THE PAIN RELIEF CENTER

DR. GABRIEL RODRIGUEZ, M.D.
DR. ROBERT CHEN, M. D.
7709 SAN JACINTO PLACE, SUITE 101 • PLANO, TEXAS 75024
PH: (214) 709 - 1904 • FAX: (214) 292 - 9329

MIGRAINE INSTITUTE

PLEASE COMPLETE ALL SECTIONS

IS YOUR CONDITION THE RESULT OF A WORK INJURY? ☐ YES ☐ NO DATE OF INJURY: / /

CASE ADJUSTER / MANAGER NAME: CASE #:

PHONE #: ( ) - EXT #:

PATIENT INFORMATION

LAST NAME: FIRST NAME: MI:

ADDRESS: CITY: STATE: ZIP:

HOME PHONE: ( ) – WORK: ( ) – CELL: ( ) –

DATE OF BIRTH: / / AGE: SEX: M / F SSN: – –

DRIVER'S LICENSE NUMBER: STATE:

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED / SEPARATED ☐ WIDOWED

E-MAIL : PREFERRED METHOD OF CONTACT: ☐ E - MAIL ☐ PHONE

SPOUSE'S NAME: SPOUSE DATE OF BIRTH: / /

SPOUSE SSN: – – SPOUSE PHONE: ( ) - CELL / WORK

EMPLOYMENT INFORMATION

EMPLOYMENT STATUS: ☐ EMPLOYED ☐ STUDENT ☐ RETIRED ☐ OTHER

EMPLOYER NAME: EMPLOYER PH: ( ) –

ADDRESS: CITY: STATE: ZIP:

OCCUPATION: ☐ FULL - TIME ☐ PART - TIME ☐ STUDENT ☐ RETIRED

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT NAME: EMERGENCY CONTACT RELATIONSHIP:

ADDRESS: CITY: STATE: ZIP:

HOME PHONE: ( ) – WORK: ( ) – CELL: ( ) –

REFERRAL INFORMATION

REFERRING PROVIDER NAME:

PHONE: ( ) – FAX: ( ) –

ADDRESS: CITY: STATE: ZIP:

PRIMARY CARE PHYSICIAN

(IF DIFFERENT FROM REFERRING PHYSICIAN)

PRIMARY CARE PHYSICIAN NAME: DATE OF LAST PHYSICAL EXAM: / /

PHONE: ( ) – FAX: ( ) –

ADDRESS: CITY: STATE: ZIP:

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PATIENT NAME: _____ **DATE OF BIRTH:** _____ **DATE:** _____

HEIGHT: _____ **WEIGHT:** _____

ALLERGIES

☐ NO KNOWN ALLERGIES

ALLERGEN	REACTION	SEVERITY	DATE OF ONSET

PAST MEDICAL HISTORY

PLEASE CHECK ***ALL*** ILLNESSES OR CONDITIONS THAT APPLY TO ***YOU***.

HEAD / ENT / EYES
- ☐ Allergic Rhinitis
- ☐ Blindness
- ☐ Cataracts
- ☐ Dentures
- ☐ Frequent Sinus Infection
- ☐ Glaucoma
- ☐ Hearing Aid(s)
- ☐ Wear Contacts / Glasses

GASTROINTESTINAL
- ☐ Cirrhosis
- ☐ Crohn's Disease
- ☐ Heartburn / GERD
- ☐ Hepatitis
- ☐ Hernia
- ☐ IBS
- ☐ Liver Disease

MUSCULOSKELETAL
- ☐ Degenerative Joint Disease
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ SLE *(Lupus)*

RENAL / ENDOCRINE
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Hypothyroid
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Thyroid Disease

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ Heart Failure *(CHF)*
- ☐ Hypertension
- ☐ Irregular Heartbeat / Rhythm
- ☐ Mitral Valve Prolapse

HEME / ONC / OTHER
- ☐ AIDS / HIV
- ☐ Bleeding Disorder
- ☐ Blood Clots *(DVT / PE)*
- ☐ Cancer *(type)* _____
- ☐ Chemo / Radiation
- ☐ Malignant Hyperthermia

NEUROLOGIC / PSYCHOLOGICAL
- ☐ ADHD
- ☐ Alzheimer's
- ☐ Anxiety
- ☐ Bipolar
- ☐ Depression
- ☐ Migraines
- ☐ Seizure
- ☐ Stroke

RESPIRATORY
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ COPD
- ☐ Sleep Apnea
- ☐ Smoker

OTHER
Please list any other problems below:

SURGICAL HISTORY

PLEASE CHECK ***ALL*** ILLNESSES OR CONDITIONS THAT APPLY TO ***YOU***.

