THE PAIN RELIEF CENTER

MIGRAINE INSTITUTE 1

PLEASE PRINT AND COMPLETE ALL SECTIONS

Is your condition the result of a work injury? Yes ☐ No ☐ If yes, please provide the following:

Case Manager Name: _____ Case Manager Phone: ( ) _____-_____

Case #: _____ Date of Injury: _____

Is your condition the result of an auto accident? Yes ☐ No ☐ If yes, please list:

Attorney name: _____ Attorney Phone: _____

PATIENT INFORMATION

Name: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____-_____ Work Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____

Date of Birth: _____ Age: _____ SSN: _____-_____-_____

Driver's License State: _____ Driver's License Number: _____

Employer Name: _____ Employer Phone: ( ) _____-_____

Employer Address: _____ City: _____ State: _____

Zip: _____ Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse Name: _____ Spouse Date of Birth: _____

Spouse SSN: _____-_____-_____ Spouse Phone: ( ) _____-_____

Emergency Contact: _____ Relationship: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____-_____ Work Phone: ( ) _____-_____ Mobile Phone ( ) _____-_____

REFERRAL INFORMATION

Referring Physician Name and Address: _____

_____

PCP Name and Address (if different from referring physician): _____

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MIGRAINE INSTITUTE 2

PAST MEDICAL HISTORY – Please check all that apply

Head:	**Respiratory:**	**Musculoskeletal:**	**Endocrine:**
☐ Trauma	☐ Asthma	☐ Arthritis	☐ Goiter
Eyes:	☐ Bronchitis	☐ Gout	☐ Hyperlipidemia (high cholesterol)
☐ Blindness	☐ COPD	☐ M/S injury	☐ Hypothyroidism
☐ Cataracts	☐ Pleuritis	☐ Ankylosing Spondylitis	☐ Thyroid disease
☐ Glaucoma	☐ Pneumonia	☐ Osteoarthritis	☐ Thyroiditis
☐ Wear glasses/contacts	☐ Lung disease	☐ Rheumatoid arthritis	☐ Type I Diabetes
Ears:	**Gastrointestinal:**	☐ Osteoporosis	☐ Type II Diabetes
☐ Hearing aids	☐ Cirrhosis		
Nose/Sinuses:	☐ Gallbladder disease	**Skin:**	**Heme/Onc:**
☐ Allergic rhinitis	☐ Heartburn	☐ Dermatitis	☐ Anemia
☐ Sinus Infection	☐ Hemorrhoids	☐ Mole(s)	☐ Cancer
Mouth/Throat/Teeth:	☐ Hepatitis	☐ Other skin condition(s)	☐ Bleeding disorder
☐ Dentures	☐ Hiatal Hernia	☐ Psoriasis	☐ Bleeds easily
Cardiovascular:	☐ Jaundice		☐ Blood clots
☐ Aneurysm	☐ Stomach Ulcer	**Neurological:**	**Infections:**
☐ Angina	**Genitourinary:**	☐ Epilepsy	☐ HIV
☐ DVT	☐ Hernia	☐ Seizures	☐ STDs
☐ Dysrhythmia	☐ Incontinence	☐ Severe headaches, migraines	☐ Tuberculosis (dz)
☐ Hypertension (HTN)	☐ Nephrolithiasis	☐ Stroke	☐ Tuberculosis (exposure)
☐ Murmur	☐ Other kidney disease	☐ TIA	☐ AIDS
☐ Myocardial Infarction (heart attack)	☐ Liver disease	☐ Alzheimer's	
☐ Heart Failure (CHF)	☐ Hepatitis	**Psychiatric:**	**Other:**
☐ Other heart disease	☐ STDs	☐ Bipolar disorder	☐ Alcoholism
	☐ UTI(s)	☐ Depression	☐ Anxiety
		☐ Hallucinations, delusions	☐ Mental illness
		☐ Suicidal ideation	☐ Fibromyalgia
		☐ Suicide attempts	☐ Other:

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MIGRAINE INSTITUTE 3

PAST SURGICAL HISTORY – Please check all that apply

Common Surgeries:			
☐ Aneurysm repair	☐ Cataract/ lens surgery	☐ Knee replacement ☐ Knee scope	☐ Sinus surgery
☐ Appendectomy	☐ Cesarean section	☐ LASIK	☐ Skin cancer excision
☐ Back surgery	☐ Cholecystectomy/ bile duct surgery	☐ Laminectomy	☐ Spinal fusion
☐ Bariatric surgery/ gastric bypass	☐ Dilation & curettage	☐ Nasal Surgery	☐ TAH-BSO
☐ Bilateral tubal ligation	☐ Hemorrhoid surgery	☐ PTCA/PCI	☐ TURP
☐ Breast resection/mastectomy	☐ Hip scope	☐ Pacemaker/ defibrillator	☐ Tonsillectomy/ adenoidectomy
☐ CABG	☐ Hip replacement	☐ Prostate surgery	☐ Vasectomy
☐ Carotid endarterectomy/stent	☐ Hysterectomy	☐ Prostatectomy	
☐ Carpal tunnel release surgery	☐ Inguinal hernia repair.	☐ Rotator cuff surgery	

