Central Texas PAIN CENTER

PSA Locations

Austin – North
4100 Duval Road
Building 3, Suite 200
Austin, TX 78759
Office: 512-485-7204
Fax: 512-485-7224

Bastrop
3101 Highway 71
Suite 211
Bastrop, TX 78602
Office: 512-953-8130
Fax: 512-265-8742

Killeen
3202 South W S Young Dr
Suite 102
Killeen, TX 76542
Office: 254-247-3322
Fax: 254-432-5388

Temple
10252 West Adams Ave
Suite 104
Temple, TX 76502
Office: 254-732-6631
Fax: 512-582-8617

CTPC Locations

Austin – South
4316 James Casey Street
Building B, Suite 200
Austin, TX 78745
Office: 512-498-1029
Fax: 512-369-3366

Bee Cave
15801 W. Hwy 71
Bldg 1, Suite 200
Bee Cave, TX 78738
Phone: 512-375-4775
Fax: 512-582-8384

Cedar Park
1401 Medical Parkway
Building C, Suite 345
Cedar Park, TX 78613
Office: 512-953-8137
Fax: 512-485-7224

Georgetown
3201 South Austin Avenue
Suite 265
Georgetown, TX 78628
Office: 512-953-8120
Fax: 512-582-8264

New Braunfels
213 Hunters Village
New Braunfels, TX 78132
Office: 830-627-3800
Fax: 830-625-2235
Pharmacy: 830-515-1278

Round Rock
7201 Wyoming Springs Drive
Suite 400
Round Rock, TX 78681
Office: 512-953-8133
Fax: 737-212-0544

San Antonio
250 East Basse Road
Suite 207
San Antonio, TX 78209
Office: 210-614-9955
Fax: 210-614-9966

San Marcos
1304 Wonder World Drive
San Marcos, TX 78666
Office: 512-953-8121
Fax: 512-667-9149

Seguin
411 South King Street
Seguin, TX 78155
Office: 830-609-9478
Fax: 830-433-9089

Waco
205 Woodhew Drive
Suite 203
Waco, TX 76712
Office: 254-732-6632
Fax: 254-732-0947

Even though we are committed to compassionate care, we must exercise proper due diligence when prescribing opioid analgesics for chronic pain. Prescription drug abuse has reached epidemic proportions in our society. Therefore, our clinic policy is that an appropriate workup must be completed prior to the dispensing of an opioid prescription. This workup will include review of previous pharmacy/clinic records, evaluation by diagnostic and laboratory tests, and acceptable completion of a urine drug screen yielding expected results. Common examples of opioid analgesics include hydrocodone, morphine, oxycodone, fentanyl, opana, and methadone. Prescriptions for these medications will not be given at an initial visit.

- Please bring your driver's license and insurance cards along with your **completed** new patient paperwork to your scheduled appointment. Payment for services is expected at the time of service (co- pays, co-insurance, private pay). We accept cash, check, money order and credit cards (Visa, American Express, MasterCard, and Discover).
- **If you have been instructed to obtain imaging reports and/or films by our staff, please bring them to your appointment. Our office requires these as part of yourconsultation. If we do not have your films at the time of your appointment, you may be rescheduled.**
- Your initial visit at the Practice is a consultation. If a doctor referred you for an injection, you must be seen for an office visit first. Procedures are scheduled after the initial consultation.
- If English is your second language, please make arrangements for someone to accompany you to your visit who can translate in order to provide you with the best healthcare service. We want you to fully understand your diagnosis and prognosis and have any questions you may have answered.

We wish to make your visit as comfortable as possible, so please do not hesitate to contact us if you have any questions at the numbers listed above.

Notice of Financial Interest
This is to serve as legal notice that the physicians at this location providing my care have a financial interest in The Pain Relief SurgiCenter, Ambulatory Surgery Center of Killeen, and Hunter's Creek Pharmacy. I understand that I am free to choose any facility for obtaining services or prescriptions that are ordered for me.