- ☐ ACL Repair
- ☐ Appendectomy
- ☐ Back Surgery
  - ☐ Laminectomy ☐ Other
  - ☐ Microdiscectomy ☐ Fusion
  - _____ *(Levels)*
- ☐ Bariatric / Gastric Sleeve / Band
- ☐ Bilateral Tubal Ligation
- ☐ Brain Surgery
  - _____ *(type)*
- ☐ Breast Augmentation *(Implants)*
- ☐ Breast Reduction
- ☐ Breast Mastectomy / Reconstruction
- ☐ CABG *(Heart Surgery)*
- ☐ Cardiac Ablation
- ☐ Cardiac Stents
- ☐ Carpal Tunnel Repair
- ☐ Cartaract Surgery
- ☐ Cesarean Section
- ☐ Colonoscopy
- ☐ D & C
- ☐ ESWL *(Kidney Stones)*
- ☐ Gallbladder Surgery *(Cholecystectomy)*
- ☐ Hernia Surgery
- ☐ Hip Replacement ☐ LEFT ☐ RIGHT
- ☐ Hysterectomy
- ☐ Knee Replacement ☐ LEFT ☐ RIGHT
- ☐ Knee Scope ☐ LEFT ☐ RIGHT
- ☐ Laparoscopy
- ☐ Neck Surgery *(Cervical)* _____ *(Levels)*
- ☐ Organ Transplant
- ☐ Pacemaker / Defibrillator
- ☐ Prostate / TURP
- ☐ Sinus / Nasal Surgery
- ☐ Shoulder Surgery *(Rotator Cuff)*
- ☐ Splenectomy
- ☐ Tonsillectomy
- ☐ Thyroidectomy
- ☐ Vasectomy
- ☐ Other *(Please List Below)*

FEMALES ONLY

DATE OF LAST MENSTRUAL PERIOD ____ / ____ / ____

☐ CURRENTLY PREGNANT

☐ PLANNING TO BECOME PREGNANT

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PATIENT NAME: **DATE OF BIRTH:** **DATE:**

REVIEW OF SYSTEMS *HAVE YOU HAD **ANY** OF THE FOLLOWING PROBLEMS WITHIN THE **LAST 3 MONTHS**?*

CONSTITUTIONAL
- ☐ Good General Health
- ☐ Difficulty Sleeping
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Loss
- ☐ Weight Gain

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Palpitations
- ☐ Swelling in Legs / Feet
- ☐ High Cholesterol
- ☐ Heart Attack
- ☐ Stroke

EYES, EARS, NOSE, THROAT
- ☐ Blurred or Double Vision
- ☐ Difficulty Hearing
- ☐ Nosebleeds
- ☐ Ringing in Ears
- ☐ Tooth Pain
- ☐ Vertigo

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Blood in Stool
- ☐ Change in Appetite
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Nausea / Vomiting

GENITOURINARY / REPRODUCTIVE
- ☐ Blood in Urine
- ☐ Breast Mass
- ☐ Groin Mass
- ☐ Involuntary Urination
- ☐ Menopausal
- ☐ Painful Urination
- ☐ Pelvic Pressure

MUSCULOSKELETAL
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Weakness
- ☐ Neck Pain

RESPIRATORY
- ☐ COVID ____ / ____ / ____
- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ Snoring
- ☐ Wheezing

NEUROLOGICAL / PSYCHIATRIC
- ☐ Anxiety / Stress
- ☐ Depression
- ☐ Dizziness
- ☐ Gait Disturbance / Unsteady
- ☐ Headache
- ☐ Loss of Consciousness
- ☐ Numbness / Tingling
- ☐ Seizures
- ☐ Tremors
- ☐ Weakness
- ☐ Suicidal Thoughts

OTHER
- ☐ Easy Bleeding / Bruising
- ☐ Hair Loss
- ☐ Nail Changes
- ☐ Rash / Itching / Hives

Any new imaging studies?	☐ YES	☐ NO	Please List _____
Any new allergies?	☐ YES	☐ NO	Please List _____
Any new medications side effects?	☐ YES	☐ NO	Please List _____
Any new medications?	☐ YES	☐ NO	Please List _____
Have you had two or more falls in the last year?	☐ YES	☐ NO	Please List _____
Are you currently Pregnant?	☐ YES	☐ NO	Do you plan to become pregnant? ☐ YES ☐ NO

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 managemen care, treatment, and services to me, as deemed reasonable and necessry 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 I 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.

