PAIN MANAGEMENT OF NORTH DALLAS, PA

ADEEL HAQ, MD
LYNNE OPPERMAN, FNP-BC
8501 WADE BLVD., SUITE 1330
Box # 31
FRISCO, TEXAS 75034
PHONE: 214/618-0853
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Patient Information

Name: ______________________ Phone: ______________________

Address: ______________________ Gender: ______________

City: ______________ State: __________ Zip: __________

Date of Birth: ____________ Marital Status: __________ Email: ______________

Guarantor Information (If patient is not the guarantor, please complete the section)

Name: ______________________ Phone: ______________________

Address: ______________________ Gender: ______________

City: ______________ State: __________ Zip: __________

Date of Birth: ____________ Marital Status: __________ Email: ______________

How did you hear about us? ______________________

Name of Referring Physician, Patient, Source, Etc. ______________________

Primary Insurance:

Insurance Company Name: ______________ Insurance Co Phone: ______________

Policy Holder name: ______________ Date of Birth: ______________

ID/Subscriber Number: ______________ Group Name / Acct #: ______________

Secondary Insurance:

Insurance Company Name: ______________ Insurance Co Phone: ______________

Policy Holder Name: ______________ Date of Birth: ______________

ID/Subscriber Number: ______________ Group Name / Acct #: ______________

______________________ ______________

Patient Signature: **Date:**

I certify that the above information is accurate, and I understand that I am responsible for payment of all charges to Pain Management of North Dallas regardless of quoted insurance benefits and eligibility.

Pain Management of North Dallas Patient Pain Profile

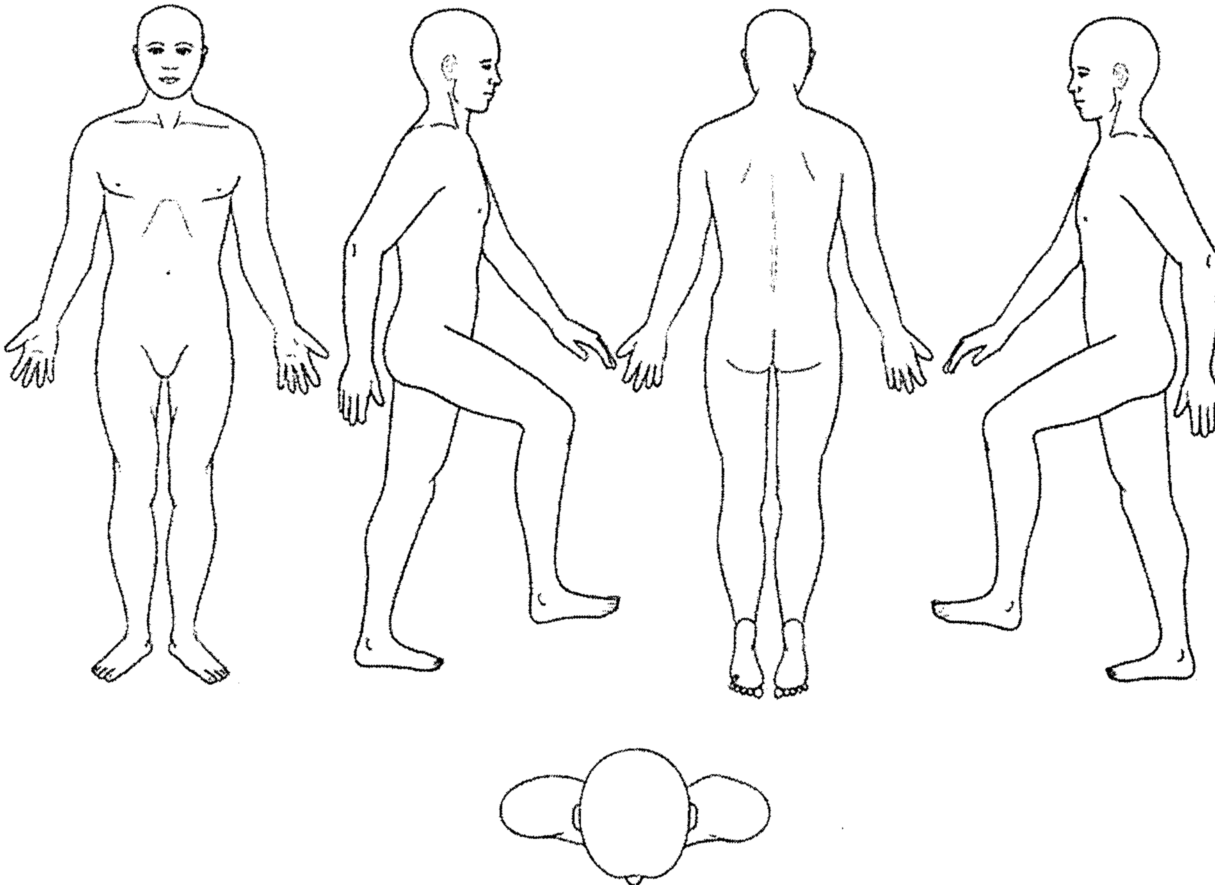
Your name: ______________________ Date of Birth: ____________________ Date: __________________

