PRINCIPAL SPINE AND PAIN CONSULTANTS
1809 Golden Trail Suite # 110
Carrollton, TX 75010
Phone: 972.316.7270 www.principalspineonline.com Fax: 972.492.5345

New Patient Evaluation Form

Name: _____ D.O.B _____ Date: _____

SudoScan YES / NO ★★★★★★★★★★ Pharmacy Confirmed: Yes / No

Office Use only

Vitals: BP: _____ HR: _____ Temp: _____ Weight: _____

Urine Collection Completed? YES / NO SOAP Completed? YES / NO

How were you referred to us? _____

Who is your PCP? _____ Send today's visit information to your PCP? YES NO

What/Where is your main PAIN problem(s)? How long?

_____ _____

_____ _____

_____ _____

How severe is your pain? (0 is no pain, 10 is the worst you have felt in your life.)

Right now _____ on average _____

Have you had any X-rays, MRI, CT Scans, EMGs, Discograms, or other diagnostic studies? Where at?

_____

_____

List any medication or Iodine ALLERGIES

_____

CURRENT MEDICATIONS YOU ARE TAKING (List dosage and strength)

_____

_____

_____

_____

_____

_____

YOUR MEDICAL HISTORY (Circle)

Acid Reflux, Anemia, Angina, Asthma, Coronary Disease, CHF
COPD/ Bronchitis/Emphysema, CVA, Depression/ Anxiety
Diabetes, GERD, Hepatitis, HIV, Hypertension (HTN..increase BP)
Hypothyroid, Kidney Disease, Morbid Obesity, Sleep Apnea,
Renal Failure, Rheumatoid Arthritis, Seizure, Smoker, Stroke, TIA

OTHERS: _____

PAST SURGERIES UNDERGONE

_____

_____

_____

_____

_____

_____

_____

FAMILY MEDICAL HISTORY-list major conditions

_____

_____

_____

_____

_____

_____

_____

SOCIAL HISTORY:

Do you drink alcoholic beverages? YES NO How Much? Social <1 drink/day _____ drinks per day
Do you use any street drugs (cocaine, Marijuana, etc)? YES NO What and when last used?
How much smoking daily? _____ packs per day, for _____ years If quit, when?
Have you had a history of addiction? YES NO To what? _____ How long? _____

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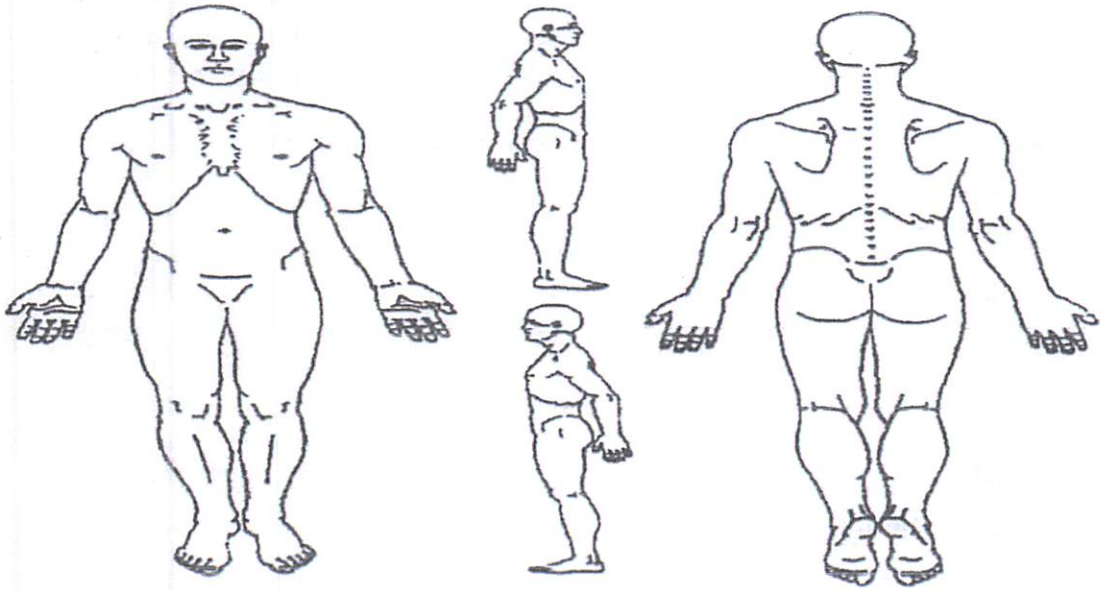
REVIEW OF SYSTEMS (Do you have any of these symptoms?)