Physicians include the following: Hans Bengtson, Daniel Frederick, Genaro Gutierrez, Jamal Hasoon, Jason Lo, Vivek Mahendru, Umar Mahmood, Pankaj Mehta, Eric Miller, Trey Mouch, Rahul Sarna, Zack Smith, Samuel Stevens, Derrick Wansom

Patient Acknowledgement Statement

Patient Name & DOB: _____

I understand that services or items that I have requested be provided to me by Central Texas Pain Center or Pain Specialists of Austin (as applicable, the "Practice") may not be covered under my insurance as being reasonable or medically necessary for my care. I understand my health plan determines the medical necessity of the services or items I request and receive. I also understand I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable or medically necessary for my care.

Advanced Practitioner Consent for Treatment

The Practice has on staff physician assistants, nurse practitioners, or advanced practice nurses to assist in the delivery of medical care of pain management.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. A nurse practitioner or advanced practice nurse is not a doctor. A nurse practitioner or advanced practice nurse is a registered nurse who has received advanced education and training in the provision of health care. Under the supervision of a physician, a physician assistant, a nurse practitioner, or an advanced practice nurse can diagnose, treat and monitor acute and chronic disease as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of the supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

A physician assistant, a nurse practitioner, or an advanced practice nurse may provide such medical services that are within his/her education, training and experience.

I have read the above and hereby consent to the services of an advanced practitioner for my health care needs. I understand that at any time I can refuse to see the advanced practitioner and request to see a physician.

Acknowledgment of Urine Testing Policy

I understand that the Practice reserves the right to perform random urine testing on any patient. I have the right to refuse the urine test but may then not be prescribed any medications or given refills of medications.

Acknowledgment of External Rx History

I understand that the Practice reserves the right to obtain an external Rx history and randomly verify past medications through the Prescription Drug Monitoring Database in order to be prescribed any medications.

Acknowledgment of Late Arrival Policy

If you are unable to make an appointment, please call within 24 hours prior to your appointment time to reschedule. If you fail to notify our office prior to missing your scheduled appointment, you will be charged a NO SHOW fee of $25 for an office visit and $50 for a procedure. Frequent NO SHOWS may result in a release from the Practice**.**

Access to Protected Health Information – HIPAA Privacy Rule's

I give permission for the Practice to leave appointment information, test results, and/or pre-operative instructions on voice message for the following phone numbers or with the following individuals:

_____

_____

PATIENT SIGNATURE & DATE: _____

Central Texas PAIN CENTER

Today's Date: _____

Location of Care: _____

PATIENT'S PERSONAL INFORMATION

Name: _____ Preferred Name: _____
Last Name First Name M.I.

Date of Birth: ____/____/____ Gender: ☐ Male ☐ Female ☐ Other _____

Marital status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

SSN: ____ - ____ - ____ Driver's License # & State: _____

Employer: _____ Employer Phone: _____

E-Mail Address: _____

Preferred Method of Communication?* ☐Home phone ☐Cell Phone ☐Work Phone ☐E-Mail/Patient Portal

*If you provide an email or phone number, you understand that you may receive these communications from the Practice. To opt-out, fill out Communication Consent.

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined to Specify Preferred Language: _____

Race: ☐American Indian ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White Other _____

Referring Provider: _____ Primary Care Provider: _____

Other Providers: _____

Emergency Contact: _____ Relationship: _____

Emergency Phone: _____ Phone Type: _____

PATIENT'S RESPONSIBLE PARTY INFORMATION

Name: _____ Date of Birth: _____

Address: _____

Phone: _____ SSN: _____ Relationship: _____

INSURANCE INFORMATION

Primary Insurance Name: _____

Insured Name: _____ DOB: _____ SSN: _____

Relationship to Patient: _____ ID #: _____ Group #: _____

Secondary Insurance Name: _____

Insured's Name: _____ DOB: _____ SSN: _____

Relationship to Patient: _____ ID #: _____ Group #: _____

***Please provide card(s) to the front desk**

Is there an ongoing lawsuit related to your visit today? ☐YES ☐NO Are you currently under worker's compensation? ☐YES ☐NO

Communication Consent

We want to stay connected with our patients. Patients in our Practice and all our affiliated clinics may be contacted via email and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. If you provide an email or phone number to the Practice, you understand that you may receive these communications from the Practice.

You may opt out of these communications at any time. The Practice does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan. Email and standard text messaging are not confidential methods of communication and may be insecure.

