimize these risks by providing thorough clinical examination and by performing diagnostics as clinically indicated. Furthermore, we continually review medical literature pertaining to current trends within our profession as well as throughout the entire medical community to ensure the safest and most effective care.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

Printed Name of Patient or Guardian _____

UNDERSTANDING SERVICES NOT CONSIDERED BY YOUR INSURANCE CARRIER

There are some services that are not covered by your insurance carrier. Below are the services that are not considered by your insurance carrier.

Spinal Decompression/ Traction | Cost: $80.00 / session _____ **(Initial)**

Decompression and is a service prescribed to treat specific issues for the Cervical Spine or the Lumbar Spine. You doctor will advise you if you are a candidate for this service.

If you are prescribed Decompression for either the cervical or lumbar spine, the number of visits you are prescribed will vary between 20- 25 visits. The number of visits will vary based on how your body responds to the Decompression service. Your visits will include standard post modality care. These standard post modalities are not billed to your insurance carrier. We will not be billing Decompression services to your insurance carrier. You have 2 options of which you can opt to pay for Decompression sessions:

_____ Option 1: Pay for sessions per date of service without discount. $960 Total

_____ Option 2: Pay for sessions in advance utilizing the "Prompt Pay" discount in the amount of $360. Total Package $600.

If you are having Decompression therapy **in combination** with any of the other not-considered services on this list, the cost will be added to your patient responsibility. In cases where a patient has taken advantage of the "Prompt Pay" discount, the patient will be asked for payment of the other services that they have received listed on this advisement.

Functional Dry Needling (FDN) | Cost: $80.00 / session _____ (**Initial)**

Functional Dry Needling is a **short-term prescribed service** that is performed by a Licensed Physical Therapist. FDN requires a short PT Evaluation with the Licensed Physical Therapist who will be performing the service. Your doctor/therapist will be setting the frequency and duration

If you are prescribed FDN, the FDN service will not be billed to your insurance carrier but all standard modalities and physical therapies will be billed. The cost for the FDN will be collected from you at the time of service. If the payment is not collected on the same date of service you have the FDN performed, it will be collected from you at the Check In/Check Out and/or be billed to you.

Therapeutic Cupping | Cost: $30.00 / session _____(**Initial**)

Therapeutic Cupping is a **short-term prescribed service** that is performed either by a modalities technician or a Licensed Physical Therapist. Your

doctor/ therapist will be setting the frequency for the short-term prescribed service. In most cases, 3 sessions are prescribed.

If you are prescribed Therapeutic Cupping, the service will not be billed to your insurance carrier, but all standard modalities and physical therapies will be billed. The cost for Therapeutic Cupping will be collected from you at the time of service. If the payment is not collected on the same date of service you have the service performed, it will be collected from you at the Check In/Check Out and/or be billed to you.

Active Release Techniques (ART) | Cost: $30.00 / session **_____ (Initial)**

ART is a **prescribed service** that is performed by your treating doctor. If you are prescribed ART in conjunction with your treatment plan, the service will not be billed to your insurance carrier, but all other therapies will be billed. The cost for ART will be collected for you at the time of service. If the payment is not collected on the same date of service you have the service performed, it will be collected from you at the Check In/Check Out and/or be billed to you.

Kinesio Taping (Taping) | Cost: $15.00 / session **_____ (Initial)**

Kinesio Taping (Taping) is a **prescribed service** that is performed either by a modalities technician or a Licensed Physical Therapist. Taping is usually prescribed once or twice during a course of treatment.

If you are prescribed Taping, the service will not be billed to your insurance carrier, but all other therapies will be billed. f the payment is not collected on the same date of service you have the service performed, it will be collected from you at the Check In/Check Out and/or be billed to you.

Laser Therapy Cost I $ 95.00/ Session

If you are prescribed Laser Therapy the number of visits you are prescribed will vary between 6-12 visits. The number of visits will vary based on how your body responds to the Laser Therapy service. We will not be billing Laser therapy services to your insurance carrier. You have 2 options of which you can opt to pay for Decompression sessions:

_____ Option 1: Pay for sessions per date of service without discount.

_____ Option 2: Pay for sessions in advance utilizing the "Prompt Pay" discount iof $ 25 per session. Example 6 visits $ 75 for a total of $450

PAIN MANAGEMENT PROGRAM

The following are some questions given to all patients who are taking 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.