X _____ ____ / ____ / ____ _____

SIGNATURE OF PATIENT OR REPRESENTATIVE *DATE* *TIME*

_____

RELATIONSHIP TO PATIENT

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PATIENT NAME: _____ **DATE OF BIRTH:** _____ **DATE:** _____

CURRENT MEDICATION ☐ **NO MEDICATIONS** *PLEASE LIST ALL MEDICATIONS (INCLUDING VIITAMINS / HERBAL MEDICATIONS)*

MEDICATION(S) *(INCLUDING VITAMINS)*	DOSAGE	FREQUENCY

HOSPITALIZATIONS *PLEASE LIST ALL HOSPITALIZATIONS*

SOCIAL HISTORY

ALCOHOL ☐ NEVER ☐ OCCASIONALLY ☐ FREQUENTLY _____ DRINKS _____ PER DAY / WEEK

TOBACCO ☐ NEVER ☐ OCCASIONALLY ☐ FREQUENTLY _____ CIGARETTES / PACKS PER DAY / WEEK
(CIGARETTES OR VAPING)
_____ YEARS _____ YEARS SINCE QUTTING

TOBACCO ☐ NEVER ☐ OCCASIONALLY ☐ FREQUENTLY _____ CANS _____ PER WEEK / YEAR
(CHEWING)
_____ YEARS _____ YEARS SINCE QUTTING

RECREATIONAL DRUGS ☐ NEVER ☐ OCCASIONALLY ☐ FREQUENTLY **APPROXIMATE DATE OF LAST USAGE** _____
_____ *(types)*

DO YOU HAVE A BALANCED / HEALTHY DIET? ☐ YES ☐ NO **DO YOU EXERCISE REGULARLY?** ☐ YES ☐ NO
IF SO, HOW OFTEN? _____

FAMILY HISTORY

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
☐ 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
☐ Cancer *(Please Specify)*	☐ Cancer *(Please Specify)*	☐ Cancer *(Please Specify)*	☐ Cancer *(Please Specify)*
_____ *(type)*	_____ *(type)*	_____ *(type)*	_____ *(type)*
☐ Deceased	☐ Deceased	☐ Deceased	☐ Deceased
☐ Unknown	☐ Unknown	☐ Unknown	☐ Unknown
☐ N / A	☐ N / A	☐ N / A	☐ N / A

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PATIENT NAME: _____ **DATE OF BIRTH:** _____ **DATE:** _____

IMAGING ☐ **NO NEW IMAGING** *PLEASE LIST ALL NEW IMAGING PERFORMED WITHIN THE PAST 3 MONTHS*

IMAGING TYPE *(X-RAY, CT, MRI, ETC)*	BODY PART IMAGED	FACILITY LOCATION	FACILITY PH #	DATE IMAGED

PREVIOUSLY TRIED THERAPIES

PHYSICAL THERAPY ☐ **YES** ☐ **NO** *IF YES, PLEASE COMPLETE THE INFORMATION BELOW*

FACILITY NAME: _____ DATES: _____ – _____ FACILITY PH #: _____

FACILITY ADDRESS: _____
STREET *CITY* *STATE* *ZIP CODE*

CHIROPRACTIC CARE ☐ **YES** ☐ **NO** *IF YES, PLEASE COMPLETE THE INFORMATION BELOW*

FACILITY NAME: _____ DATES: _____ – _____ FACILITY PH #: _____

FACILITY ADDRESS: _____
STREET *CITY* *STATE* *ZIP CODE*

INJECTION THERAPY ☐ **YES** ☐ **NO** *IF YES, PLEASE COMPLETE THE INFORMATION BELOW*

FACILITY NAME: _____ DATES: _____ – _____ FACILITY PH #: _____

FACILITY ADDRESS: _____
STREET *CITY* *STATE* *ZIP CODE*

MEDICATION THERAPY ☐ **YES** ☐ **NO** *IF YES, PLEASE COMPLETE THE INFORMATION BELOW*

(e.g., NARCOTICS, MUSCLE RELAXANTS, ANTI-INFLAMMATORIES, & NERVE MEDICATIONS)

MEDICATION NAME	DOSAGE	FREQUENCY	% OF PAIN RELIEF	DATE BEGAN	DATE STOPPED	CURRENTLY TAKING?
						☐ YES ☐ NO
						☐ YES ☐ NO
						☐ YES ☐ NO
						☐ YES ☐ NO
						☐ YES ☐ NO

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DATE: _____

DEAR PATIENT,

AS OF JANUARY 1ST, 2021, NEW PHARMACY REGULATIONS REQUIRE ***ALL*** PRESCRIPTIONS TO BE SENT ELECTRONICALLY. PLEASE PROVIDE THE CONTACT INFORMATION FOR YOUR PREFERRED PHARMACY. DUE TO CLINIC HOURS, PLEASE BE AWARE THAT SOME PRESCRIPTIONS MAY NOT BE SENT UNTIL THE END OF BUSINESS.