Where is your pain: ____

Does this pain radiate? If so where? ____

Use this diagram to indicate the area of your pain. Mark the location of pain with:

A: ache **P= pins and needles** **B=burning** **S=stabbing** **N=numbness** **O=other**



What is your pain at its lowest on a 0/10 scale? ________ What is your pain level when it's the highest? ________

What is your pain level goal?_____**/10**

When did pain begin? _______________

How did pain begin? (please circle):

Work accident **Following Surgery** **Incident at home** **No specific event**

Other: ____

Was the pain (please circle one): **Sudden** **Gradual**

Is the pain (please circle one): **Constant** **Intermittent**

Mark the effect that each has on your pain level:

	Increases pain	Decreases pain	No effect
Bending Backward	☐	☐	☐
Bending Forward	☐	☐	☐
Changes in Weather	☐	☐	☐
Climbing Stairs	☐	☐	☐
Looking up or down	☐	☐	☐
Stress	☐	☐	☐
Heat/Ice	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐

What other factors worsen or affect your pain which is not mentioned above?

____

____

____

Do you have any. of these symptoms associated with your pain: (Please circle):

Loss of bowel or bladder control **Arm or Leg Weakness** **Fever or Chills**

Numbness or tingling in arms or legs

Please circle if you have had any of the following treatments and indicate "Y" or "N" if they were effective:

Physical Therapy **Chiropractor** **Acupuncture**

Traction **Hydrotherapy** **TENS** **Ultrasound therapy**

Please list any spine surgeries that you have had:

Spinal Level	**What type (fusion, discectomy, laminectomy, etc.)**	**Date**	**Surgeon**

Interventional Pain Treatment History (Please check any that you have had)

☐ Epidural Steroid Injection — (circle all levels that apply) Cervical/Thoracic/Lumbar

☐ Joint Injection — Joint(s)

___

☐ Medial Branch Blocks/Facet Injections - (circle levels) Cervical/Thoracic/Lumbar

☐ Caudal or Facet Injection

___

☐ Nerve Blocks — Area/Nerve(s) -

___

☐ Radiofrequency Nerve Ablation — (circle levels) — Cervical/Thoracic/Lumbar

☐ Spinal Cord Stimulator — Trial Only/Permanent Implant

___

☐ Trigger Point Injections — Where?

___

☐ Vertebroplasty/Kyphoplasty — Level(s)

___

☐ Sympathetic Block

___

Which of these procedures listed above have helped with your pain?

___

Have you had any diagnostic studies (please list date and facility where you received them):

MRI/CT____________________ X-ray ____________________

EMG: ____________________ Discogram: ____________________

Please list all medical providers who have evaluated you or prescribed narcotic pain medications for your pain: (please include name of medication prescribed)

___

___

Please indicated if you have been diagnosed with any of the following and the date of diagnosis:

	YES	DATE		YES	DATE		YES	DATE
AIDS/HIV			DEPRESSION			LYMPHOMA		
ANXIETY			FIBROMYALGIA			LUPUS		
ABNORMAL HEART RHYTHM			GERD/PEPTIC ULCER			MULTIPLE SCLEROSIS		
ARTHRITIS			HERNIA			MIGRAINES		
BLOOD CLOT			HEMORROIDS/ CONSTIPATION			OSTEOPOROSI/ OSTEOPENIA		
BLEEDING DISORDER (specify)			HEART DISEASE			PROSTATE PROBLEMS		
CANCER (type)			HIGH BLOOD PRESSURE			POLYCYTHEMIA		
CATARACT/ GLAUCOMA			HEART ATTACK			PSYCHIATRIC DISORDER		
COPD			HEART BYPASS			SKIN DISEASES		
CHRONIC PAIN (specify)			HIGH CHOLESTEROL			STROKE		
CHRONIC LIVER DISEASE			HEPATITIS: A B C			THYROID DISEASE		
DIABETES			KIDNEY DISEASE			SLEEP APNEA		

Other:

____

____

Please list any surgeries that you have had in the past and the date:

____

____

____

CURRENT MEDICATIONS				
Medication	Dose	Frequency	Does it help?	List any side effects

What medications have you taken for pain in the past?

Dose	How many times per day	Did it help?	List any side effects

Please circle if you are taking any of the following:

Aspirin **Ticlid** **Warfarin/Coumadin**

Heparin **Aggrenox** **Plavix** **Lovenox** **Fragmin**

Please list any over the counter supplements you are taking:____

Please list medication allergies:

____

Please list other allergies: (including food, anesthesia, tape, latex, IV dye):

Social History:

Tobacco Use: ______ How often per week_______ How many years_______ Have you quit? ______

Alcohol Use: _______ How often per week_______ How many years_______ Have you quit? ______

Exercise: __________ How often and what kind? ____

Occupation: ___________ Full/Part Time_______Disabled______Retired______Homemaker______Student_____

Does your job require you to bend in an awkward position? If so, please explain____

Does anyone in your family suffer from chronic pain? If yes, please list relative and where they have pain:____

Review of Systems: Mark the following symptoms that you currently suffer from:

Constitutional:

☐ Chills ☐ Difficulty sleeping ☐ Easy bruising ☐ Night Sweats ☐ Fatigue ☐ Fevers

☐ Insomnia ☐ Low sex drive ☐ Tremors ☐ Unexplained Weight Gain ☐ Weakness

☐ Unexplained Weight Loss

Eyes: ☐ Recent Visual changes

Ears/Nose/Throat/Neck: ☐ Dental Problems ☐ Earaches ☐ Hearing Problems

☐ Nosebleeds ☐ Sinus problems

Cardiovascular:

☐ Chest Pain ☐ Bleeding Disorder ☐ Blood Clots ☐ Fainting ☐ Palpitations ☐ Swelling in feet

☐ Shortness of breath during sleep

Respiratory:

☐ Cough ☐ Wheezing ☐ Shortness of breath

Gastrointestinal: ☐ Constipation ☐ Acid Reflux ☐ Abdominal Cramps

☐ Diarrhea ☐ Nausea/Vomiting Hernia

Musculoskeletal:

☐ Back Pain ☐ Joint Pains ☐ Joint Stiffness ☐ Joint Swelling ☐ muscle spasms ☐ Neck Pain

Genitourinary/Nephrology:

☐ Flank Pain ☐ Blood in Urine ☐ Painful Urination ☐ Decreased Urine Flow/Frequency/Volume

Neurological:

☐ Dizziness ☐ Headaches ☐ Tremors ☐ Numbness/Tingling Seizures

Psychiatric:

☐ Depressed Mood ☐ Feeling Anxious ☐ Stress Problems ☐ Suicidal Thoughts ☐ Suicidal Planning

☐ Thoughts of Harming Others

☐ All other review of systems negative

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PATIENT CONSENT TO TREATMENT

By reading and signing this document, I, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medications, anesthesia, medical services, and surgical or diagnostic procedures (including but not limited to the use of lab and radiographic studies) as ordered or approved by my attending physician(s), or any healthcare professional assigned to my care by my attending physician(s), and I acknowledge and consent to the following:

1. INDEPENDENT CONTRACTORS: PAIN MANAGEMENT OF NORTH DALLAS, PA/DR ADEEL HAQ may utilize independent contractors for office, outpatient or inpatient treatment/procedures. These include, but are not limited to, surgical assistants, physical therapists, and consulting and referral physicians. Healthcare professionals that are independent contractors are not agents or employees of PAIN MANAGEMENT OF NORTH DALLAS, PA/DR ADEEL HAQ are responsible for their own actions. I understand that PAIN MANAGEMENT OF NORTH DALLAS, PA/DR ADEEL HAQ shall not be liable for the acts or omissions of independent contractors. This Consent to Treatment also applies to any independent contractor utilized by my physician(s).

2. VALUABLES: PAIN MANAGEMENT OF NORTH DALLAS, PADR ADEEL HAQ assumes no responsibility for, and I hereby release PAIN MANAGEMENT OF NORTH DALLAS, PA/DR ADEEL HAQ from liability for, loss or damage to any of my personal property while on the premises and/or receiving treatment.

3. AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF THIRD PARTY PAYMENTS: 1 hereby expressly authorize PAIN MANAGEMENT OF NORTH DALLAS, PA/DR ADEEL HAQ and all healthcare professionals providing care to release all necessary information to PAIN MANAGEMENT OF NORTH DALLAS, PA/DR ADEEL HAQ any insurance company, health plan or other entity (third party payor) which may be responsible for paying for my care. I authorize and direct all payors to pay all benefits due for such care directly to PAIN MANAGEMENT OF NORTH DALLAS, PA/DR ADEEL HAQ and all professionals (including independent contractors) providing for such care, and I hereby assign such sums to them. I understand this authorization and assignment shall remain valid unless I provide written notice of revocation to PAIN MANAGEMENT OF NORTH DALLAS, PA/DR ADEEL HAQ and the third-party payor signed and dated by me; however, such revocation shall not be effective as to information released and/or charges incurred prior to such revocation.

4. PAYMENT FOR SERVICES: In return for services to be provided by PAIN MANAGEMENT OF NORTH DALLAS, PADR ADEEL HAQ, 1 promise to pay for services rendered by PAIN MANAGEMENT OF NORTH DALLAS, PA/DR ADEEL HAQ to me or for my benefit. If the services 1 receive from PAIN MANAGEMENT OF NORTH DALLAS, PA/DR ADEEL HAQ are covered by a third-party payor, PAIN MANAGEMENT OF NORTH DALLAS, PA/DR ADEEL HAQ may elect to bill and accept payment from such third party. I will pay the portion of these bills which the third-party payor determines are my responsibility. In the case of services which I agree to receive but which are not covered by the third party, I will pay the amount due upon receipt of services. If no third party is involved in paying for my services, I agree to pay in full for such services at the time the services are received.

5. AUTHORIZATION AND RELEASE FOR PHOTOGRAPHS: I authorize and release PAIN MANAGEMENT OF NORTH DALLAS, PA/DR ADEEL HAQ and its employees and agents to take photographs, videos, x-rays, and/or other photographic, electronic or other images of me and to use them as may be medically appropriate. Such images may be used for educational or other purposes as necessary and appropriate. These images may be maintained as a permanent part of my medical record. I understand and acknowledge that PAIN MANAGEMENT OF NORTH DALLAS, PA/DR ADEEL HAQ may use cameras for security and patient monitoring, and patient confidentiality will be maintained for all such images.

6. NO GUARANTEE OF RESULTS: PAIN MANAGEMENT OF NORTH DALLAS, PA/DR ADEEL HAQ physicians and healthcare professionals cannot guarantee any specific result(s) of any examination, treatment, procedure or medical care. I release PAIN MANAGEMENT OF NORTH DALLAS, PA/DR ADEEL HAQ, its physicians and healthcare professionals from any liability for any accident or injury that is not directly caused by the negligence of PAIN MANAGEMENT OF NORTH DALLAS, PADR ADEEL HAQ, or its employees, agents, representatives or assigns.

7. During the course of my care and treatment, I understand that various types of examinations, tests, diagnostic or treatment procedures ("procedures") may be necessary. These procedures may be performed by physician(s), nurses, technicians, physician assistants, or other healthcare professionals. While routinely performed without incident, there may be material risks associated with these procedures. If I have any questions concerning these procedures, I will ask my physician(s) to provide me with additional information. I also understand my physician may ask me to sign additional Informed Consent documents relating to specific procedures.

8. I understand that the healthcare professionals involved in my care will rely on my documented medical history, as well as other information provided by me, my immediate family, or others having information about me, in determining whether to perform or recommend procedures. I agree to provide accurate and thorough information regarding my medical history and any conditions or events which may impact medical decision-making.

By signing this document, I certify that I have read and understand its contents and the information provided by me is accurate and complete (including insurance information and current eligibility for benefits).

A copy of this document may be utilized the same as the original.

_______________________________________ **Date:** ______________________

Patient/Parent/Guardian/Authorized Representative Signature:

If not signed by the patient, please indicate relationship to the patient on the line below:

____

Pain Management of North Dallas
8501 Wade Blvd., Suite 1330
Frisco, TX 75034
Phone: 214-618-0853
Fax: 214-618-0859

CONTROLLED MEDICATION AGREEMENT

I agree to participate in a controlled substance agreement with Pain Management of North Dallas, PA (hereafter referred to as "PMND"). I will be provided with controlled substances only if I adhere to the following rules:

1. Compliance. I will use controlled substances only as directed by the PMND medical staff and will refrain from using any illegal drugs while on these medications.

____

2. **No early refills**. I understand that I may not increase my dose without prior approval by PMND. I understand that the safe-keeping of my medications is my sole responsibility and that **I will not receive replacements for lost or stolen medications.**

____

3. Change in pain. Any changes in my pain pattern that cause me to request an increase in pain medication must be addressed at an office visit for evaluation.

____

4. Refill requests. Refills for controlled substances will be done at **30-day intervals**, unless explicitly authorized by PMND. I understand that prescription and medication refill requests are only accepted 9:00am - 3:00pm, Monday through Friday. **NO MEDICATION OR REFILL REQUESTS WILL BE TAKEN DURING NIGHTS, WEEKENDS, OR HOLIDAYS.**

____

5. Diversion. I understand that it is illegal to share or sell my prescription drugs to other people, and agree to take strict precautions to prevent unauthorized access to my medications.

____

6. All controlled substances must be obtained at the same pharmacy, when possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:

____ **Phone:**____________________________

7. Exclusive provider of controlled pain medications. I will receive controlled pain medicines only from the PMND medical staff, unless explicit authorization is received from PMND. I agree to inform my other doctors that I am receiving these medications.

____

8. Urine Drug Screens: I understand that it is the policy of PMND to administer random and/or discretionary urine drug screens and agree to submit to such tests if requested by the PMND medical staff.

____

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ADDITIONAL INFORMATION

1. Side effects. I understand that controlled medications may cause a variety of side effects, including, but not limited to: nausea, vomiting, constipation, dry mouth, difficulty with urination, weight changes, suppressed immune system, altered hormone levels (thyroid, sexual hormones), itching, allergic reactions, fluid and blood chemistry imbalances, and altered sexual function. I understand that taken improperly, controlled substances may cause excess sedation, depressed breathing and even death, especially if combined with alcohol or other mood- or consciousness-altering substances. I understand that these medications may alter my ability to drive a car or other heavy machinery and I will comply with all state and federal laws regarding such activities while using these medications.