FAMILY HISTORY- Please check all that apply

Mother:	Father:	Brother(s):	Sister(s):
☐ No health concern	☐ No health concern	☐ No health concern	☐ No health concern
☐ Arthritis	☐ Arthritis	☐ Arthritis	☐ Arthritis
☐ Asthma	☐ Asthma	☐ Asthma	☐ Asthma
☐ Bleeding disorder	☐ Bleeding disorder	☐ Bleeding disorder	☐ Bleeding disorder
☐ Coronary artery disease <age 55	☐ Coronary artery disease <age 55	☐ Coronary artery disease <age 55	☐ Coronary artery disease <age 55
☐ COPD	☐ COPD	☐ COPD	☐ COPD
☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes
☐ Heart attack	☐ Heart attack	☐ Heart attack	☐ Heart attack
☐ Heart disease	☐ Heart disease	☐ Heart disease	☐ Heart disease
☐ High cholesterol	☐ High cholesterol	☐ High cholesterol	☐ High cholesterol
☐ Hypertension	☐ Hypertension	☐ Hypertension	☐ Hypertension
☐ Mental illness	☐ Mental illness	☐ Mental illness	☐ Mental illness
☐ Osteoporosis	☐ Osteoporosis	☐ Osteoporosis	☐ Osteoporosis
☐ Stroke	☐ Stroke	☐ Stroke	☐ Stroke

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MIGRAINE INSTITUTE 4

☐ Cancer (please specify):	☐ Cancer (please specify):	☐ Cancer (please specify):	☐ Cancer (please specify):
☐ Deceased	☐ Deceased	☐ Deceased	☐ Deceased
☐ Unknown	☐ Unknown	☐ Unknown	☐ Unknown
	☐	☐ N/A	☐ N/A

SOCIAL HISTORY – Please check all that apply

Tobacco:	**Alcohol:**	**Cardiovascular:**	**Sexual Activity:**
☐ Current every day smoker	☐ Do not drink	☐ Eat healthy meals	☐ Exposure to STI
☐ Current some day smoker	☐ Drink daily	☐ Regular exercise	☐ Homosexual encounters
☐ Former smoker	☐ Frequently drink	☐ Take daily aspirin	☐ Not sexually active
☐ Heavy tobacco smoker	☐ Occasional drink	**Safety:**	☐ Safe sex practices
☐ Light tobacco smoker	☐ History of alcoholism	☐ Household smoke detector	☐ Sexually active
☐ Never smoker	**Drug Abuse:**	☐ Keep firearms in house	
☐ Smoker, current status unknown	☐ Intravenous drug use	☐ Wear seatbelt	
☐ Unknown if ever smoked	☐ Illicit drug use		
Custom Items:	☐ No illicit drug use		
☐ Caffeine Usage			

Height: _____

Weight: _____

Patient Signature: _____ Date: _____ Time: _____

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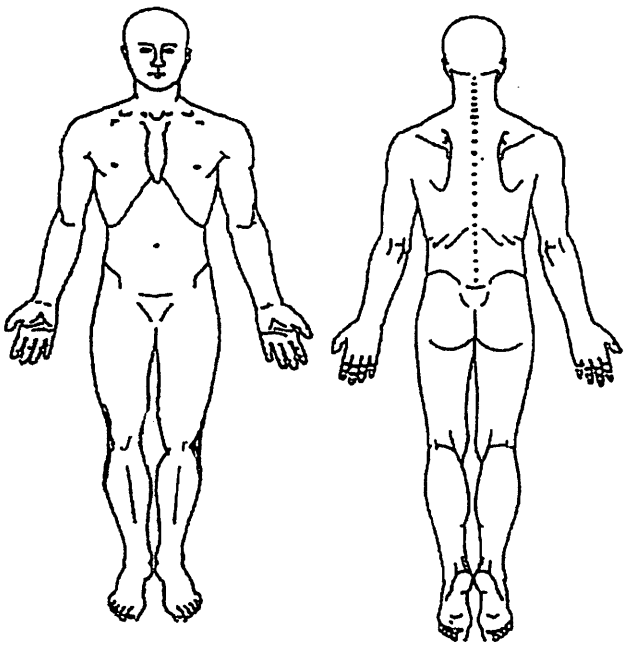
Your Name:_____ Date of Birth: _____ Todays Date: _____