SOAPP® VERSION 1.0-SF

Please answer the questions below using the following scale:

0 = Never 1 = Seldom 2 = Sometimes 3 = Often 4 = Very Often

1. How often do 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 you taken medication other than the way it was prescribed? 0 1 2 3 4

4. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years? 0 1 2 3 4

5. 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.

PAIN MANAGEMENT AGREEMENT

I understand that I have a right to comprehensive pain management. I wish to enter a treatment agreement to prevent a possible chemical addiction. I understand that failure to follow any of these agreed statements might result in my Pain Management Physician not providing ongoing care for me.

I, _____, agree to undergo pain management by my Pain Management Physician.

I agree to the following statements:

- ✓ I will not accept any narcotic prescriptions from another doctor, including Emergency Room or Dental visits.
- ✓ I will be responsible for making sure that I do not run out of my medications on weekends and holidays, because abrupt discontinuation of these medications can cause severe withdrawal syndrome.
- ✓ I understand that I must keep my medications in a safe place.
- ✓ I understand that my Pain Management Physician will not supply additional refills for the prescriptions of medications that I may lose.
- ✓ If my medications are stolen, my Pain Management Physician may refill the prescription one time only if a copy of the police report of the theft is submitted to the physician's office.
- ✓ I will not give my prescription to anyone else.
- ✓ I will only use one pharmacy.
- ✓ I will keep my scheduled appointments with my Pain Management Physician unless I give notice of cancellation 24 hours in advance.
- ✓ I agree to refrain from all mind/mood altering/illicit drugs including alcohol unless authorized by my Pain Management Physician.
- ✓ My treatment plan may change based on the outcome of therapy, especially if pain medications are ineffective. Such medications will be discontinued.

I understand that my Pain Management Physician believes in the following "Patients' Bill of Rights."

PATIENTS' BILL OF RIGHTS includes the following:

- ✓ Have your pain prevented or controlled adequately
- ✓ Have your pain and medication history taken.
- ✓ Have your pain questions answered.
- ✓ Know what medication{s), treatment or anesthesia will be given.
- ✓ Know the risks, benefits, and side effects of treatment.
- ✓ Know what alternative pain treatments may be available.
- ✓ Ask for changes in treatments if your pain persists.
- ✓ Receive compassionate and sympathetic care.
- ✓ Receive pain medication on a timely basis.
- ✓ Refuse treatment without prejudice from your physician.
- ✓ Include your family in decision-making.

My Pain Management Physician may terminate this agreement at any time if they have cause to believe that I am not complying with the terms of this agreement, or to believe that I have made a misrepresentation or false statement concerning my pain or my compliance with the terms of this agreement.

I understand that I may terminate this agreement at any time. If the agreement is terminated, I will be discharged as a patient and would strongly consider treatment for chemical dependency if clinically indicated.

PATIENT SIGNATURE _____ DATE _____

PHYSICIAN SIGNATURE _____ DATE _____

WITNESS SIGNATURE _____ DATE _____

PAIN DISABILITY INDEX

Date _____

Patient Name _____

For each of the 7 categories listed, please circle the number on the scale that best describes the level of disability you typically experience. A score of "0" means no disability at all, and a score of "10" signifies that all of these types of activities have been totally disrupted or prevented by your pain.

Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

FAMILY/HOME RESPONSIBILITY *(such as house cleaning or errands)*:

1 2 3 4 5 6 7 8 9 10

No Disability — Total Disability

RECREATION *(such as sports, exercise, and other similar leisure time activities)*:

1 2 3 4 5 6 7 8 9 10

No Disability — Total Disability

SOCIAL ACTIVITY *(such as going to parties, dining out, and other social functions)*:

1 2 3 4 5 6 7 8 9 10

No Disability — Total Disability

OCCUPATION *(all activities related to one's job, including non-paying jobs)*:

1 2 3 4 5 6 7 8 9 10

No Disability — Total Disability

SEXUAL BEHAVIOR

1 2 3 4 5 6 7 8 9 10

No Disability — Total Disability

SELF-CARE *(such as bathing and dressing)*:

1 2 3 4 5 6 7 8 9 10

No Disability — Total Disability

LIFE-SUPPORT ACTIVITY *(eating, sleeping and breathing)*:

1 2 3 4 5 6 7 8 9 10

No Disability — Total Disability

OVERALL DISABILITY SCORE (out of a possible 70): _____