Constitutional:	fever	weight gain	weight loss	
Ears:	ear discharge	dizziness	earaches	
Head/Neck/Eyes:	visual changes	headaches	neck pain	pain in eyes
Nose/Throat:	nosebleeds	hoarseness	swallowing difficulty	
Cardiovascular:	chest pain	leg swelling	poor circulation	blood clots
	irregular heart beat	palpitations	high blood pressure	
Respiratory:	coughing	wheezing	asthma	
Gastrointestinal:	heartburn	nausea/vomiting	painful bowel movement	
	stomach ulcer	diarrhea	constipation	
Musculoskeletal:	muscle cramps	muscle twitches	arthritis	swollen joints
	stiffness	cold-weather pain		
Skin:	rash	shingles	itching	
Neurological:	weakness	numbness	tremors	poor coordination
Psychiatric:	depression	anxiety	mood swings	irritability
Hematologic:	easy bruising	anemia		
Endocrine:	excessive thirst	excessive urination	heat/cold intolerance	
Urinary:	painful urination	loss bladder control	blood in urine	kidney stones
Men only:	prostate trouble	erectile dysfunction		
Women only:	irregular periods	menstrual cramps	vaginal discharge	menopausal

Pain Diagram for Principal Spine and Pain Consultants

(Please Circle the area where the pain is located.)



Name (PRINT):_____

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HIPPA - Consent for Additional uses of Health Information

Patient Name (Print): _____ Date: _____

Additional Uses of Information

Your health information may be used by our staff to send you appointment reminders. Our office will contact you through the phone number you have provided and through email for appoint reminders, outstanding balances, or other office concerns. If you do not want us to contact you via the phone number you have already provided, and/or leave a voice message on those phone numbers, please choose one or more of the following alternate methods for us to use to contact you:

May we leave messages concerning your appointment with anyone at your workplace?

0 Yes 0 No 0 N/A

May we leave messages on your voice-mail at work?

0 Yes 0 No 0 N/A

May we leave messages on your voice-mail at home?

0 Yes 0 No 0 N/A

If you are over (or under) the age of 18, may we discuss your appointments and/or treatments with your parents?

0 Yes 0 No 0 N/A

If you are over the age of 18, may we discuss you appointments and/or treatments with your children?

0 Yes 0 No 0 N/A

If you answered "no" to any of the above, please inform us of your preferred method of contacting you.

_____

Please provide us with names of those persons, if any, with whom we may discuss your appointments and/or treatment:

_____

HIPPA Notice of Privacy Practices

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

Uses and Disclosures:
Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of your laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or may be consulted by staff members.

Payment:
Your health information may be used to seek payment from your health plan, from other sources of coverage such as automobile insurer, or credit card companies that you may use to help pay for services. For example, your health plan may request and receive information on dates of service, services provided, and medical condition being treated. Other vendors such as labs, imaging facility, Pharmacy that provides service for comprehensive care might also request Medical records. Your records are issued by our office if your insurance provider is requesting these notes for payment or preauthorization..

Health Care Operation:
Your health information may be used as necessary to support the day-to-day activities and management of Principal Spine and Pain Consultants P.A. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement:
Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and Public health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Research:
Provider may disclose your medical information to people preparing to conduct a research project (for example, to help them look for patients with specific medical needs) so long as the medical information the review is not removed from the premises of this practice. Provider may also disclose the medical of decedents for a research project, so long as the information is necessary for the research.

Other Use and Disclosure Requires Your Authorization:
Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment;
- The right to inspect and copy your protected health information;
- The right to amend or submit corrections to your protected health information;
- The right to receive an accounting of how and to whom your protected health information has been disclosed; and
- The right to receive a printed copy of this notice.

Practice Duties. We are required by law to maintain the privacy of you protected health information and to provide you with this "Notice of Privacy Practices".

We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices. As permitted by law, we reserve the right to amend or modify our privacy practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Request to Inspect Protected Health Information. You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting this practice. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to our address. You may also submit complaints to the Secretary of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.