Reason for Today's Visit: ☐ Medication Refill ☐ Medication Change ☐ Post-Procedure Assessment

☐ Review MRI/EMG or Test Results ☐ New Pain or Injury: _____

Use the diagram to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms: "N"umbness "P"ins and Needles "A"ching "S"tabbing "B"urning



Pain level with medication? _____/10

Pain level w/o medication? _____/10

What aggravates your pain? _____

When relieves your pain? _____

Where is your worst area of pain located? _____

When did your pain begin? _____

List any additional areas of pain: _____

_____

What word **best describes** the frequency of your pain?

☐ Constant ☐ Intermittent

When is your pain at its **worst?** ☐ Mornings

☐ During the day ☐ Evenings ☐ Middle of the night

Check all that describe your pain today:

☐ Aching	☐ Hot/Burning	☐ Spasms	☐ Throbbing
☐ Cold	☐ Numb	☐ Squeezing	☐ Tingling/Pins and Needles
☐ Cramping	☐ Shock-like	☐ Stabbing/Sharp	☐ Tiring/Exhausting
☐ Dull	☐ Shooting		

Since Your Last Visit:

Has your pain? ☐ Increased ☐ Decreased ☐ Stayed the Same

Did you have a procedure? ☐ No ☐ Yes **If yes,** how much pain relief did you obtain?____ %. Were there any problems? ☐ No ☐ Yes If yes, please explain:_____

Do you have significant back/buttock/leg pain with prolonged standing and/or prolonged walking that is relieved with sitting and/or lying down? ☐ No ☐ Yes If yes, is your pain also alleviated with bending forward (using a shopping cart, leaning on the kitchen counter, etc.? ☐ No ☐ Yes

Any new imaging studies? ☐ No ☐ Yes Please List: _____

Any new allergies? ☐ No ☐ Yes Please List:_____

Any new medication side effects? ☐ No ☐ Yes Please List:_____

Any new medications? ☐ No ☐ Yes Please List: _____

Are you currently pregnant? ☐ No ☐ Yes Post menopause Do you plan to become pregnant? ☐ No ☐ Yes

Have had two or more falls in the last year? ☐ No ☐ Yes

Review of Systems - Mark all of the following symptoms that you CURRENTLY suffer from:

Constitutional: ☐ Chills ☐ Difficulty Sleeping ☐ Fatigue ☐ Fevers ☐ Night Sweats	**Genitourinary/ Nephrology:** ☐ Blood in Urine ☐ Involuntary Urination ☐ Loss of Bowel Control ☐ Painful Urination ☐ Pelvic Pressure	**Neurological:** ☐ Dizziness ☐ Headaches ☐ Instability When Walking ☐ Numbness/Tingling ☐ Weakness
Cardiovascular/ Raspatory : ☐ Chest Pain ☐ Cough ☐ Difficulty Breathing ☐ Fainting ☐ High Blood Pressure ☐ Swelling in the Feet	**Ears/Nose/Throat/ Neck:** ☐ Difficulty Hearing ☐ Earaches ☐ Hay fever/Allergies ☐ Nosebleeds ☐ Recurrent Sore Throats ☐ Ringing in the Ears ☐ Sinus Problems	**Psychiatric:** ☐ Anxiety/Stress ☐ Depressed Mood ☐ Suicidal Thoughts ☐ Suicidal Planning
Gastrointestinal: ☐ Constipation ☐ Dark and Tarry Stools ☐ Diarrhea ☐ Nausea/Vomiting	**Eyes:** ☐ Recent Visual Changes	**Musculoskeletal:** ☐ Back Pain ☐ Joint Pain ☐ Neck Pain

Consent and Authorization

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. The consent will remain fully effective until it is revoked in writing. You have the right to discontinue services at any time.

I voluntarily request that The Pain Relief Center provide pain management care, treatment, and services to me, as deemed reasonable and necessary by the assigned healthcare provider(s). I consent to reasonable and necessary medical examination, evaluation, testing and treatment which may include diagnostic, radiology and laboratory procedures. I understand I may be asked to provide urine, oral swab, and/or blood samples. I have the right to refuse specific tests but understand this may impact my pain management treatment. If invasive interventional treatment is recommended, I will be informed of the benefits and risk prior to performance of such treatment and will be provided with a separate consent form outlining such benefits and risk.

BY SIGNING BELOW, I AM AGREEING TO THE CONSENTS AND RELEASES DESCRIBED ON THIS FORM. I HAVE READ THIS CONSENT AND HAVE BEEN ABLE TO ASK QUESTIONS.