2. Tolerance, Dependence and Addiction. I understand that controlled substances may cause physical dependence and that sudden withdrawal may cause symptoms such as abdominal and muscle cramps, sweats, chills, nausea and vomiting. In rare cases it may cause death. I understand that these drugs must be withdrawn slowly. I understand that I

may become tolerant to these drugs and require increasing doses for the same amount of pain relief. I understand that there is a small but real chance that I may become psychologically addicted to these medications.
I also understand that it is my responsibility to anticipate the need for refills and make refill requests in a timely manner. I will not make repeated calls to the office for prescriptions, nor will I subject the office staff to rude or abusive behavior if prescriptions are not filled as quickly as I would like.
I understand that if I take more than the prescribed amount of medication, or my medication is lost or stolen, I run the risk of having withdrawal symptoms because my medication will NOT be refilled early.
I agree to participate in a detoxification program if prescribed by a PMND physician.

3. Pregnancy. I understand that controlled substances may have adverse effects on the fetus, and that there is a strong likelihood that any baby born to a woman taking controlled substances will probably be physically dependent and could suffer withdrawal symptoms. FOR FEMALE PATIENTS: I agree to notify PMND if I become, or intend to become, pregnant. If I have not been sterilized or am not postmenopausal, I agree to take reasonable and prudent precautions to ensure that I will not become pregnant while taking these medications.

4. Refills:
I also understand that it is my responsibility to anticipate the need for refills and make refill requests in a timely manner. I will not make repeated calls to the office for prescriptions, nor will I subject the office staff to rude or abusive behavior if prescriptions are not filled as quickly as I would like.

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5. Pharmacy: I understand that it is the policy of many pharmacies and medical insurance carriers to notify health care providers when they discover that a patient is receiving controlled substances from multiple prescribers or multiple pharmacies.

6. Termination. Termination of controlled medication therapy may be instituted for any violation of this agreement or at the clinical discretion of the PMND staff. I agree to obtain an alternate source of medical care and controlled substances within 30 days of notification of violation of this agreement or enroll in a detoxification program within this time frame. I will not hold any member of the PMND staff liable for any sequelae of discontinuance of controlled substances provided 30 days of notification of termination is provided. I will not seek controlled substances from the PMND staff if I decide to discontinue participation in the pain treatment program.

I have read and understand all of the above terns. I have had the opportunity to ask questions about these terms and all of my questions have been answered to my satisfaction. I agree to abide by the terms and provisions of this agreement and understand that failure to do so will lead to termination of treatment.

Patient's Printed Name: ______________________________

Patient's Signature: ______________________________

AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. This form must be completely filled out.

Patient Name: ____________________ SSN#: __________________

Phone Number: ___________________ DOB: __________________

Email Address: ____

Medical Provider to release records: ____

Persons/organizations receiving the information: ____

Circle specific articles of information (and insert specific dates if applicable):
____________Dates Progress Notes Labs Operative Reports Radiology Report Correspondence
Hospital Records Other Provider Records Test Results Consultations PT Notes Entire Chart
Radiology Films* Billing _________________ Other

***All films will be duplicated digitally using Dicom Software and provided on CD.**

Section B: Must be completed only if a health plan or health care provider has requested the authorization

* Will the health plan or care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? ____yes ____no
* I understand that my health care and the payment for my health care will not be affected if I do not sign this form.
* I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it Further, **I understand there may be a fee for a copy of this information**.

Section C: Must be completed for all authorizations

* What is the purpose of the use or disclosure? ____
* I understand that this authorization will expire on ___/___/___. Or at the term of ________________________________event. If not specified, this release will expire 180 days from the date signed.
* I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any effect on any actions they took before they received the revocation.
* I understand that my records are protected under state and federal law. I understand that specific information to be disclosed may include history of drug or alcohol abuse, mental health treatment, AIDS or any other medical information. *** **I understand there may be a fee for a copy of this information.**

____ ____________________________

Signature of patient or patient's representative: **Date:**
(Form MUST be completed before signing)

Printed name of patient's representative: ____
Relationship to the patient: ____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

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Prescription Policy

Pain Management of North Dallas, PA (PMND) diagnoses and treats patients in pain for a variety of injury and illnesses. We may prescribe medications for you to help relieve the pain. These medications, when used properly, can help patients feel better and lead more productive lives. These medications can also be misused, causing harm to patients and others. For this reason, the State of Texas and the Federal Drug Enforcement Administration regulate the use of medications. PMND follows those laws.