Select below to opt-out of communication via text and/or email regarding various aspects of your medical care, which may include, but shall not be limited to, reminders, feedback, and general health reminders/information, test results, prescriptions, appointments, and billing.

Opt-out:

_____ I decline/revoke to receive communication via **text**.

_____ I decline/revoke to receive communication via **email**.

_____ _____

Patient Name Date of Birth

_____ _____

Patient/Patient Representative Signature Date

Central Texas PAIN CENTER

NAME:_____ DATE OF BIRTH: _____

PAST MEDICAL HISTORY

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

PAST SURGICAL HISTORY

Please list and indicate dates.

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

FAMILY HISTORY

Please list any disease, illness, or ailments in your IMMEDIATE FAMILY (i.e. mother-breast cancer, father- diabetic, paternal grandfather-heart disease, maternal grandmother-hypertension).

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

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NAME:_____ DATE OF BIRTH: _____

SOCIAL HISTORY

Any tobacco use? ☐ Yes ☐No If yes, how many per day?_____ Years?_____

Any alcohol use? ☐Yes ☐No If yes, how much? _____

Recreational drug use? ☐Yes ☐No If yes, which drug? _____

Do you live alone? ☐ Yes ☐No If no, who do you live with? _____

REPRODUCTIVE HISTORY

Are you Pregnant: ☐Yes ☐No If **YES**, how many weeks? _____

Date of last period?_____

Date of last Pap smear?_____ Date of last mammogram? _____

PHARMACY NAME & LOCATION

_____

ALLERGIES

_____

_____

CURRENT MEDICATIONS

***Please list pain medications and blood thinners first**

Medication (ex. Ibuprofen)	Dosage (ex. 400 mg)	Frequency (ex. three times a day)

Central Texas PAIN CENTER

NAME:_____DATE OF BIRTH: _____

REVIEW OF SYSTEMS

In the past few months, have you had any of the following symptoms or difficulties? If you have any difficulty that bears further explanation, please indicate so and explain in the additional notes section.

✓ **CHECK** ALL APPLICABLE

General:
☐ Chills ☐ Fatigue ☐ Fever ☐ Change of Appetite ☐ Weight Loss

Allergy/Immunology:
☐ Hay fever ☐ Hives ☐ Frequent infections

Ophthalmologic:
☐ Blurred Vision ☐ Diminished visual acuity ☐ Double Vision ☐ Eye pain ☐ Light sensitivity

HENT:
☐ Decreased hearing ☐ Difficulty Swallowing ☐ Ear pain ☐ Hoarseness ☐ Ringing in ears

Endocrine:
☐ Cold Intolerance ☐ Heat Intolerance ☐ Thyroid problems

Respiratory:
☐ Cough ☐ Shortness of breath ☐ Wheezing

Cardiovascular:
☐ Leg Swelling ☐ Palpitations ☐ Swelling in hands/feet

Genitourinary:
☐ Bladder incontinence ☐ Blood in urine ☐ Frequent urination ☐ Painful urination

Gastrointestinal:
☐ Blood in stool ☐ Change in bowel habits ☐ Constipation ☐ Heartburn ☐ Nausea ☐Vomiting

Musculoskeletal:
☐ Back problems ☐ Joint stiffness ☐ Muscle aches ☐ Painful joints

Hematology:
☐ Bleeding problems ☐ Easy bruising ☐ Swollen glands

Skin:
☐ Itching ☐ Rash ☐ Skin lesions

Neurologic:
☐ Dizziness ☐ Numbness ☐ Seizures ☐ Tingling ☐ Tremor ☐ Weakness

Psychiatric:
☐ Anxiety ☐ Depression ☐ Insomnia ☐ Substance abuse

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NAME:_____ DATE OF BIRTH: _____

PAIN EVALUATION

Location of pain _____

Onset of pain _____(days, weeks, months, or years)

Cause of pain _____(accident, unknown)

Your occupation _____ Is this work related? ☐Yes ☐No

Other physicians/specialties you have seen for this pain, including other pain management clinics:

_____

Characteristics of your pain: ☐ Constant ☐ Intermittent Duration_____

Pain Intensity from 1 – 10 (where 10 is the worst):_____at its worst; _____at its least