Signature of Patient or Representative

Time

Relationship to Patient

THE PAIN RELIEF CENTER

MIGRAINE INSTITUTE 6

PAIN QUESTIONAIRE

Current Medication (please list all medications/ vitamins including dosage and frequency): ☐ None

_____

_____

_____

**if you need additional space to document medications, please attach a medication list to paperwork.*

Allergies (please list allergen, reaction, severity and date of onset): ☐ No known allergies

_____

_____

_____

**If you need additional space to document allergies, please attach an allergy list to paperwork.*

REVIEW OF SYSTEMS – Are you currently or have you ever had problems with the following

Immune System	☐ Yes	☐ No	Describe: _____
Cardiovascular	☐ Yes	☐ No	Describe: _____
Constitutional (chills, weight gain/loss)	☐ Yes	☐ No	Describe: _____
Endocrine (temperature sensitivity)	☐ Yes	☐ No	Describe: _____
Ears, Nose, Throat	☐ Yes	☐ No	Describe: _____
Eyes/ Vision	☐ Yes	☐ No	Describe: _____
GI (abdominal pain, bladder, bowel)	☐ Yes	☐ No	Describe: _____
GU (painful urination, incontinence)	☐ Yes	☐ No	Describe: _____
Hema/Lymphs (easy bleeding)	☐ Yes	☐ No	Describe: _____
Integumentary (brittle hair, nails)	☐ Yes	☐ No	Describe: _____
Musculoskeletal	☐ Yes	☐ No	Describe: _____
Neurological (dizziness, weakness, gait)	☐ Yes	☐ No	Describe: _____
Psychiatric (anxiety, depression)	☐ Yes	☐ No	Describe: _____
Reproductive	☐ Yes	☐ No	Describe: _____
Respiratory	☐ Yes	☐ No	Describe: _____

Please describe any other issues not listed above: _____

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PATIENT: _____

DOB: _____

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☐ GABRIEL RODRIGUEZ, MD
☐ ROBERT CHEN, MD

PROCEDURE DATE: _____

ANESTHESIA PRE-OPERATIVE EVALUATION

1.	HAVE YOU EVER HAD A **HEART ATTACK**?	YES	NO
2.	HAVE YOU EVER HAD **CHEST PAIN**? (RELATED TO HEART PROBLEM)	YES	NO
3.	HAVE YOU EVER HAD **HEART SURGERY** (CABG, STENTS, ABLATION)?	YES	NO
4.	HAVE YOU HAD AN **ABNORMAL HEARTBEAT**? (A-FIB, PVCS, ARRHYTHMIA)	YES	NO
5.	DO YOU HAVE A **PACEMAKER** OR **DEFIBRILLATOR**?	YES	NO
6.	ARE YOU ON A **BLOOD THINNER**? IF SO, MED NAME: _____	YES	NO
7.	HAVE YOU EVER HAD A **BLOOD CLOT**? (PE OR DVT)	YES	NO
8.	HAVE YOU EVER HAD **HEART FAILURE** (CHF)?	YES	NO
9.	ARE YOU **OVER** THE AGE OF **60**?	YES	NO
10.	HAVE YOU EVER HAD A **STROKE**?	YES	NO
11.	DO YOU HAVE SEVERE **LUNG** ISSUES (PULMONARY HTN, SLEEP APNEA)?	YES	NO
12.	ARE YOU TAKING **PHENTERMINE** OR ANY **OTHER DIET MEDICATION**?	YES	NO

13. LIST ANY **HEART OR LUNG** ISSUES **NOT** ALREADY LISTED ABOVE:

_____

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS:

HAVE YOU HAD AN **EKG**?	YES	NO	DATE: _____
HAVE YOU HAD A **STRESS TEST**?	YES	NO	DATE: _____
HAVE YOU HAD AN **ECHOCARDIOGRAM**?	YES	NO	DATE: _____

PRIMARY CARE PHYSICIAN: _____ PH: _____ FAX: _____

CARDIOLOGIST: _____ PH: _____ FAX: _____

PATIENT SIGNATURE: X _____ **DATE:** _____

FOR OFFICE USE ONLY

NOTES:

CLEARANCE ON FILE? ☐ YES ☐ NO

CLEARANCE DATE: _____

VALID DATES: _____

REVIEWED BY PROVIDER: _____ **DATE:** _____

REVISED OCTOBER 2021

THE PAIN RELIEF CENTER

MIGRAINE INSTITUTE 8

GENERAL ANXIETY DISORDER SCALE (GAD-7)				
Over the last 2 weeks, how often have you been bothered by the following problems	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
	Score: 0	Score: 1	Score: 2	Score: 3
1. Feeling nervous, anxious or on edge				
2. Not being able to stop or control worrying				
3. Worrying too much about different things				
4. Trouble relaxing				
5. Being so restless that it's hard to sit still				
6. Becoming easily annoyed or irritable				
7. Feeling afraid as if something awful might happen				
Total Score				
Sum of total scores				
If you checked off any problems, how difficult have these made it for you to do work, take care of things at home, or get along with people?	☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult			
For office use only: 0-4 none, 5-9 mild, 10-14 moderate, 15+ severe				

Have you been diagnosed with:

	In the past	Currently have it
Fibromyalgia	_____	_____
Irritable bowel syndrome	_____	_____
Pelvic pain	_____	_____
Temporomandibular disorder (TMJ)	_____	_____
Painful bladder syndrome	_____	_____
Bipolar disorder (manic-depressive)	_____	_____

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MIGRAINE INSTITUTE 9

PATIENT HEALTH QUESTIONNAIRE (PGQ-9)				
Over the last two weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
	Score: 0	Score: 1	Score: 2	Score: 3
1. Little interest or pleasure in doing things				
2. Feeling down, depressed or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself – or that you are a failure or have et yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety and restless than you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead or of hurting yourself in some way				
Sum of total scores				
10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?	☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult			
For office use only: 0-4 none, 5-9 mild, 10-14 moderate, 15-19 moderately severe, 20+ severe				

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MIGRAINE INSTITUTE 10

Note: if you have NEVER had any major stressful experience in the past, score 1 for all items.

If you had a **major stressful event,** what was it? _____

_____ When did it occur? _____

POST-TRAUMATIC STRESS DISORDER QUESTIONNAIRE (PCL-C)
Instructions to patient: Below is a list of problems and complaints that people sometimes have in response to stressful experiences. Please read each one carefully, put an X in the box to indicate how much you have been bothered by that problem in the past month.

		Not at all	A little bit	Moderately	Quite a bit	Extremely
B	1. Repeated, disturbing *memories, thoughts,* or *images* of a stressful experience from the past?					
	2. Repeated, disturbing *dreams* of a stressful experience from the past?					
	3. Suddenly acting or *feeling* as if a stressful experience *were happening again* (as if you were reliving it)?					
	4. Feeling *very upset* when *something reminded you* of a stressful experience of the past?					
	5. Having physical reactions (e.g., heart pounding, trouble breathing, swearing) when something reminded you of a stressful even from the past?					
C	6. Avoid thinking about or talking about a stressful experience from the past or avoiding having feeling related to it?					
	7. Avoiding activities or situations because they remind you of a stressful experience from the past?					
	8. Trouble remembering the important parts of a stressful experience from the past?					
	9. Loss of interest in activities that you used to enjoy?					
	10. Feeling distant or cut off from others?					
	11. Feeling emotionally numb or being unable to have loving feelings for those close to you?					
	12. Feeling as if your future somehow will be cut short?					
D	13. Trouble falling or staying asleep?					
	14. Feeling irritable or having angry outbursts?					
	15. Having difficulty concentrating?					
	16. Being "superalert" or watchful or on guard?					
	17. Feeling jumpy or easily startled?					

For office use only: Supports DSM: 1B + 3C + 2D

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MIGRAINE INSTITUTE 11

Name: _____ Date: _____ Time: _____

PREVIOUSLY TRIED THERAPIES:

PHYSICAL THERAPY: _____

DATES: _____

NAME OF FACILITY: _____

PHONE NUMBER AND ADDRESS: _____

_____

CHIROPRACTIC CARE: _____

DATES: _____

NAME OF FACILITY: _____

PHONE NUMBER AND ADDRESS: _____

_____

INJECTION THERAPY: _____

DATES: _____

NAMES OF FACILITY: _____

PHONE NUMBER AND ADDRESS: _____

_____

MEDICATIONS THERAPY TRIED SUCH AS NARCOTICS, MUSCLE RELAXANTS, ANTI-INFLAMATORIES, AND NERVE MEDICATIONS: _____

_____

_____

_____

_____

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MIGRAINE INSTITUTE 12

Combination Therapy Sedative Risk Education Letter

The CDC Guideline for Prescribing Opioids for Chronic Pain recommends that patients should not be prescribed opioids and benzodiazepines, opioid cough medicines, CNS depressants, Gabapentin, or Soma (carisoprodol) concurrently whenever possible due to the risk of slowed or difficult breathing and potentially fatal overdose. Common symptoms from concomitant use include unusual dizziness or lightheadedness, extreme sleepiness, slowed or difficult breathing, or unresponsiveness.

The FDA also issued a Safety Alert warning about serious risks and death when combining opioids with benzodiazepines, opioid cough medicines, CNS depressants, Gabapentin, or Soma (carisoprodol). Benzodiazepines include lorazepam/Ativan, alprazolam/Xanax, diazepam/Valium, clonazepam/Klonopin, temazepam/Restoril, etc. Gabapentin also has a high risk of misuse, especially when taken in combination with opioids.

This warning letter is to notify you of the dangers, including possible fatal effects, of combining opioid medications with benzodiazepines, opioid cough medicines, CNS depressants, Gabapentin, or Soma (carisoprodol). In an effort to reduce your risk, please contact your prescribing physician to try to safely decrease your use of these medications within the next 90 days so you remain eligible to receive opioid pain medication prescriptions. Please take measures to discuss other forms of treatment with your doctors who are prescribing benzodiazepines, opioid cough medicines, CNS depressants, Gabapentin, or Soma (carisoprodol).

It is further recommended that you not combine alcohol, Cannabinoids, or Kratom with your current medication regimen. Continued use of alcohol with this medication can lead to increased side effects from the opioid medication, unintentional overdose, and possible death. Continued use of Cannabinoids and/or Kratom with these medications can lead to increased side effects from the opioid medications, unintentional overdose, or possible death. While we understand Cannabinoids and/or Kratom are approved for therapeutic treatment for chronic pain conditions in certain states, they are not approved in Texas at this time and remain illegal. Please try to discontinue your combined use of Cannabinoids, Kratom, and/or alcohol and prescription pain medications.

Please know that continued use of benzodiazepines, opioid cough medicines, CNS depressants, Gabapentin, Soma (carisoprodol), Cannabinoids, Kratom, and/or alcohol may make you ineligible for opioid therapy.

Your health and well-being are of the utmost importance-to us as The Pain Relief Center. Please feel free to contact my office or myself personally at nurse@painendshere.com for further questions regarding this letter.

By signing below, I acknowledge and agree that I have read this form and understand its contents.

Patient name: _____

Signature: _____

Date: _____ Time: _____

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MIGRAINE INSTITUTE 13

CONTROLLED SUBSTANCE AGREEMENT

- **This contract applies only if the physician or other healthcare provider prescribes controlled medications to you.**

Controlled substance medications (e.g. "narcotics," benzodiazepines, "valium," or opiates) can be useful but have a high potential for misuse and abuse. They are closely controlled by local, state, and federal governments. If used improperly, they may cause adverse effects, such as vomiting, severe constipation, lethargy, overdose, or even death. These medications can impair the ability to drive and operate machinery. If you are prescribed controlled substance medications by a healthcare provider at the Pain Relief Center, you must agree to the following conditions:

1. I (the patient) am responsible for my controlled substance medications. If the prescription is lost, misplaced, stolen, or if I run out sooner than my healthcare provider intended, I understand that it will not be replaced.
2. I will not request or accept controlled substance medications from any other physician or individual unless prior arrangements have been made with The Pain Relief Center. Exceptions are hospital and emergency room visits, but these must be reported to the physician in a timely fashion.
3. I will follow The Pain Relief Center refill policies for controlled substance medications. Policies include:
    1) Refills are authorized only during regular business hours and require a visit with a provider in the clinic.
    2) Refill requests on Fridays and over the weekends will not be addressed until the next business day. **NO EXCEPTIONS WILL BE MADE.**
    3) Refills are not authorized if the patient "runs out early" or as an emergency if the patient suddenly realizes that he or she will "run out tomorrow." The Pain Relief Center expects patients to anticipate the next refill date.
4. I will use only one pharmacy for all my pain medications.
5. I understand that if I violate any of the above conditions or decline to take a urine test for controlled substances at my healthcare provider's request, my prescription for these medications may be ended immediately. The Pain Relief Center also reserves the right to report the specifics of the situation to my primary care physician, local medical facilities, or law enforcement authorities.

Patients prescribed controlled substance medications by healthcare providers at The Pain Relief Center should also understand that tolerance (the need for more pain medication to achieve same effect), dependence (the presence of withdrawal symptoms when abruptly ceasing the medication), and addiction (abnormal psychological dependence characterized by desire or euphoria when taking these medications) can develop while taking these medications. The main treatment goal is the improvement of functions, which also requires maintenance of a healthy lifestyle.

By signing below, I acknowledge and agree that I have read this form and understand its contents.

Patient name: _____

Signature: _____

Date: _____ Time: _____

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MIGRAINE INSTITUTE 14

FINANCIAL POLICY AND BILLING PROCEDURES

- All patients must complete our "Patient Information Sheet."
- Full payment is due at the time services are rendered, unless other arrangements have previously been made and agreed upon. (e.g. credit card on file for balance)
- We accept all major credit cards and/or cash as forms of payment.
- **Referrals, if necessary, must be presented at time of your visit. IT IS YOUR RESPONSIBILITY TO OBTAIN AND TRACK YOUR OWN REFERRAL.**

The fees we charge for services are usual and customary for this area. Your insurance policy may base its allowance on a fixed fee schedule, which may or may not coincide with our fees. You should be aware that different insurance companies can vary greatly on the types of coverage you may have. You should also be aware that your insurance carrier determines your financial responsibility, not our staff.

If you are an HMO or PPO patient, it is your responsibility to make sure all referral information from your primary care physician is in our office prior to your visit. We will require this referral authorization before we can render services to you. **If you do not provide the appropriate referral information at the time of your visit and services are rendered to you, you agree to pay our doctors their billed rate as a fee-for-service patient, foregoing any health care insurance coverage you may otherwise have had.** If you have Medicare, we will file the claim forms representing services rendered to you as "assignment accepted." If you have any secondary insurance, you agree to provide us with this information at the time of your visit so that we may file the appropriate claim forms for you.

All patients are responsible for paying their annual deductible, coinsurance, and copay balances, as well as any non-covered service charges at the time of your visit. We do not accept Medicaid patients. If you are a Medicaid patient or anticipate applying for Medicaid for the payment of services rendered to you, by signing this agreement you understand that our doctor(s) is accepting you as a private-pay patient and not as a Medicaid patient for any services rendered to you and that you will be responsible for paying for the services you receive from our doctor(s). We will not file a claim with Medicaid for the services we provide to you.

I, _____(Patient or Legal Guardian) have read the above information and fully understand that I am responsible for the payment of all applicable charges at the time services are rendered. I authorize the release of my medical and billing information for the purpose of seeking reimbursement through my medical policy, and I also agree that I am financially responsible for all charges not covered by my insurance policy.

Signature: _____

Date: _____ Time: _____

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THE PAIN RELIEF CENTER

MIGRAINE INSTITUTE 15

HIPAA Privacy Authorization Form General Release for Health Care Providers

**Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Authorization

I authorize The Pain Relief Center and all of its associated healthcare providers to use and disclose the protected health information described below to health care providers involved in my care.

Effective Period

This authorization for release of information covers the following period of healthcare:

- All past, present, and future periods.

Extent of Authorization:

- I authorize the release of my complete health record

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ Date: _____ Time: _____

Signature of patient or personal representative

_____

Printed name of patient or personal representative and his or her relationship to patient

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THE PAIN RELIEF CENTER

MIGRAINE INSTITUTE 16

HIPAA RELEASE FORM FOR RELATIVES AND NON-HEALTH CARE PROVIDERS

Name:_____ Date of Birth: _____/_____/_____

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information. This information may be released to:

[ ] Spouse: _____
[ ] Child(ren): _____
[ ] Other: _____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by myself in writing.

Please Call [ ] my home [ ] my work [ ] my cell number: _____

If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

The best time to reach me is (day)_____between (time)_____

Signed: _____ Date: _____/_____/_____ Time: _____

Witness: _____ Date: _____/_____/_____ Time: _____

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THE PAIN RELIEF CENTER

MIGRAINE INSTITUTE

PROCEDURE CANCELLATION POLICY

We strive to render excellent health care to you and the rest of our patients. In an attempt to be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When you miss your scheduled appointment, that time cannot be used to treat another patient.

Our policy regarding cancelling your appointment is as follows:

We require that you give **The Pain Relief Center** and its affiliates a 24-hour notice in the event that you need to reschedule your surgical appointment. This allows for other patients to be scheduled into that time slot. If you are unable to attend or miss your surgical appointment and you fail to contact our office within the required time, this is considered a "NO SHOW," and a fee of $100 will be charged to you. This fee cannot be billed to your insurance company, and it will be your responsibility to pay the fee in full before we reschedule a new time for the procedure.

If you have any questions regarding this policy, please let our staff know, and we will be glad to clarify any questions you have.

I have read and understand the Procedure Cancelation Policy of **The Pain Relief Center** and its affiliates, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice, of which I will be notified in writing.

I, _____ (Print Name), have received a copy of The Pain Relief Center and its affiliates' procedure cancellation policy.

Signature of patient: _____ Date: _____ Time: _____

Witness Signature: _____

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THE PAIN RELIEF CENTER

MIGRAINE INSTITUTE 18

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

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

Phone: H) _____ **Phone: W)** _____

Address: _____ **City/State/Zip:** _____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ **Facility Phone:** _____

Facility Address: _____ **Facility Fax:** _____

City, ST, Zip: _____

Dates and Type of information to disclose:

- ☐ Full Records
- ☐ Dates Other: _____
- ☐ Specific Information requested:

_____

The purpose of disclosure is:

- ☐ Change of Insurance or Physician
- ☐ Continuation of care (e.g., VA Med Ctr)
- ☐ Referral
- ☐ Other: _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency syndrome virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: The Pain Relief Center

Address: 7709 San Jacinto Place Suite 101

City, State, Zip: Plano, Tx 75024 ☐ **Please mail records**

Fax: 214-292-9329 **Phone:** 214-709-1904 ☐ **Please fax records**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to me insurance company when the law provides my insurance my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition:** _____ **If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign the authorization. I need mot sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential of an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X _____ _____ _____

Signature of patient/ Parent/ Guardian or authorized Representative (attach documentation) **Date** **Time**

_____ _____

Printed name of Authorized Representative Relationship/ Capacity to patient

_____ (Address and phone number of Authorized representative)

THE PAIN RELIEF CENTER

MIGRAINE INSTITUTE 19

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

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

Phone: H) _____ **Phone: W)** _____

Address: _____ **City/State/Zip:** _____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: The Pain Relief Center **Facility Phone:** 214-709-1904

Facility Address: 7709 San Jacinto Pl. Suite 101 **Facility Fax:** 214-292-9329

City, ST, Zip: Plano, Texas, 75024

Dates and Type of information to disclose:

- ☐ Full Records
- ☐ Dates Other: _____
- ☐ Specific Information requested:

_____

The purpose of disclosure is:

- ☐ Change of Insurance or Physician
- ☐ Continuation of care (e.g., VA Med Ctr)
- ☐ Referral
- ☐ Other: _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency syndrome virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: _____

Address: _____

City, State, Zip: _____ ☐ **Please mail records**

Fax: _____ **Phone:** _____ ☐ **Please fax records**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to me insurance company when the law provides my insurance my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition:** _____ **If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign the authorization. I need mot sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential of an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X _____ _____ _____

Signature of patient/ Parent/ Guardian or authorized Representative (attach documentation) **Date** **Time**

_____ _____

Printed name of Authorized Representative Relationship/ Capacity to patient

_____ (Address and phone number of Authorized representative)

THE PAIN RELIEF CENTER

MIGRAINE INSTITUTE 20

DISCLOSURE OF PHYSICIAN OWNERSHIP
NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

You have the right to choose the provider of your health care services. Therefore, you have the option to use providers other than those in which Dr. Gabriel Rodriguez has a personal stake.

Please take notice that Gabriel Rodriguez, M.D. has a financial interest in the following companies:

1. Dallas Anesthesia Consultants – Collin County Anesthesia Consultants
2. PLANO IOM, PLLC / Neuromonitoring
3. Eminent Medical Center
4. Robert Chen, PLLC
5. Carrollton Anesthesia Consultants, PLLC (Owner)

You will not be treated differently by your physician if you choose to obtain health care services from another company.

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

Thank you,

The Pain Relief Center

By signing below, I acknowledge and agree that I have read this form and understand its contents.

Patient name: _____

Signature: _____

Date: _____ Time: _____

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THE PAIN RELIEF CENTER

MIGRAINE INSTITUTE 21

OUT-OF-NETWORK NOTICE

1. This notice is to inform you that some of the services provided by our office are billed as out-of-network services. These include but are not limited to anesthesia and neuromonitoring services.

2. Most insurance companies cover out-of-network services, but some insurance companies may not. Based on your insurance company's policy, you may receive a bill.

3. If you would like specific details or have any questions on how your medical service may be billed, please ask at the front desk to speak to our administrator or call our administrator at 214-709-1904.

4. By signing this notice, you acknowledge that you have been notified of our office policy concerning out-of-network services.

Please do not add or subtract any statement in this form. If you have any additional questions, please contact our Administrator at 214-709-1904.

Thank you,

The Pain Relief Center

By signing below, I acknowledge and agree that I have read this form and understand its contents.

Patient Name: _____

Patient Signature: _____

Date: _____ Time: _____

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www.painendshere.com

THE PAIN RELIEF CENTER

Dear _____,

Date: _____

Starting **January 1st, 2021**, we will begin electronically sending all prescriptions to your pharmacy due to the new pharmacy regulations. Please choose one pharmacy to send all your prescriptions to. Also, have in mind due to the volume of patients, your prescriptions may be sent until the end of business day. Thank you.

Pharmacy Name:

_____

Pharmacy Address:

_____

Pharmacy Phone number:

_____

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