THANK YOU!

PREFERRED PHARMACY

PREFERRED MAIL
ORDER PHARMACY _____ PHONE ( ) –

STREET ADDRESS *CITY* *STATE* *ZIP*

PREFERRED
LOCAL PHARMACY _____ PHONE ( ) –

STREET ADDRESS *CITY* *STATE* *ZIP*

PATIENT LABEL

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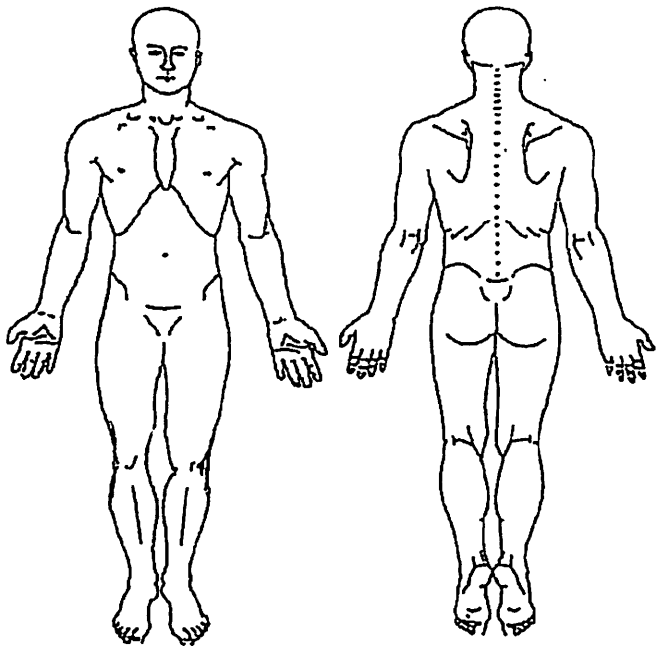
PATIENT NAME: _____ **DATE OF BIRTH:** _____ **DATE:** _____

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 BELOW TO INDICATE THE ***LOCATION*** AND ***TYPE*** OF PAIN. ***MARK THE DRAWING*** WITH THE FOLLOWING LETTERS THAT BEST DESCRIBE YOUR SYMPTOMS:

"N" = NUMBNESS "P" = PINS AND NEEDLES "A" = ACHING "S" = STABBING "B" = BURNING



WHAT ***AGGRAVATES*** YOUR PAIN? _____

WHAT ***RELIEVES*** YOUR PAIN? _____

WHERE IS THE ***WORST PAIN*** LOCATED _____

WHEN DID YOUR PAIN ***BEGIN***? _____

PAIN LEVEL ***WITH*** MEDICATION? _____ / **10**

PAIN LEVEL ***WITHOUT*** MEDICATION? _____ / **10**

WHAT WORD **BEST DESCRIBES** THE ***FREQUENCY*** OF YOUR PAIN?

☐ CONSTANT ☐ INTERMITTENT

WHEN IS YOUR PAIN AT ITS ***WORST***?

☐ MORNING ☐ MID-DAY ☐ AFTERNOON ☐ EVENING ☐ LATE NIGHT

CHECK *ALL* THAT DESCRIBE YOUR PAIN *TODAY*:

☐ ACHING ☐ SHOOTING ☐ BURNING / HOT ☐ SPASMS ☐ COLD ☐ SQUEEZING
☐ CRAMPING ☐ STABBING / SHARP ☐ THROBBING ☐ NUMB ☐ DULL ☐ SHOCK-LIKE
☐ TINGLING / PINS & NEEDLES ☐ TIRING / EXHAUSTING

SINCE YOUR LAST VISIT

HAS YOUR PAIN ☐ **INCREASED** ☐ **DECREASED** ☐ **REMAINED THE SAME**

DID YOU HAVE A PROCEDURE? ☐ **YES** ☐ **NO** ***IF YES***, HOW MUCH PAIN RELIEF DID YOU OBTAIN? _____ **% / 100 %**

DID YOU EXPERIENCE ANY POST-SURGICAL COMPLICATIONS? ☐ **YES** ☐ **NO** ***IF YES***, *PLEASE EXPLAIN BELOW*

_____

DO YOU HAVE ANY SIGNIFICANT BACK / BUTTOCK / LEG PAIN WITH PROLONGED STANDING AND / OR PROLONGED WALKING? ☐ **YES** ☐ **NO**