Print Name: _____
{Patient or responsible party)

Signature: _____ **Date:** _____
{Patient or responsible party)

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I authorize Principal Spine and Pain Consultants to obtain health information from:

_____.

_____

Please Release

( ) MEDICAL NOTES
( ) MENTAL HEALTH (other than psychotherapy notes)
( ) LABORATORY RESULTS
( ) RADIOLOGY REPORTS
( ) OTHER : _____

The purpose of this release is for (check one or more):
( ) At the request of the patient/patient representative.
( ) Other (state reason)_____

_____	_____	_____
Print Name	Signature of patient	Date

NOTICE
Principle Pain and Spine Consultants, 1809 Golden Trail Ct , Suite 110, Carrollton TX 75010 and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

YOUR RIGHTS
This authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing Authorization except in the following cases: (1) to conduct research- related treatment (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

This authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to Principle Pain and Spine Consultants, 1809 Golden Trail Ct , Suite 110, Carrollton TX 75010. The revocation will take effect when Principle Pain and Spine Consultants receives it, except to the extent Principle Pain and Spine Consultants or others have already relied on it. You are entitled to receive a copy of this Authorization.

_____ (Patient Initial) Financial Responsibility Agreement

I understand and agree that I will be financially responsible for any and all charges not paid by my insurance company for my visit(s). This includes any medical visit, lab testing, anesthesia, DME, x-ray (s), and any other screening or diagnostic testing ordered by the physician or the physician's staff.

I understand and agree that it is my responsibility, and not the responsibility of the physician or the physician's staff, to know if my insurance will pay for my medical service or visit, procedures, DME, anesthesia, preventative exam, physical, lab testing, x-ray, EKG or any other screening or diagnostic testing ordered by the physician. I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network amount, usual or customary limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment at the time of service for all office visits, injections, x-rays, lab testing, and any surgical procedures that have been ordered. Additional surgical procedures cannot be anticipated until surgery has been performed, therefore, there may be additional balance due for those unexpected procedures.

I understand and agree that it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company and/or plan. If my insurance company or plan does not recognize the physician or provider I am seeing, it may result in claims being denied, higher deductible or out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

If I am insured under an HMO, MC, POS or EPO policy, it is my responsibility to obtain a referral from my primary care physician for my initial visit. Failure to do so may result in claim denial and/or loss of benefits. It is also my responsibility to find out if prior authorization is required for my procedures and get that prior authorization from my insurance provider. My Doctor's office will assist in this process, but it is my responsibility to make sure this is done before any treatment is accepted. If for any reason my insurance denies my claim, it is my responsibility to pay the allowable amount.

If I am a Worker's Compensation patient, I understand that I am to provide all necessary billing information. I am to provide my date of injury, claim number, adjustor name and contact information, employer information and insurance carrier information including phone and fax numbers. I understand that if my Worker's Compensation claim has been denied, I am responsible for payment in full.

I assume full responsibility for any balance owed after my insurance plan has paid including any supplies or services that are not a covered benefit. I am also responsible for visits or procedures not covered by my insurance company or claims that get denied due to various reasons.

I hereby authorize Principle Spine and Pain Consultants to furnish information to my insurance carriers concerning my illness and treatments and hereby assign to the physician(s) all payments for medical services rendered to me or my dependents. I understand that I am responsible for any amount not paid by or denied by my insurance. I also understand and agree that I accept responsibility for paying the physician's bill and any other bills relating to this case, including injectable, equipment, supplies, DME, Labs, and anesthesia regardless of insurance payments.

_____ (Patient Initial) Medicaid Patients:

Principal spine and pain consultants are not in network with Medicaid. Patients with Medicaid will be responsible for the amount that is covered by Medicaid. Sorry for any inconvenience this might cause.

I understand Principal Spine and Pain Consultants is accepting me as a private pay patient for the period that I choose to come to this office, and I will be responsible for paying for any services I receive. The provider will not file a claim to Medicaid for services provided to me.

Print Name: _____
{Patient or responsible party}

Signature: _____ **Date:** _____
{Patient or responsible party}

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Notice of Office Policies

Thank you for choosing us for your healthcare needs. We would like to take this time to explain our office policies. Our office communicates with our patients concerning appointments, patient bills, and other office concerns via phone number you have provided or through the email that was provided. Please carefully read and address any concerns you might have.

Office Hours:
Our office is open Monday to Friday, 8:30AM to 5:30PM. Lunch is between 12:00PM to 1:OO PM. If you should have a medical emergency after hours please contact 911 and proceed to the nearest emergency room.

Appointments:
There is **a $25.00 missed appointment fee and a $100 missed procedure fee**. We understand emergencies happen and there will be times that you will need to reschedule your appointment. Dr. Kurian tries not to double book his patients to give them the individual attention that he wants to provide his patients. Since we are holding this spot for your appointment, it is your responsibility as the patient to contact the office 24 hours before your appointment if you need to cancel or reschedule your appointment. Without proper notice we will charge a $25 cancellation or no show fee to respect Dr. Kurian's time for new patient visits and follow up visits. For cancellations for procedures without a 24 hour notice, patients will be fined a $100 cancellation fee.

Insurance:
We will file an insurance claim with your insurance company. However, your deductibles and co-payments/co-insurance payments are expected at the time services are rendered. In order to file your insurance claims appropriately, we ask that you keep our office informed of any insurance or address changes during your course of treatment. If you are insured under an HMO, MC, POS or EPO policy, it is your responsibility to obtain a referral from your primary care physician for your initial visit. Failure to do so may result in claim denial and/or loss of benefits. It is also the patient's responsibility to find out if prior authorization is required for any procedures. If for any reason your insurance denies your claim, it is your responsibility to pay the unpaid or not covered balance.

Work Related Injuries:
It is your responsibility as the employee to provide the Injury Status Report to your employer. Any unpaid or not covered treatment will be the your responsibility.

FORMS:
FMLA, work release forms, Disability, Etc: Forms will be completed within 5 business days. There is a **minimum charge of $25.00** payable to the office due at the time the forms are dropped off at the office.

Prescription Refills:
Medication refills are done only during regular office hours. Refills are not addressed after 4:00pm or on holidays/weekends. It may take up to 2 business days for your request to be handled.

Medical Records:
Our office utilizes Prognocis EMR for copying medical records. This service may take up to 7 business days to be completed. There is a minimum charge of $25.00 for this service. Records to other physicians are done free of charge.

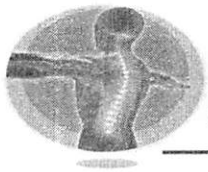
Acknowledgement of Receipt of Office Policies and HIPPA Privacy Practices Notice

By signing below, I acknowledge that I have read and fully understand the HIPPA Privacy Practices Policies and the office policies of Principal Spine and Pain Consultants.

I understand that the medical practice may amend or revise these policies at any time.

Print Name: _____
{Patient or responsible party}

Signature: _____ **Date:** _____
{Patient or responsible party}



PRINCIPAL
Spine AND Pain
CONSULTANTS

MEDICATION REFILL POLICY

Thank you for choosing Principal Pain and Spine Consultants. In order to help you receive the best care, we have created a medication refill instruction sheet. It is as follows:

- Medication refill requests should be made Monday – Thursday. Please allow 2-3 **business** days for the request to be processed.
- Please call 972-316-7270 or 940-222-8943 for a medication refill.

- Please make sure you are aware of how much medication you have left and contact us before you run out of medication, so that your medication is refilled on time. Running out of your medication may cause side effects.

NO SHOW POLICY

Principal Pain and Spine Consultants is dedicated to providing quality patient care to all of our patients. In order to maintain a high level of patient care, our office has established a "NO SHOW" policy.

A patient shall be considered a "No Show" when the patient fails to appear for his/her appointment or cancels within 24 hours of their appointment time. We ask that our office be notified as far in advance as possible for cancellation or rescheduling. This allows us to schedule other patients that may be waiting for appointments.

- The first "No Show" will warrant a phone call; notifying the patient that his/her appointment was missed.
- Subsequent "No Show" may result in a decision to discharge the patient from the practice. When this decision is rendered, a letter will be sent to the patient giving them 30 days to find a new provider. All of the patient's medical records will be forwarded to the new provider upon the patient signing a medical records release.
- There is a No Show Fee of $25 for an office visit and $100 for a procedure

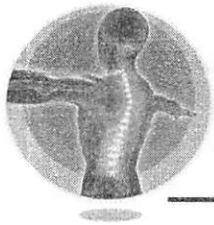
We thank you for your patronage and want to make sure patients are clear of our policies. Please sign below acknowledging understanding, acceptance and receipt of this policy.

I have read the Medication Refill Policy and the No Show Policy and understand it:

If I have any questions regarding these policies, I will ask a staff member to clarify the above policies.

