



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

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

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 your consultation. 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, Charles Mouch, Rahul Sarna, William 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: _____



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



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).

- _____
- _____
- _____
- _____
- _____



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



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** _____

NAME: _____ DATE OF BIRTH: _____

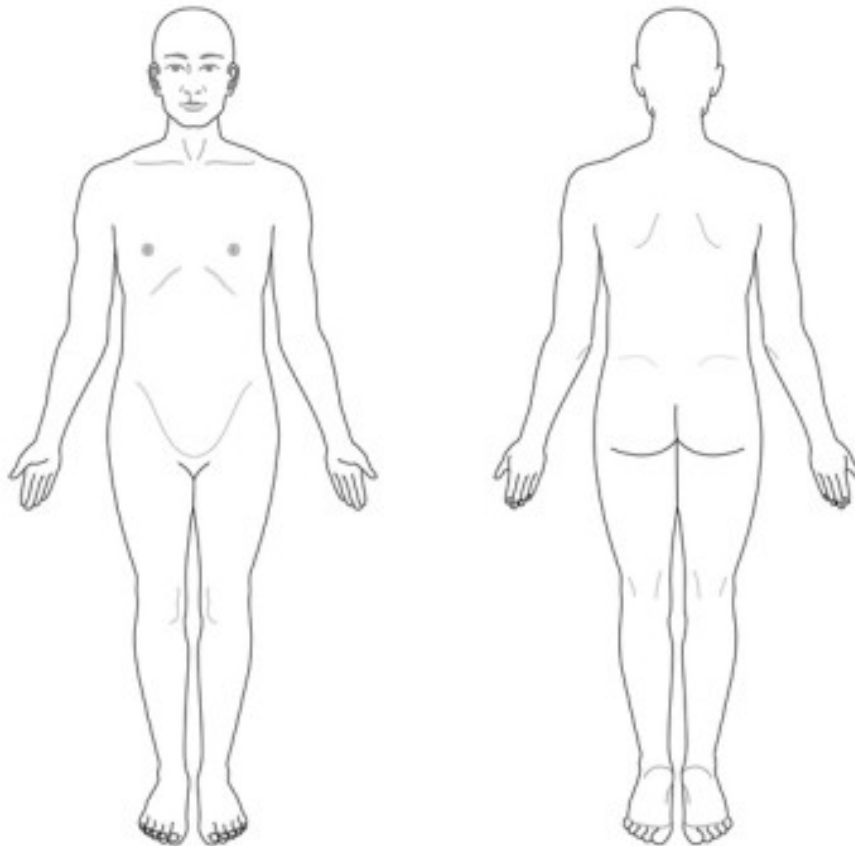
Topical Compounded Pain Creams Yes No **If yes, which cream?** _____

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:
