# Pain Specialists of America

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

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

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

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

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

**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

**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

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

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

**Visit our website for additional Information: www.psadocs.com**

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 mustbe 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 examplesof 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 <u>imaging reports and/or films</u> 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 officevisit first. Procedures are scheduled after the initial consultation.
- If English is your second language, please let us know at least 48 hours in advance if you need us to provide a language interpreter for your appointment. 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 listedabove.

**Notice of Financial Interest**
This is to serve as legal notice that the physicians at this location providing you care have a financial interest in PSA Surgery Center of Austin and PSA Surgery Center of Killeen. You have the right to choose any facility for obtaining services or prescriptions that are ordered for you. You will not be treated differently by your physician if you choose to use another facility.

Physicians having a financial interest include the following: Hans Bengtson, Yuen Cheng, Daniel Frederick, Genaro Gutierrez, Jamal Hasoon, Jason Lo, Pankaj Mehta, Trey Mouch, Rahul Sarna, Derrick Wansom

# Patient Acknowledgement Statement

Patient Name & DOB: _____

I understand that services or items that I have requested be provided to me by Pain Specialists of America (as applicable, the "Practice") may not be covered under my insurance as being reasonable or medically necessary for my care. I understandmy 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 anytime 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 testbut 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 thePrescription 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 notifyour 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 forthe following phone numbers or with the following individuals:

_____

**PATIENT SIGNATURE & DATE:** _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Information about you and your health is personal, and we are committed to protecting your privacy. This notice tells you about our privacy practices, the ways in which we may use and share your health information, and how you can get access to your health information. This notice also describes your rights and our responsibilities regarding the use and disclosure of health information.

## Our Uses and Disclosures

We typically use and share your health information in the following ways:

**Treat you**: We can use your health information and share it with other professionals who are treating you. Examples: we will share health information about you with an ambulatory surgical center where you are scheduled for a procedure; we will share your health information with a physician to whom you have been referred for further treatment.

**Bill for our services**: We can use and share your health information to bill and receive payment from health plans and other entities. Example: we will share your health information with your health insurance plan so it will pay for services we provide to you.

**Run our organization**: We can use and share your health information to run our operations, train medical students, improve your care and contact you when necessary. Examples: we may call you by name in the waiting room when your physician is ready to see you; we may use your health information in our quality improvement reviews.

We can also de-identify your health information and use and disclose such de-identified information for any purpose.

**Communicate regarding treatment alternatives or appointment reminders**: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related services that may be of interest to you.

**How else can we use or share your health information?** We are allowed or required to share your health information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information, see: https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

**Help with public health and safety issues**: We can share information about you for certain situations, such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

**Do research**: We can use or share your information for health research.

**Food and Drug Administration (FDA)**: We may share health information with the FDA relative to adverse events with respect to food, medications, devices, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs or replacement.

**Comply with the law**: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

**Respond to organ and tissue donation requests**: We can share health information about you with organ procurement organizations.

**Work with a medical examiner or funeral director**: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers' comp, law enforcement & other government requests**: We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions**: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

**Your Rights**

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

**Get an electronic or paper copy of your medical record**:

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Please contact the office directly where you receive care.
- We will provide a copy or a summary of your health information in accordance with applicable state and federal requirements.
- We may charge a reasonable, cost-based fee.
- If you ask that we send a copy of your medical record/other health information to someone other than you, we may ask you to complete a written auth. You may revoke an authorization to use or disclose your health information except to the extent that action has already been taken in reliance on your authorization. To revoke your authorization, send written notice to:

  Privacy Officer, Daniel Frederick, MD
  4100 Duval Road, Bldg 3, Suite 200, Austin, TX 78759. Phone: 855.876.7246

**Ask us to correct your medical record**: You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

**Request confidential communications**: You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

**Get a copy of this privacy notice**: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. You may also view a copy of this notice on our website.

**Ask us to limit what we use or share**:
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

**Get a list of those with whom we've shared information**. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**File a complaint if you feel your privacy rights have been violated.**
- You can complain if you feel we have violated your privacy rights by contacting the office where you receive care directly.
- You can also contact our Privacy Officer:
  Privacy Officer, Daniel Frederick, MD
  4100 Duval Road, Bldg 3, Suite 200, Austin, TX 78759. Phone: 855.876.7246
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

## Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

**In these cases, you have both the right and choice to tell us to**:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

**In these cases, we never share your information unless you give us written permission**:
- Marketing purposes, Sale of your information, Most sharing of psychotherapy notes

**Fundraising**: We may contact you for fundraising efforts, but you can tell us not to contact you again.

## Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

## Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Effective Date: 5/2022

# Patient and Financial Policy

Thank you for choosing Pain Specialists of America. In order to inform you of our current financial and office policy, please read the document below and sign the financial agreement. Our providers, clinical, and office staff are here to help you in any way possible and strive to make your experience with us pleasant and comforting. Keep a copy of this document for your records and should you have any questions please do not hesitate to ask one of our associates.

