PAIN MANAGEMENT OF NORTH DALLAS, PA

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Attention FRISCO Location New Patients:
Please bring the following to your first appointment:

- Medication list
- ANY imaging report (X-ray, CT, MRI)
- ANY records pertinent to your treatment

DIRECTIONS TO OUR FRISCO CLINIC:
Google or Apple Maps will take you to the correct area however, incorrect location. Follow your GPS until “Arrived” then follow the bottom instructions.
We are in Mateo Park, 2 buildings in from Wade. Our clinic is adjacent to Spanish Schoolhouse and Fingerprint Preschool. We are behind DocuNav and neighbors with Spangler Chiropractor. We are West of the big clock.

Pain Management of North Dallas, PA

Registration Form

Last Name:	First Name:		
Date of Birth:	Sex:	Race/Ethnicity:	
Mailing Address:		City/State/Zip:	
Primary Phone:	Alternative Phone:	Okay to text: __Yes __No	
Employer:	Occupation:	Work Phone:	
Referred by:			
Primary Care Physician:			
Pharmacy Name:	Pharmacy Address:		
Pharmacy Phone:			
Insurance Information			
Primary Insurance Carrier:		ID/Policy#:	
Group number:	Policy Holder Name:		
Policy Holder Date of Birth:	Relationship to patient:		
Emergency Contacts			
Name:	Relationship:	Phone:	
Name:	Relationship:	Phone:	

By signing below patient is agreeing above information is correct.

Printed Name:	Signature:
Date:	Relationship to patient if not self:

Pain Profile

Patient Name: _____ Date of Birth: _____

Where is your pain: _____

Does your pain radiate: _____

What is your pain level today: _____ What is your best pain level: _____ Worst? _____

When did your pain begin: _____ How did pain begin: _____

What makes your pain worse(ex: bending, lifting, walking, standing) :

_____

_____

_____

What makes your pain better:

_____

_____

Medications taken for this pain or in the past that have helped:

_____

_____

_____

Medications taken for this pain or in the past that have NOT helped:

_____

_____

_____

Any associates symptoms with your pain: (please circle)