IF YES, IS YOUR PAIN RELIEVED WITH SITTING AND / OR LYING DOWN? ☐ **YES** ☐ **NO**

IF YES, IS YOUR PAIN ***ALSO*** ALLEVIATED WITH BENDING FORWARD?
(e.g., USING A SHOPPING CART, LEANING ON A KITCHEN COUNTER, ETC.) ☐ **YES** ☐ **NO**

PATIENT: _____

DOB: _____

THE PAIN RELIEF CENTER

☐ GABRIEL RODRIGUEZ, MD

☐ ROBERT CHEN, MD

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 IN-OFFICE USE ONLY **CLEARANCE ON FILE?** ☐ YES ☐ NO

NOTES:

☐ **PCP**
DATE OBTAINED: _____

☐ **CARDIAC**
DATE OBTAINED: _____

☐ **OK TO PROCEED, *IF NO MEDICAL CHANGES***

_____ _____

PROVIDER SIGNATURE **DATE**

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PATIENT NAME: _____ DATE OF BIRTH: _____ DATE: _____

GENERAL ANXIETY DISORDER SCALE (GAD-7) Over the ***last 2 weeks***, how often **have you been bothered** by ***any*** of he following problems?

ACTIVITY *(Place an "X" in the corresponding column)*	**NOT AT ALL** *SCORE: 0*	**SEVERAL DAYS** *SCORE: 0*	**OVER HALF OF THE DAYS** *SCORE: 2*	**NEARLY EVERY DAY** *SCORE: 3*
1. Feeling ***nervous***, ***anxious***, or "***on edge***".				
2. Not being able to ***stop*** or ***control*** **worrying.**				
3. Worrying **too much** about ***many things***.				
4. Trouble relaxing.				
5. Being so restless that it's difficult to sit still.				
6. Becoming ***easily annoyed*** or ***irritable***.				
7. **Feeling afraid**, as if something awful might happen.				
TOTAL SCORE: *(TOTAL FROM EACH COLUMN)*				
SUM OF TOTAL SCORES:				

FOR OFFICE USE ONLY: **0 - 4 NONE** **5 - 9 MILD** **10 - 14 MODERATE** **15+ SEVERE**

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? ☐ **NO DIFFICULTY** ☐ **SOMEWHAT DIFFICULT** ☐ **VERY DIFFICULT** ☐ **EXTREMELY DIFFICULT**

HAVE YOU EVERY BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS? *(PLEASE MARK **ALL** THAT APPLY)*

DISORDER	**HAD IT IN THE PAST**	**CURRENTLY HAVE IT**
FIBROMYALGIA	☐	☐
IRRITABLE BOWEL SYNDROME	☐	☐
PELVIC PAIN	☐	☐
PAINFUL BLADDER SYNDROME	☐	☐
BIPOLAR DISORDER (MANIC - DEPRESSIVE)	☐	☐

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PATIENT NAME: _____ **DATE OF BIRTH:** _____ **DATE:** _____

POST-TRAUMATIC STRESS DISORDER QUESTIONNAIRE (PCL-C)

*IF YOU HAVE **NEVER EXPERIENCED** A MAJOR STRESSFUL EVENT, SCORE "1" FOR **ALL** ITEMS.*

IF YOU HAVE HAD A ***MAJOR STRESSFUL EVENT***, PLEASE DESCRIBE THE EVENT BELOW: **DATE OF EVENT:** _____

INSTRUCTIONS TO PATIENT:	Below is a list of problems and complaints that people may sometimes have in response to stressful experiences.

Please read each one carefully ! For each stress-induced response you have experienced ***within the PAST MONTH***, place an "**X**" in the corresponding box which accurately describes the severity of your response.