_____ _____

Patient Signature Date



PRINCIPAL
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CONSULTANTS

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT

AS REQUIRED BY THE TEXAS MEDICAL BOARD

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

3Rd Edition: Developed by the Texas Pain Society, April2008 (www.texaspain.org)

NAME OF PATIENT: _____ DATE: _____

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

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician to treat my condition. 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 pain.

It has been explained to me that these medication(s) may 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).

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 for drugs and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances may result in my being discharged from your care.

For female patients only:

To the best of my knowledge **I am NOT pregnant.**

If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment. I accept that it is **MY responsibility** to inform my physician immediately if I become pregnant.

If I am pregnant or am uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY.

All of the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo/ fetus / baby.

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension(low blood pressure), arrhythmias(irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medication(s) for the treatment of my chronic pain.

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

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

PAIN MANAGEMENT AGREEMENT:

I UNDERSTAND AND AGREE TO THE FOLLOWING:
That this pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called 'narcotics, painkillers', and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). **Therefore, medication(s) will only be provided so long as I follow the rules specified in this Agreement.**

My physician may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior:

- My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the **medication(s) may be discontinued.**
- I will **disclose** to my physician **all medication(s)** that I take at any time, prescribed by any physician.
- I will use the medication(s) **exactly as directed by my physician.**
- I agree **not to** share, sell or otherwise permit others, including my family and friends, to have access to these medications.
- I will **not allow or assist in the misuse/diversion of my medication; nor will I give or sell them** to anyone else.
- All medication(s) must be obtained at **one pharmacy, where possible.** Should the need arise to change pharmacies, my physician must be informed. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement if requested. 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.** If I am traveling, I will inform my physician and will make arrangements in advance of the planned departure date. I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.
- I will receive medication(s) **only from ONE physician** unless it is for an emergency **or** the medication(s) that is being prescribed by another physician is approved by my physician. Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.
- If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then **my physician may try alternative medication(s) or may taper me off all medication(s).** I will not hold my physician liable for problems caused by the discontinuance of medication(s).
- I **agree to submit to drug 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, or referral to, an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an addictionologist or a physician who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.
- I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize **that my active participation** in the management of my pain is extremely important. I agree to **actively**

participate in all aspects of the pain management program recommended by my physician to achieve increased function and improved quality of life.

- I agree that I **shall inform any doctor** who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.
- I hereby give my physician **permission to** discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).
- I must take the medication(s) as instructed by my physician. **Any unauthorized increase** in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.
- I must **keep all follow-up appointments** as recommended by my physician or my treatment may be discontinued.

I certify and agree to the following:

1) I am **not currently using illegal drugs or abusing prescription medication**(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

2) I have **never been involved** in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.)

3) **No guarantee or assurance has been made** as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life.

4) I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain. **I fully understand the explanations regarding the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.**

_____

Patient Signature

_____

Physician Signature (or Appropriately Authorized Assistant)

_____

_____

Name and contact information for pharmacy

PRINCIPAL SPINE AND PAIN CONSULTANTS
1809 Golden Trail Suite #110
Carrollton, TX 75010
Phone: 972.316.7270 www.principalspineonline.com principalspine@gmail.com Fax: 972.492.5345

Disclosure

_____DISCLOSURE OF FINANCIAL INTREST

Initials

The Principal Spine and Pain Consultant physician you are seeing may have a financial interest in the facilities listed below. The facilities and our physicians are committed to providing clinical excellence in a safe and attractive environment for you and your family members. Their financial interest in these facilities enables them to have a voice in administration and their policies. This involvement helps to ensure the highest quality of care for you. Should you have any concern regarding this notice, please ask your physician or a member of the staff. My initials above verify that I have read and understand the above statement and information.

Star Neurodiagnostics 1809 Golden Trail Ct Suite 110 Carrollton TX, 75010 972-316-7270	**Advocate Anesthesia** 1809 Golden Trail Ct Suite 110 Carrollton TX, 75010 972-316-7270
Star Anesthesia and Comprehensive Spine and Pain Management 1809 Golden Trail Ct Suite 110 Carrollton TX, 75010 972-316-7270	**Lotus Labs** 1735 Keller Springs Suite 210 Carrollton TX, 75006 972-242-LABS (5227)

ACKNOWLEDGEMENT:

- I have read and understand the Disclosure of Financial Interest. If referred to one of the above facilities, I acknowledge I do have the right to choose another facility of my choice for these services. I have the option to have my care provided at any health care facility I choose. Please ask staff for alternative facilities. I further acknowledge that I signed this Notice prior to any referral made to any of the above facilities.

