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

Email: _____

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 pain you ever felt in your life)

Right now_____ Average _____

How did your pain start CIRCLE all that applies to you

Suddenly	*Gradually*		
While bending	*While walking*	*When fell down*	*Other* _____
While jumping	*While lifting weight*	*After car accident*	*While playing*

How often do you have pain? Constant Intermittent

What is the pain like?

Achy	*Sore*	*Cramping*	*Dull*	*Throbbing*
Numb	*Stabbing*	*Pressure*	*Sharp*	*Shooting*
Pins/needles	*Hot/burning*	*Tingling*	*Other* _____	

Does your pain radiate or shoot to another location? NO

Left Head	*Right head*	*Trunk*	*Other*_____
Left Arm	*Right arm*	*Flank*	
Left Leg	*Right leg*	*Groin*	

What makes your pain worse? NOTHING

Bending	*Sitting a long time*	*Going up stairs*	*Turning left*
Lifting	*Standing a long time*	*Going down stairs*	*Turning right*
Movement	*Standing straight up*	*Increased activity*	*Walking*

*Other*_____

What makes your pain better? NOTHING

Medications	*Massage*	*Heat*	*Walking*	*Other:*_____
Injections	*Exercise*	*Cold*	*Manipulation*	
Physical therapy	*Rest*	*Sitting*	*Standing*	*Lying flat*

Are you having any of these associated symptoms? NONE

Muscle Cramps	*Poor Sleep*	*Loss of bowel/bladder control*
Weakness	*Feeling sad*	
Numbness	*Feeling frustrated*	

Do you have a history of these conditions? Fibromyalgia, IBS, Rheumatoid Arthritis

Do you use any supporting devices? Cane Crutches Walker Wheelchair

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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?** _____

SLEEP HISTORY:

How many hours of sleep do you have each night? _____		
Are You awakened at night due to pain?	**YES**	**NO**
Do you difficulty falling asleep?	**YES**	**NO**

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

Any other symptoms you would like to discuss? _____
_____

What is your goal for pain management? _____
Are you interested in back brace to manage your pain? _____Therapy? _____tense unit?_____

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..

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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.

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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

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.

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**

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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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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