	STRESS-INDUCED RESPONSE	**NOT SEVERE**	**MILDLY SEVERE**	**MODERATELY SEVERE**	**QUITE SEVERE**	**EXTREMELY SEVERE**
B	1. *Repeated*, ***disturbing memories, thoughts***, or ***images*** of a stressful experience from the past?					
	2. *Repeated*, ***disturbing dreams*** of stressful experience from the past?					
	3. Suddenly ***acting*** or ***feeling*** as if a stressful experience were ***happening again*** *(i.e., as if you are reliving it)*?					
	4. ***Feeling very upset*** when something *reminds you* of a stressful experience of the past?					
	5. Having ***physical reactions*** *(e.g., heart pounding, trouble breathing, sweating)* when reminded of a past event?					
C	6. **Avoid** ***thinking*** or ***talking*** *about* a stressful experience from the past or ***avoiding feelings*** related to it?					
	7. **Avoiding** ***activities*** or ***situations*** *which remind you* of a stressful experience from the past?					
	8. **Trouble remembering** *important details* related to a stressful experience from the past?					
	9. **Loss of interest in** ***activities*** which 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*** will somehow be **cut short**?					
D	13. Trouble ***falling*** or ***staying*** asleep?					
	14. Feeling ***irritable*** or having ***angry outbursts***?					
	15. Have **difficulty** ***concentrating on*** or **staying focused on a task**?					
	16. Feeling "***superalert***", ***watchful,*** or "***on guard***"?					
	17. Feeling "***jumpy***" or ***easily startled***?					

FOR IN- OFFICE USE ONLY:	**Supports DSM:**	**1B**	+	**3C**	+	**2D**

THE PAIN RELIEF CENTER

DR. GABRIEL RODRIGUEZ, M.D.
DR. ROBERT CHEN, M. D.
7709 SAN JACINTO PLACE, SUITE 101 • PLANO, TEXAS 75024
PH: (214) 709 - 1904 • FAX: (214) 292 - 9329

MIGRAINE INSTITUTE

PATIENT NAME: _____ **DATE OF BIRTH:** _____ **DATE:** _____

PATIENT HEALTH QUESTIONNAIRE (PGQ-9)

*Over **the last two weeks**, how often have you beenbothered by **any** of the following problems?*	**NOT AT ALL** *SCORE: 0*	**SEVERAL DAYS** *SCORE: 1*	**MORE THAN HALF OF THE DAYS** *SCORE: 2*	**NEARLY EVERYDAY** *SCORE: 3*
Little interest or pleasure in doing things.	0	1	2	3
Feeling down, depressed or hopeless.	0	1	2	3
Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
Feeling tired or having little energy.	0	1	2	3
Poor appetite or overeating.	0	1	2	3
Feeling bad about yourself - or that you are a failure or have let yourself or your family down.	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
Moving or speaking so slowly that other people have noticed. Or versly – been so fidgety and restless than you have been moving around a lot more than usual.	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself.	0	1	2	3

IN-OFFICE USE ONLY - DO NOT WRITE BELOW THIS LINE

TOTAL		=	0	+	+	+

FOR OFFICE USE ONLY **0 - 4 NONE** **10 - 14 MODERATE** **15 - 19 MODERATELY SEVERE** **20 + SEVERE**

How difficult **have these problems made it for you to work or go to school, complete tasks at home, enjoy recreational activities or socialize with family and friends?**

☐ **NO DIFFICULTY** ☐ **VERY DIFFICULT**

☐ **SOMEWHAT DIFFICULT** ☐ **EXTREMELY DIFFICULT**

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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 *(PRINTED)*	**PATIENT SIGNATURE**
DATE	**TIME**

THE PAIN RELIEF CENTER

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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:**
   - Refills are authorized ***only during regular business hours*** and ***require a visit*** with a provider in the clinic.
   - Refill requests *on Fridays* and *over the weekends* **will not** be addressed until the **next business day**. **NO EXCEPTIONS WILL BE MADE.**
   - 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	**PATIENT SIGNATURE**
DATE	**TIME**

THE PAIN RELIEF CENTER

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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 a* nd/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 responsibilit* y 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.***

PATIENT NAME *(PRINTED)*	**PATIENT SIGNATURE**
DATE	**TIME**

THE PAIN RELIEF CENTER

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MIGRAINE INSTITUTE

HIPAA PRIVACY AUTHORIZATION FORM
GENERAL RELEASE FOR HEALTHCARE 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.

PATIENT NAME *(PRINTED)*	**REPRESENTATIVE NAME (IF NEEDED)**
PATIENT / REPRESENTATIVE SIGNATURE	**RELATIONSHIP TO PATIENT**
DATE	**TIME**

THE PAIN RELIEF CENTER

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MIGRAINE INSTITUTE

HIPAA RELEASE FORM FOR RELATIVES OF NON-HEALTHCARE PROVIDERS

PATIENT 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 Phone _____ Other _____

If unable to reach me:

_____ You may leave a detailed message.

_____ Please leave a message asking me to return your call.

_____ Other instructions: _____

The best time to reach me is _____ between _____ **AM** **PM** .
DAY OF THE WEEK ***TIME***

_____ _____ _____
PATIENT SIGNATURE **DATE** **TIME**

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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, _____, have received a copy of **The Pain Relief Center** and its affiliates'
PRINT NAME
procedure cancellation policy.