Our policy:

1. Written prescriptions will not be replaced if lost, stolen or misplaced.
2. Prescriptions are to be taken as directed. In other words, do not change the frequency of the dose unless otherwise directed by a PMND professional. If a change does occur, this will be noted in your chart.
3. Certain controlled substances such as OxyContin, MS Contin and Percocet are written for a 30-day supply. It is necessary to make monthly follow up appointments in order to receive a refill. By law, controlled substance medications cannot be refilled over the phone.
4. Refills for prescriptions listed below may be refilled every three months. As a result, if you were not seen in the hospital or office, prescriptions cannot be refilled.
    - Sleep aids such as: Ambien
    - Anti-inflammatories such as: Vioxx, Bextra, Celebrex
    - Narcotics such as: Lortab, Vicodin, Hydrocodone
    - Muscle Relaxers such as: Soma, Robaxin, Flexural
5. If your prescription bottle indicates that you have refills remaining, contact your pharmacy directly. If there are no refills left, you will need to contact our office and schedule an appointment.
6. Refills will not be authorized at night, on weekends or holidays. Be sure to plan ahead to make sure you have enough pills.
7. Before your visit to PMND, please check your supply of medication. If you need a refill, please ask.
8. Refill requests for prescriptions not prescribed by a PMND physician will not be authorized.
9. If you believe you may be pregnant, discover you are pregnant at any time, or plan to become pregnant, it is your responsibility to inform this office immediately.
10. Urinary drug screens will occur prior to any narcotic regimen and approximately every three months following.

I have read the above prescription policy and I am aware of the necessary steps in order to have prescription(s) refilled.

______________________________ ______________________________

Patient Signature: **Date:**

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Assignment of Benefits/Release of Information/Notice of Privacy Practices/Appt of Authorized Representative

Please read and initial each paragraph*

_____ **Pain Management of North Dallas. PA** and associated physicians are committed to securing the privacy of your health information. We are supplying you with a copy of our Notice of Privacy Practices. You are not required to read this notice. By initialing, you are acknowledging receipt of this notice.

_____ I request that payment of authorized Medicare and other insurance benefits be made on my behalf to **Pain Management of North Dallas. PA** any services furnished to me by any healthcare providers associated with that group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or insurance company any information needed to determine these benefits or the benefits payable for related services.

_____ I appoint **Pain Management of North Dallas, PA** to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

_____ Unless I request to the contrary, in writing, I will receive appointment reminders on my home telephone answering system and/or other information regarding my treatment or invoices by mail to my home address.

Patient Financial Responsibility Statement

In order to maintain our fees at the lowest possible level, it is important that we have a good understanding with our patients regarding financial responsibility. We hope that this summary will be helpful toward that end. We encourage you to discuss it with us and to ask questions.

We understand that your health coverage is provided through____________________________________

- If you have out-of-network benefits, we will happily file claims on your behalf.
- You must pay any co-payment and applicable deductible amounts at the time of services unless other arrangements have been made with our office.
- The remainder of your bill will be sent to your health plan for direct payment to our office.
- If your insurance carrier has not paid our claim within 45 days, we will expect payment from you.
- If, by mistake, your health plan remits payment to you, you will send it to us along with all paperwork which accompanied it.
- Your health plan may refuse payment of a claim for some of the following reasons:
  1) You have not met your deductible for the full calendar year.
  2) The type of medical service required is not covered by your plan.
  3) The health plan was not in effect at the time of the service.
  4) You have other insurance which must be filed first.

Please understand that financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be included in your plan. If your health plan denies this claim for any of these or other reasons, our office cannot be responsible for this bill. It is your responsibility as the patient to pay the denied amounts in full.

Our primary mission is to provide you with quality, cost effective, medical care. Together we are trying to adapt to the changing way health care is financed and delivered. Again, we value you as a patient and our first priority is to provide you with the best possible care. With this housekeeping chore complete, we are pleased to serve you.