Please keep us informed of any address, telephone number, or name changes. If we are unable to contact you regarding your bill, we will refer the balance to our outside collection agency.

Please notify our office within 24 hours to reschedule or cancel an appointment. This will allow our staff to offer this time slot to another patient in need of an appointment.

We accept the following forms of payment: cash, credit cards, cashier's checks, money orders, and personal checks.

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**RETURNED CHECKS**

• Returned checks will accrue a $50.00, as well as any applicable bank fees to your account.

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**INSURANCE**

• It is your responsibility to know your level of benefits for services provided. Being that our providers are specialist, many services are required to have prior authorizations by the insurance company and/or Primary Care Physician. Please contact your insurance company before your appointment to ensure proper authorization and an estimate of payment due as we are not certain what the patient balance will be until the insurance company processes your claim.
• Payment of fees, co-pays, co-insurance and deductibles are due at the time of service.
• Co-pays are a requirement placed on you by your insurance company and therefore cannot be waived or reduced. Should you forget or cannot provide your co-pay at the time of visit; you will be asked to reschedule your appointment.
• You are solely responsible for your balance in the form of co-insurance, deductible, or non- covered services as required by your insurance company.
• You will be contacted prior to your appointment and notified of any balance due on your account and will be expected to bring payment to your appointment. You will be required to make arrangements with the financial counselor if you cannot pay the balance in full.
• Should any balance remain unpaid more than 90 days past the processing date with the insurance company, a statement will be sent to the guarantor of the account and payment will be due upon receipt of the statement.

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**WORKER'S COMPENSATION**

• Please keep in contact with your adjuster prior to and after your appointment to receive any pertinent information regarding your claim and injury.
• Authorizations may be required for certain procedures and could take up to 1 week to obtain.
• Should your case become closed, undergo peer review, or determined that Maximum Medical improvement has been met you must contact your referring physician and adjuster for written approval before scheduling any appointment or services.

**PATIENT SIGNATURE & DATE:** _____

Pain Specialists of America

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

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# Patient Medical History

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: ☐ aching ☐ burning ☐ electrical shocks ☐ numbness ☐ sharp ☐ shooting ☐ stabbing

Other _____

What makes your pain worse? _____

What makes your pain better? _____

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

Which of the prior treatments or tests have you had? **Include date of service and results**

☐ MRI_____

☐ CT_____

☐ Physical Therapy _____

☐ Injections_____

☐ Chiropractic Treatment_____

☐ Acupuncture_____

☐ Physical Therapy _____

☐ Massage Therapy_____

☐ EMG/Nerve Testing _____

Other _____

How many hours per night do you sleep? _____

Prior Surgeries, Include dates and names of surgery _____

_____

Do you have a family history of any kind of illness? _____

Are you allergic to: ☐ IV Iodine ☐ Latex ☐ Topical Iodine ☐ Shellfish Your reaction: _____

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Medication allergies and reactions:_____

Current list of medications you are taking, including over the counter. Include strength and daily dose:

_____

_____

_____

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

Any alcohol use? ☐Yes ☐No Type: _____ How much? _____How often? _____

Do you have a history of or current drug use? ☐Yes ☐No If yes, which type of drug? _____

Do you have a history of:

Drug Abuse ☐Yes ☐No Alcohol Abuse ☐Yes ☐No Prescription Drug Abuse ☐Yes ☐No

**FEMALE PATIENTS ONLY**

☐ I am NOT pregnant

☐ I am _____weeks pregnant Name of OB/GYN _____

Current Pharmacy: _____ Address: _____

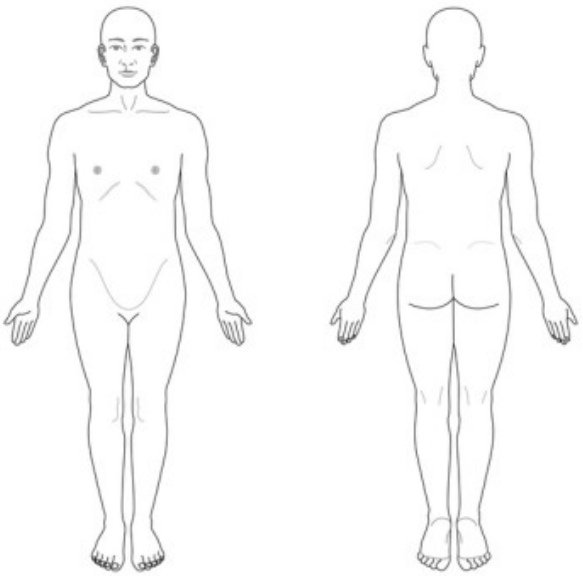
Phone Number: _____ Fax Number:_____

**REVIEW OF SYSTEMS**

✓**CHECK** ALL that you have experienced in the last month

**General:** ☐ Fever ☐ Chills ☐ Weight Loss ☐ Fatigue
**Eyes:** ☐ Blurred Vision ☐ Photophobia ☐ Eye pain ☐ Double Vision
**Cardiovascular:** ☐ Chest pain ☐ Palpitations ☐ Peripheral edema
**Respiratory:** ☐ Shortness of breath ☐ Cough ☐ Recent Infections
**GE:** ☐ Constipation ☐ Abdominal pain ☐ Bowel incontinence ☐Nausea ☐ Vomiting
**Genitourinary:** ☐ Dysuria ☐ Bladder incontinence
**Musc-skeletal:** ☐ Joint pain ☐ Swelling ☐ Warmth ☐ Spasms ☐ Cramps
**Skin:** ☐ Lesions ☐ Rash
**Heme/lymph:** ☐ Bleeding ☐ Bruising
**Neurological:** ☐ Weakness ☐ Numbness ☐ Tingling ☐ Syncope ☐ Headache ☐ Loss of balance
**Psychiatric:** ☐ Depression ☐ Anxiety ☐ Hallucination
**ENT:** ☐ Decreased hearing ☐ Ringing in ears ☐ Difficulty Swallowing ☐ Hoarseness
**Immunologic:** ☐ Hives ☐ Hay fever ☐ Persistent infections

**PLEASE MARK ANY AREA(S) ON THE BODY WHERE YOU FEEL PAIN**



**Additional Notes:**

_____

_____

_____

_____

_____

_____

Pain Specialists of America

# AUTHORIZATION TO PHOTO, VIDEO, RECORD AND INTERVIEW FOR MEDIA AND MARKETING RELEASE

Full Name _____

Street Address _____

State, City, Zip code _____

Birth Date _____ Email address _____

Cell Phone # : _____ Home Phone # : _____

Thank you for expressing an interest in letting us share your story with other patients and the public. Please take your time to review this authorization before signing. This authorization will allow us to share your personal information with other patients, the media, and the public.

By my signature below, I give my permission to Pain Specialists of America, its affiliates, assigns, contractors, employees and staff (collectively, "PSA") to be photographed, videotaped, recorded, and interviewed by PSA, the media, or any other person for use and disclosure by PSA for the purposes of education, promotion, advertising, marketing, publication, and distribution, within and outside PSA, in any and all media including, without limitation, websites, magazines, news articles, radio, video productions, and social media (e.g., Facebook, YouTube, etc.).

I acknowledge that this authorization is not a commitment by PSA to use my photo, video, recording or interview and that PSA reserves the right to not use my information, or to use only part of my information. I hereby release any right, title, or interest in the photo, video, recording or interview, and to any control over their use or any proceeds that may arise. I release and forever discharge and agree to hold harmless PSA from any and all liability arising from the photo, video, recording or interview, or any use or disclosure by PSA of the photo, video, recording or interview.

I also acknowledge that PSA may conduct a background check on me using publicly available records.

I understand that:

- This authorization is voluntary. My treatment will not be impacted if I sign this authorization or not.
- This authorization will not expire. It will remain valid unless and until I revoke it. *Please see our Notice of Privacy Practices for how to revoke an authorization*.
- Any revocation will be effective as soon as PSA receives it, except to the extent PSA has taken action in reliance on this authorization.
- Once the photo, video, recording or interview is used or disclosed, such information may no longer be protected by federal and state privacy laws and could be re-disclosed by the person(s) receiving it.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

*SHARE YOUR STORY*. **INSPIRE OTHERS.**

REV5.22 ****File in Patient's chart under Consent Forms****