PATIENT SIGNATURE **DATE** **TIME**

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MIGRAINE INSTITUTE

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 (OWNER)
2. PLANO IOM, PLLC / NEUROMT, PLLC (OWNER)
3. EMINENT MEDICAL CENTER (SHAREHOLDER)
4. ROBERT CHEN, PLLC (OWNER)
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 PRACTICE/COMPANY.

I ACKNOWLEDGE BY MY SIGNATURE BELOW THAT I HAVE RECEIVED AND READ THE PAIN RELIEF CENTER'S **FINANCIAL DISCLOSURE** AND **OUT-OF-NETWORK NOTICE**, THAT MY QUESTIONS REGARDING THIS **FINANCIAL DISCLOSURE** AND **OUT-OF-NETWORK NOTICE** HAVE BEEN ANSWERED TO MY SATISFACTION BY A REPRESENTATIVE OF THE PAIN RELIEF CENTER, AND THAT I BELIEVE I HAVE SUFFICIENT INFORMATION TO SIGN THE ACKNOWLEDGMENT BELOW. I FURTHER UNDERSTAND THIS DOES NOT AFFECT MY RIGHT TO REFUSE ANY PARTICULAR EXAMINATION, TEST, PROCEDURE, TREATMENT, THERAPY OR MEDICATION RECOMMENDED OR DEEMED MEDICALLY NECESSARY BY MY TREATING HEALTH CARE PROVIDER(S).

PRINT PATIENT NAME	**PATIENT SIGNATURE**
DATE	**TIME**

THE PAIN RELIEF CENTER

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MIGRAINE INSTITUTE

OUT-OF-NETWORK NOTICE

This notice is to inform you that some of our services provided by our office are billed as out of network services. This includes, but is not limited to, **Anesthesia and Neuromonitoring.**

ASSIGNMENT OF PAYMENTS -- I understand the anesthesia fees and neuromonitoring fees are separate from all other surgical fees, anesthesia and neuromonitoring fees for services are based on local/regional standards. However, individual insurance policies may vary as to the extent of their coverage. You will be held responsible for any balance due on your account. This notice is to inform you that our services provided by our office are billed as out of network services. Most insurances companies cover out-of-network services, but some Insurances may not. If you have any questions, our billing company is available to answer any questions (972) 991 – 9950. By signing this, you acknowledge that you have been notified of the out-of-network services.

I have been given an opportunity to ask questions about services methods, the procedures to be used, the billing procedures and out-of-network notice, the risks and hazards involved, and alternative forms of anesthesia/analgesia. I believe that I have sufficient information to give this informed consent. This form has been fully explained to me, I have read it or have had it read to me, and I understand its contents.

Please do not add or subtract any statement to this form. If you have any additional questions, please contact our practice administrator at (214) 709 – 1904.

BY SIGNING THIS, YOU ACKNOWLEDGE THAT YOU HAVE BEEN NOTIFIED OF THE OUT-OF-NETWORK SERVICES.

_____ _____

PRINTED PATIENT NAME **PATIENT SIGNATURE**

_____ _____

DATE **TIME**

GABRIEL RODRIGUEZ, M. D. ROBERT CHEN, M.D. ALLISON BARDIN, P. A.

THE PAIN RELIEF CENTER

FOR OFFICE USE ONLY	
TEMP: _____	F° / C°
DATE: _____	

COVID-19 CORONAVIRUS PATIENT SELF-ASSESSMENT TOOL

Due to the pandemic of Covid-19, we are asking everyone to complete the following questionnaire:

1. Have you been vaccinated for COVID-19?

   ☐ YES ☐ NO

2. Have you been in close contact with anyone known or suspected to have the COVID-19 virus? *(Close contact is defined as within 6 feet for three minutes (3) or more)*

   ☐ YES ☐ NO

3. Do you have any of the following symtoms:

   Fever? ☐ YES ☐ NO

   Cough? ☐ YES ☐ NO

   Trouble breathing? ☐ YES ☐ NO

If you answered ***YES*** to any of these questions ***and*** have respiratory symptoms:

- If you believe your symptoms are life threatening, go to the nearest hospital emergency department. We recommend that you call the emergency department immediately so the staff can provide you with arrival instructions.
- If you have any respiratory infections or symptoms, please go home and get tested for COVID-19.
- If you suspect that you may have COVID-19 or if you have recently tested positive, you may qualify for a telemedicine consultation for a possible medication continuance.