Loss of bowel or bladder control Weakness in arms or legs fevers or chills

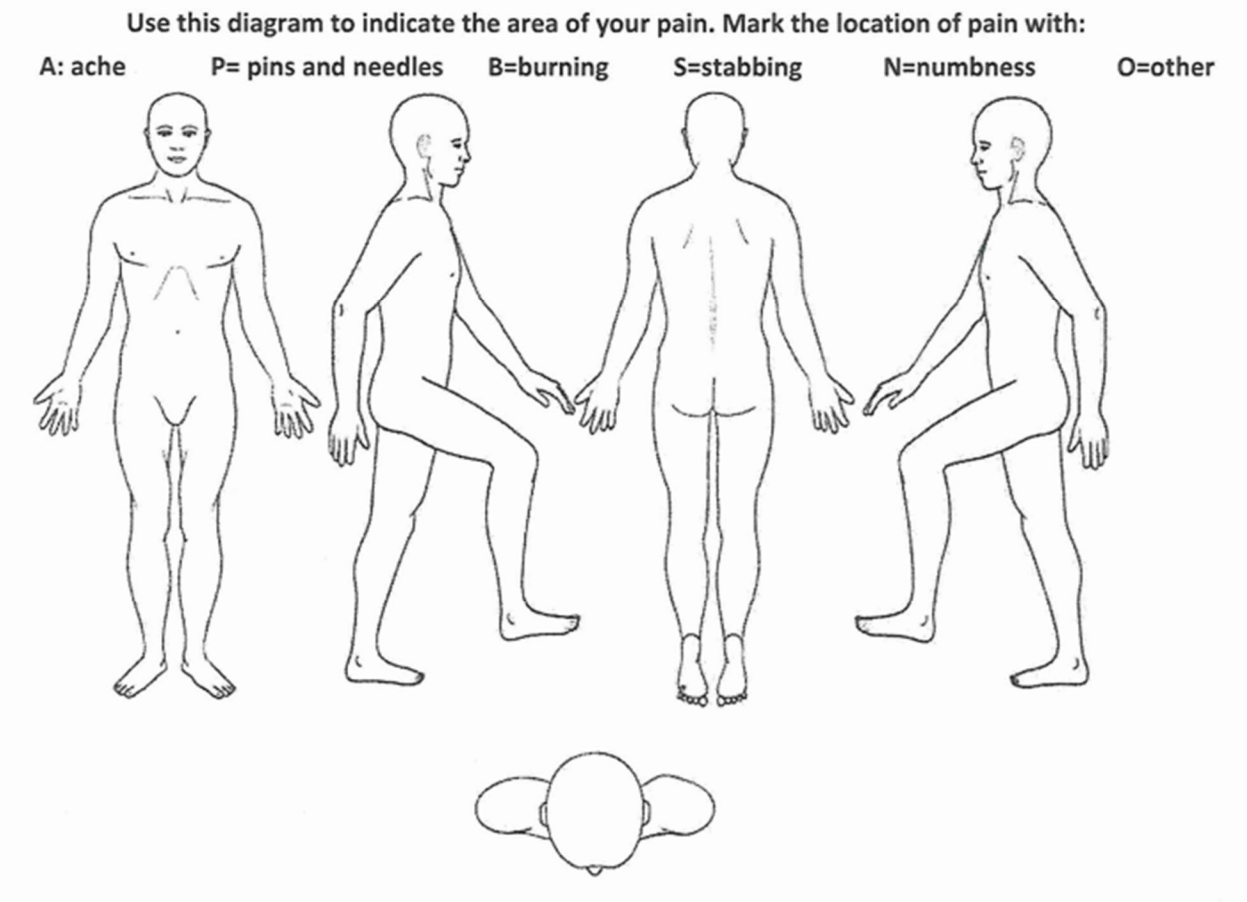
numbness or tingling in arms or legs

Past Treatments:

Please select if you have had any of the following treatments:

Type of Treatment	Effective? Yes or No	Type of Treatment	Effective? Yes or No Date? Levels?
Physical Therapy		Spinal Surgery	
Chiropractor		Facet Injections	
Acupuncture		Epidural Injections	
Tens Units		Trigger Points	
Aquatherapy		Rhizotomies	
Decompression		Spinal Cord Stimulators	
Other:			

Pain Profile part 2



Have you had any diagnostic studies(mri's x-rays, ct's), if so name the facility:

_____

_____

_____

Please list all medical providers who have treated your pain or who have prescribed pain medications in the past :

_____

_____

_____

Is your pain affecting your mood, if so how: _____

Have you ever taken medications other than prescribed? _____

Health History

Patient Name:	DOB:	Date:

Medical Conditions
Check all that apply

	AIDS/HIV		Chemical dependency		Hepatitis		Thyroid Problems
	ADHD		Chicken Pox		Hernia		Ulcers
	Alcoholism		Chronic Pain		High Blood Pressure		
	Anemia		Depression		High Cholesterol		
	Anxiety		Diabetes		Kidney Disease		
	Appendicitis		Eating Disorder		Liver Disease		
	Arthritis		Emphysema		Migraine/Headaches		
	Asthma		Epilepsy/Seizure		Multiple Sclerosis		
	Bipolar disorder		GERD		Prostate Problems		
	Cancer		Glaucoma		STD		
	Cataracts		Heart Disease		Stroke		

Auto immune:	Other:

Current Medications (write on back of this sheet if there is not enough room)

Medication Name	Strength	Frequency	Side effect?

Allergies:

Medication/Substance	Type of Reaction	Medication/Substance	Type of Reaction

Surgical History

Year	Performing Doctor	Name of Procedure/Surgery

Hospitalizations

Year	Reason	Year	Reason

Social History

Y N	Substance	How much/often	Marital Status	
	Caffeine		Current Occupation Employment:	
	Alcohol		Full time/part time:	
	Marijuana		Exercise:	
	Recreational Drugs			
	Tobacco			

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, medical services, 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 physician(s), and I acknowledge and consent to the following:

1. **INDEPENDENT CONTRACTORS:** Pain Management of North Dallas 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 of Pain Management of North Dallas and are responsible for their own actions. I understand that Pain Management of North Dallas shall not be reliable 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 assumes no responsibility for, and I hereby release Pain Management of North Dallas 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 THRID PARTY PAYMENTS**: I hereby expressly authorize Pain Management of North Dallas and all healthcare professionals providing care to release all necessary information to 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 and all professionals (including independent contractors) providing 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 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. **AUTHORIZATION AND RELEASE FOR PHOTOGRAPHS**: I authorize and release Pain Management of North Dallas 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 may use cameras for security and patient monitoring, and patient confidentiality will be maintained for all such images.
5. **NO GUARENTEE OF RESULTS**: Pain Management of North Dallas 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 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, or its employees, agents, representatives.
6. During 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 physicians(s), nurses, technicians, physician's 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.
7. 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)

Printed Name:	Signature:
Date:	Relationship to patient if not self:

PAIN MANAGEMENT AGREEMENT

I agree to participate in a controlled substance agreement with PAIN MANAGEMENT OF NORTH DALLAS, PA/Dr. Adeel Haq (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 REQUEST:** Refills for control substances will be done at 30-day intervals, unless explicitly authorized by PMND. I understand that prescription and medication refill request are only accepted 8:00am-4:00pm, Monday through Friday. NO MEDICATION REQUESTS WILL BE TAKEN DURING NIGHTS, WEEKENDS, OR HOLIDAYS. Patient is required to call 3-7 days in advanced to request refills. I will allow 24–48-hour turnaround time for any refill request to be at the pharmacy
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.
7. Exclusive provider of controlled pain medications. I will receive controlled pain medicines only from PMND medical staff, I 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 request by the PMND medical staff.

I have read agreement above and understand that if I violate any of the above conditions, my prescription may be terminated immediately and possibly result in being discharged from the practice.

Patient Signature:	
Date:	Relationship to patient if not self:

Disclosure of Physician Ownership and Financial Interest

State and federal guidelines may require that physicians who may have an affiliation or ownership interest in or with in and out of network facilities/services to which the physician refers we must disclose this information. In the interest of providing our patients with complete information, we are providing the names of the out of network facilities where Pain Management of North Dallas, PA may have an ownership interest/affiliation with Latera Anesthesia, Wexford Anesthesia, Memorial Pain Management, Tadlock Pain Management, Plano Infusions, North Plano Infusions, Premier Center of Surgical Arts, Mckinney Center of Surgical Arts at 5316 W Plano Pkwy Plano, TX 75093. During your course of treatment at Pain Management of North Dallas, PA, Mavs Pain Management, and Maus Pain Management, you may be referred to one of these facilities for medical services. You have the right to choose the facility where you receive medical treatment/services, including the right to choose a facility/service other than the ones listed above.

By signing below, I acknowledge receipt of the above disclosure information and have a right to a copy of this form.

Patient Signature:	
Date:	Relationship to patient if not self:

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, health changes, itching, allergic reactions. I understand that taken improperly, controlled substances may cause excess sedation, depress 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 medication 's.

2. **Tolerance**, **dependence, and addiction.** I understand the controlled substances may cause physical dependence and sudden withdrawal may cause symptoms such as abdominal and muscle cramps, sweats, chills, nausea and vomiting in rare cases and may cause death I understand that the drugs must be withdrawn slowly. I understand that I may become a tolerant to these drugs and require increasing doses for the same amount of pain relief I understand that there's a small but real chance that I may become addicted to these medications. I also understand that it is my responsibility to anticipate the need of refills requests in a timely manner I will not make repeated calls to the office for prescriptions, now 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 medications will NOT be refilled early.

3. **Pregnancy.** I understand the controlled substances may have adverse effects on a fetus and there's a strong likelihood that any baby born to a woman taking control substances will probably be physically dependent and may suffer withdrawal symptoms. For female patients: I agree to notify PMND If I become to become pregnant. If I have not been sterilized or am not post-menopausal. I agree to take reasonable and prudent precautions to ensure I will not become pregnant while taking these medication's.

4. **Refills.** I also understand that is my responsibility to anticipate the need of refills requests in a timely manner I will not to 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 for them to be.

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

6. **Termination**. Termination of controlled medication therapy may be instituted for any violation or disagreement or at the clinical discretion of the PMND provider I agree to obtain an alternative source of medical care and control substances within 30 days of notification in violation of disagreement or enroll in a detoxification program within this timeframe I will not hold any member of the PMND staff liable for any sequelae of discontinuance or controlled substances provided 30 days of notification of termination is provided.

I have read and understand all the above terms. 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 the failure to do so will it termination of treatment.

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	
Social Security Number	
Phone#	
Date of Birth	
Email address	

Section B: Must be completed only if a health plan or health care provider has requested the authorization.
I understand that my health care and the payment for my health 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 ____/____/_____. Or at the term of _____ event. If not specified this release will expire 360 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.

Patient Signature:	
Date:	Relationship to patient if not self:

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 Medical Board and the Federal Drug Enforcement Administration regulate the use of medications. PMND follows these regulations.

Our Policy Includes:

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 provider
3. Controlled substances are written in a 30-day supply. It is necessary to make monthly follow up appointments in order to receive a refill.
4. Refills for prescriptions listed below may be refilled every three months (per physician discretion).
    a. Anti-inflammatories, muscle relaxers, etc.
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 to make sure you have enough pills. Refill requests will take 24-48 hours to process once approved.
7. Before you visit PMND, please check your supply of medication. If you need a refill please ask.
8. Refill request 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 PMND immediately.
10. Drug screens will occur prior to any opioid limitation. It will be up to physician discretion how often they are repeated.

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:	Relationship to patient if not self:

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

- 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 Practiced. You are not required to read this notice. By initialing, you are acknowledging receipt of this notice.
  Initial: _____
- I request that payment of authorized Medicare and other insurance benefits be made on my behalf to Pain Management of North Dallas, PA for any services furnished to me by any healthcare providers associated with that group. I authorize medical information about me to be released to the Health Care Financing Administration and its agents or insurance company any information needed to determine these benefits payables for related services.
  Initial: _____
- 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 payment.
  Initial: _____
- Unless I request to the contrary, in writing, I will receive appointment reminders 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 without 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:
  - You have not met your deductible for the full calendar year
  - The type of medical service required is not covered by your plan
  - The health plan was not in effect at the time of the service
  - You have other insurance which must be filled 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 heath care is financed and delivered. Again, we value you as a patient and our priority is to provide you with the best possible care. With this the 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 carried.

HIPPA RELEASE FORM

Patient Name: _____
Date of Birth: _____

I authorize the release of information including diagnosis, records, rendered to me and billing information.

This information may be released to:

Name	Relationship	Phone Number

Patient Signature:	
Date:	Relationship to patient if not self:

NO SHOW/CANCELLATION POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from receiving much needed treatment. Conversely, the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit due to a seemingly "full" appointment book.

Patients who fail to show for their scheduled appointment or did not notify the office within 24 hours of their scheduled appointment time, will be subject to a "No Show Cancellation" fee of $50.00. If cancelled by the physician as a medical necessity, then the patient is not subject to this charge.

Patient Signature:	
Date:	Relationship to patient if not self:

SOAPP

Patient Name: _____
Date of Birth: _____
Date: _____

The following are some questions give to all patients at Pain Management of North Dallas, PA who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. 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

How often do you have mood swings?	
How often do you smoke a cigarette within an hour after you wake up?	
How often have you taken medication other that the way that it was prescribed?	
How often have you used illegal drugs(for ex: marijuana, cocaine, crystal meth etc.) in the past 5 years?	
How often, in your lifetime, have you had legal problems or been arrested?	
TOTAL	

Please include any additional information you wish about the above answers.
_____
_____
_____

Thank you!

OFFICE AND FINANCIAL POLICIES

We would like to thank you for choosing Pain Management of North Dallas as your medical provider we want to keep you informed of our current office and financial policies prior to any treatment.
All payments and expected at the time of service:
Payment is required at the time of services are rendered. This includes your applicable copayment, coinsurance and deductible's for participating insurance companies. If your coverage is currently under pre-existing condition clause, payment in full as expected at the time of your visit. If you have not met your deductible, the full amount of the visit is due on the day of service. It is also expected that you will pay any remaining balances at the time of service.

The copayment, coinsurance 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 your services in full. If a procedure is required you'll be asked to pay in advance.

Medicare: if you do not have secondary insurance you'll be responsible for the 20% coinsurance at time of services.

Statements: Itemize statements of charges can be requested by the patient and will be mailed or provided by front desk

Insurance card: You must present a current and active insurance card on your new patient visit. Insurance must be active at time of visit or 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 workplace 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 your medical claims. Failure to properly report this injury to your employer may result in your claim being denied. Denied claims will be your responsibility in full.

No insurance: Payment in full is expected at the time of your visit for an uninsured patients

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.

Missed appointments/Cancellations: If you are unable to keep your appointment please give 24-hour notice to avoid being charged if you missed your scheduled appointment you will receive a $50 charge at your next scheduled visit. Excessive abuse of scheduled appointments may result in discharge from the practice.

Return check/rejected ACH withdrawals: a $30 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 $25 for the completion of medical forms. Payment is due at the time that you pick up the forms. Please allow 7 to 14 business days for the completion of these forms.

Prompt payment: 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 set up 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 our billing department to discuss payment or any concerns.

Thank you for allowing us to service you.

Adeel Haq, MD
Pain Management of North Dallas, PA