Sincerely,
Pain Management of North Dallas, PA

I have completed this form with accurate information. I have read and understand my obligations and responsibilities. I acknowledge that I am fully responsible for supplying correct insurance information, billing information, and payment of any services not covered or approved by my insurance carrier.

SOAPP

Name: ______________________________ **Date:** ____________________

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

Please answer the questions below using the following scale:

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

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

Thankyou.

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Office and Financial Policies

We would like to thank you for choosing Pain Management of North Dallas, PA (PMND) as your medical provider. To keep you informed of our current office and financial acknowledgement prior to any treatment.

All payment is expected at the time of service:

Payment is required at the time services are rendered. This includes your applicable **co-payment, co-insurance and deductibles** for participating insurance companies. If your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. If you have not met your deductible, the full amount of the e visit is due on the day of service. It is also expected that you will pay any remaining balance at the time of service.

The co-payment, co-insurance requirement cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier.

High Deductible Health Plans: If you have a high deductible plan, be prepared to pay for all services in full as you incur them. If surgery is requested, you will be asked to pay in advance of booking a surgery time.

Medicare: If you do not have secondary insurance you will be responsible for the 20% co insurance at the time services are rendered.

Statements: Itemized statement of charges can be requested by the patient and will be mailed with 10 days.

Insurance Card: You must present a current insurance card at each visit. If you do not present a current insurance card, you will be responsible for payment in full at the time of your visit.

Worker's Compensation: If your injury is due to an accident in your work place, please be sure to contact your employer and inform them of your injury. We will need to receive authorization from your employer before we can process any of your medical claims. Please have your employer contact our Worker's Compensation Department at 214/618-0853. Failure to properly report this injury to your employer may result in your claims being denied. Denied claims will be your responsibility.

No Insurance: Payment in full is expected at the time of your visit for an uninsured patient.

Estimates: An estimate of cost will be provided if requested by an uninsured patient, a patient not covered by a government program or an insured patient seeking out-of-network services.

Interest: This practice does not charge interest for amounts past due and left unpaid by a third- party payor.

Auto Accident Injury/Liability: If you are being treated as part of a personal injury lawsuit or claim, we require payment in full at the time of your visit. We will not bill your attorney or motor vehicle insurance for charges incurred due to a personal injury case.

Missed Appointments / Untimely Cancellations: Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. If you are unable to keep your appointment, please give 24-hours' notice to avoid being charged. If you miss your scheduled appointment you will receive a **$25.00** charge at your next scheduled appointment. Excessive abuse of scheduled appointments may result in discharge from the practice.

Returned Checks/Rejected ACH Withdrawals: A **$30.00** charge will be added to your account for any checks returned or ACH withdrawals rejected by your bank for any reason in addition to any fees that your financial institution may charge you. These balances must be paid in full prior to your next appointment.

Disability or Insurance Forms: There will be a charge of **$10.00** per page for the completion of medical forms. Payment is due at the time that you pick up the forms. Please allow 7-10 days for the completion of these forms.

PROMPT PAYMENT: Just as we make every effort to accommodate you when you are in need of medical care, we expect that you will make every effort to pay your bill promptly. If your account becomes delinquent and you have not established or met payment options with our billing office, your account will be turned over to a collection agency and we will ask you to seek your medical care from another medical office. Please contact the billing department at **214/6180853** to discuss payment.

Questions or concerns related to billed charges shall be directed to the Billing Office at 214/618-0853.

Thank you for allowing us to service you.

Adeel Haq, MD
Pain Management of North Dallas, PA

PAIN MANAGEMENT OF NORTH DALLAS, PA

ADEEL HAQ, MD

THERE WILL BE A $25 NO SHOW FEE FOR ALL PATIENTS MISSED APPOINTMENTS.

PLEASE CALL US AT LEAST 1 DAY BEFORE YOUR APPOINTMENT IF YOU ARE UNABLE TO KEEP IT.

THANK YOU!

-PMND STAFF-