_____ _____

PATIENT SIGNATURE **DATE**

7709 San Jacinto Place, Ste 101 • Plano, Texas 75024 • PH: 214-709-1904 • FAX: 214-292-9329
www.PainEndsHere.com

THE PAIN RELIEF CENTER

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DR. ROBERT CHEN, MD
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HAS ANY RELATIVE HAD A PROBLEM WITH THE FOLLOWING *(PLEASE CIRCLE **YES OR NO** FOR EACH ITEM BELOW)* ALCOHOL ☐ YES ☐ NO ADDICTION ☐ YES ☐ NO MENTAL ILLNESS ☐ YES ☐ NO	NEVER	SELDOM	SOMETIMES	OFTEN	VERY OFTEN
	0	1	2	3	4
1. How often do you have a mood swing?					
2. How often have you felt a need for a higher dose of medication to treat your pain?					
3. How often have you felt impatient with your doctors?					
4. How often have you felt that things are just too overwhelming that you just can't handle them?					
5. How often is there tension in your home?					
6. How often have you counted pain pills to see how many are remaining?					
7. How often have you been concerned that people will judge you for taking pain medication?					
8. How often do you feel bored?					
9. How often have you taken more pain medication than you were supposed to?					
10. How often have you worried about being left alone?					
11. How often have you felt a craving for medication?					
12. How often have others expressed concern over your use of medication?					
13. How often have any of your close friends had a problem with alcohol or drugs?					
14. How often have others told you that you have a bad temper?					
15. How often have you felt consumed by the need to get pain medication?					
16. How often have you run out of pain medication early?					
17. How often have others kept you from getting what you deserve?					
18. How often, in your lifetime, have you had legal problems or been arrested?					
19. How often have you attended an AA or NA meeting?					
20. How often have you been in an argument that was so out of control that someone got hurt?					
21. How often have you been sexually abused?					
22. How often have others suggested that you have a drug or alcohol problem?					
23. How often have you had to borrow pain medication from your family or friends?					
24. How often have you been treated for an alcohol or drug problem?					
TOTAL					

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MIGRAINE INSTITUTE

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/STATE/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: PLANO STATE: TX ZIP: 75024

FAX: (214) 292 - 9329 PH: (214) 709 - 1904

☐ PLEASE MAIL RECORDS

☐ PLEASE FAX RECORDS

I understand I may revoke this authorization at any time. If I revoke this authorization, I understand that 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 my 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 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 unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact the authorized individual or organization making the 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.

_____ _____

PATIENT / PARENT / REPRESENTATIVE / GUARDIAN NAME (*ATTACH DOCUMENTATION*)

RELATIONSHIP / CAPACITY TO PATIENT

_____ _____

SIGNATURE PATIENT / PARENT/ AUTHORIZED REPRESENTATIVE

ADDRESS / PHONE NUMBER FOR AUTHORIZED REPRESENTATIVE

THE PAIN RELIEF CENTER

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MIGRAINE INSTITUTE

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 PLACE, SUITE 101 FACILITY FAX: (214) 292 - 9329

CITY/STATE/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: _____ ☐ PLEASE MAIL RECORDS

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ ☐ PLEASE FAX RECORDS

FAX: _____ PH: _____

I understand I may revoke this authorization at any time. If I revoke this authorization, I understand that 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 my 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 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 unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact the authorized individual or organization making the 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.

_____ _____

PATIENT / PARENT / REPRESENTATIVE / GUARDIAN NAME *(ATTACH DOCUMENTATION)*

RELATIONSHIP / CAPACITY TO PATIENT

_____ _____

SIGNATURE PATIENT / PARENT/ AUTHORIZED REPRESENTATIVE

ADDRESS / PHONE NUMBER FOR AUTHORIZED REPRESENTATIVE

THE PAIN RELIEF CENTER

DR. GABRIEL RODRIGUEZ, M. D.
DR. ROBERT CHEN, M.D.
7709 SAN JACINTO PLACE, SUITE 101 • PLANO, TEXAS 75024
PH: (214-709 – 1904 • FAX: (214) 292 – 9329

MIGRAINE INSTITUTE

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/STATE/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: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

FAX: _____ PH: _____

☐ **PLEASE MAIL RECORDS**

☐ **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 my 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:**

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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.

_____ _____

PATIENT / PARENT / REPRESENTATIVE / GUARDIAN NAME *(ATTACH DOCUMENTATION)*

RELATIONSHIP / CAPACITY TO PATIENT

_____ _____

SIGNATURE PATIENT / PARENT/ AUTHORIZED REPRESENTATIVE

ADDRESS / PHONE NUMBER FOR AUTHORIZED REPRESENTATIVE