_____ _____

Patient Name (Printed) **Date**

_____ _____

Patient or Guardian Signature **Date**

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Carrollton, TX 75010
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PATIENT COLLECTION GUIDELINES FOR LOTUS LABS

EFFECTIVE JANUARY 1, 2014

Your physician has referred you to Lotus Labs because we take great pride in having high standards for quality of care, low error rates, state-of-the-art equipment, and ease of access for physician's to talk to and get details on their patient's lab results. We take great pride in providing in the quality and accuracy of all the lab tests we provide. Further, your physician has the ability at Lotus Labs to actively participate in the patient care decision making process which ensures that a high level of service is the standard.

As you are aware, your insurance company has designated a portion of the medical expenses as your financial liability by way of a deductible and/or co-insurance amount which normally will be billed by Lotus Labs. We would like to take this opportunity to provide you with a summary of our billing and collection practices for commercial insurance.

Since we are "out-of-network" with your insurance carrier, every carrier will pay the lab tests very differently. It is very difficult, if not impossible, to determine the exact amount you will owe until after your insurance carrier has paid your lab claim.

After the insurance company has paid its portion, including all reasonable options being pursued by us to collect from your insurance carrier, the account is adjusted to reflect the actual amount of your claim to determine any remaining balance owed on your deductible and/or co-insurance, if any.

At that point, we will send you a series of letters/statements for the patient financial responsibility at monthly intervals. On an individual case basis, we will work with you regarding any remaining deductible and/or co-insurance that you may owe.

We recognize that many patients may be struggling with unfavorable economic conditions. Therefore, we will not utilize harassment such as phone calls to your home or place of business, law firms that result in law suits, or other high pressure tactics, much less damage your credit ratings or worsen any financial hardships that you may be enduring. We believe our patients make every effort to pay what they can afford in a reasonable time period and we are grateful to provide our services and be sympathetic to your personal financial circumstances.

I have read and understand Lotus Labs Billing policy. I was given an opportunity to ask all questions and have willingly agreed to my lab test going to Lotus Labs.

_____

Patient Signature

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Carrollton, TX 75010
Phone: 972.316.7270 www.principalspineonline.com principalspine@gmail.com Fax: 972.492.5345

PATIENT COLLECTION GUIDELINES FOR STAR ANESTHESIA & COMPREHENSIVE SPINE AND PAIN MANAGEMENT

EFFECTIVE JANUARY 1, 2012

Your physician has referred you to Star Anesthesia and Comprehensive Spine and Pain Management because we take great pride in having high standards for quality of care, state-of-the-art equipment, employee only board certified Anesthesiologist and CRNA, and ease of access for surgeon to talk to and get details on their patient prior to the procedure. We take great pride in providing in the quality and accuracy of all the lab tests we provide. Further, your physician has the ability with Star Anesthesia to actively participate in the patient care decision making process which ensures that a high level of service is the standard.

As you are aware, your insurance company has designated a portion of the medical expenses as your financial liability by way of a deductible and/or co-insurance amount which normally will be billed by Star Anesthesia. We would like to take this opportunity to provide you with a summary of our billing and collection practices for commercial insurance.

Since we are "out-of-network" with your insurance carrier, every carrier will pay the lab tests very differently. It is very difficult, if not impossible, to determine the exact amount you will owe until after your insurance carrier has paid your anesthesia claim for the procedure you are about to have.

After the insurance company has paid its portion, including all reasonable options being pursued by us to collect from your insurance carrier, the account is adjusted to reflect the actual amount of your claim to determine any remaining balance owed on your deductible and/or co-insurance, if any.

At that point, we will send you a series of letters/statements for the patient financial responsibility at monthly intervals. On an individual case basis, we will work with you regarding any remaining deductible and/or co-insurance that you may owe.

We recognize that many patients may be struggling with unfavorable economic conditions. Therefore, we will not utilize harassment such as phone calls to your home or place of business, law firms that result in law suits, or other high pressure tactics, much less damage your credit ratings or worsen any financial hardships that you may be enduring. We believe our patients make every effort to pay what they can afford in a reasonable time period and we are grateful to provide our services and be sympathetic to your personal financial circumstances.

I have read and understand Star Anesthesia Billing policy. I was given an opportunity to ask all questions and have willingly agreed to Star Anesthesia providing my anesthesia services.

_____

Patient Signature