Your pain is: ☐sharp ☐ shooting ☐ burning ☐ stabbing ☐ electrical shocks ☐ numbness ☐ aching

Other _____

What makes your pain worse? _____

What makes your pain better? _____

Do you have: ☐ numbness ☐ localized weakness ☐ bowel incontinence ☐ bladder incontinence

How many hours per night do you sleep? _____

PREVIOUS TREATMENTS

Which of the prior treatments or tests have you had? Include **date of service**, **body part, results, & facility**:

☐ MRI _____

☐ CT/X-rays_____

☐ Acupuncture _____

☐ Braces (DME) _____

☐ Chiropractic Treatment _____

☐ EMG/Nerve Testing _____

☐ Massage Therapy _____

☐ Physical Therapy _____

☐ TENS_____

☐ **Injections** _____

_____

_____

Central Texas PAIN CENTER

NAME:_____ DATE OF BIRTH: _____

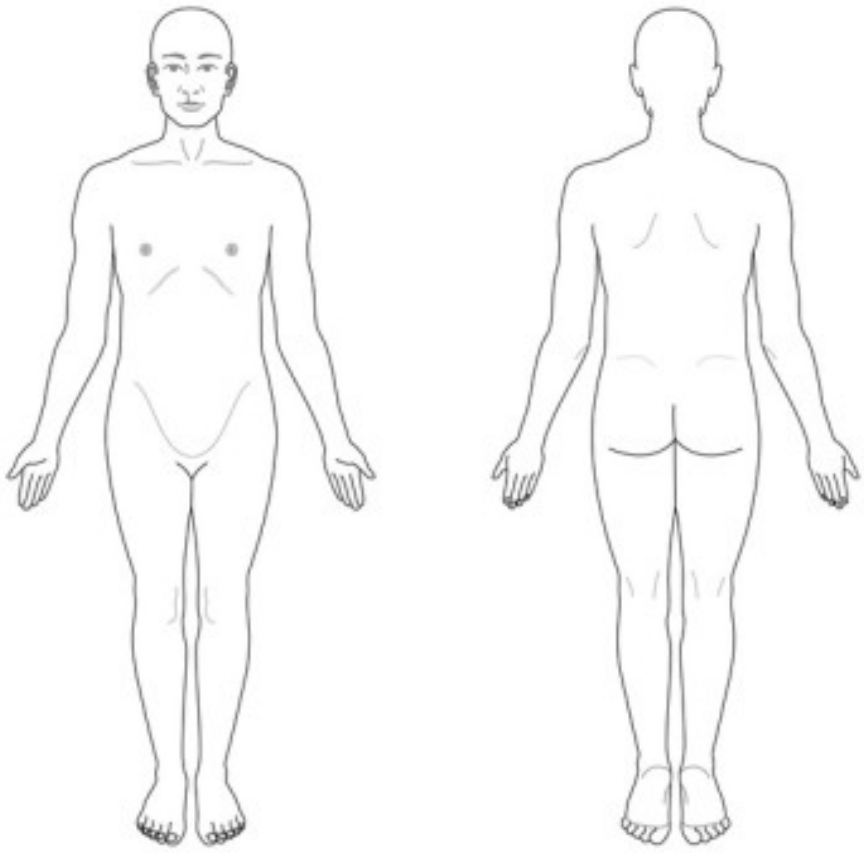
☐ Topical Compounded Pain Creams ☐Yes ☐No **If yes, which cream?** _____

☐ Prescribed Medications (circle all that apply): Pain Medications Muscle Relaxers Anti-Inflammatory Steroids

☐ Please **CIRCLE** all tried medications below. Also mark **X** in the box if tried for at least 6 weeks.

	Amitriptyline		Baclofen		Celebrex		Cymbalta		Depakote
	Effexor/Venlafaxine		Fentanyl Patch		Gabapentin		Ibuprofen		Meloxicam
	Morphine Sulfate ER		Nabumetone		Naproxen		Nucynta		Tizanidine
	Topamax		Tramadol/Ultram		Tramadol ER		Tylenol #3		Tylenol #4

Please mark the area(s) on your body where you feel pain.



Additional Notes:

_____

_____

_____

_____