

**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**

3310 E. Central TX  
Expressway Building B,  
Suite 201  
Killeen, TX 76543  
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 Marcos**

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

**Seguin**

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

**Temple**

305 Clinite Grove Blvd  
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](http://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 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 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 listed above.

**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: Yuen Cheng, Daniel Frederick, Genaro Gutierrez, Jason Lo, Pankaj Mehta, Trey Mouch



## 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 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.

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### 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.

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### 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.

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### 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.

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### 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 your 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.

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### Access to Protected Health Information – HIPAA Privacy Rules

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: \_\_\_\_\_

\_\_\_\_\_

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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/](http://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](http://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.



## 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 aren't 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:** \_\_\_\_\_



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



## Patient Medical History

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

### PAIN EVALUATION

Location of pain \_\_\_\_\_

Onset of pain \_\_\_\_\_ (days/weeks/months/years) Cause of pain \_\_\_\_\_

Accident  Work Injury Your occupation \_\_\_\_\_

Referring \_\_\_\_\_ Primary Care Provider \_\_\_\_\_

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

Characteristics of your pain:  Constant  Intermittent  Sudden  Gradual

Pain Intensity: 0 – no pain    2    3    4    5    6    7    8    9    10 – worst imaginable pain

Your pain is:  Aching  Burning  Electrical Shocks  Numbness  Sharp  Shooting  Stabbing  Tingling

Does it radiate?  Yes  No Other \_\_\_\_\_

What makes your pain worse? \_\_\_\_\_

What makes your pain better? \_\_\_\_\_

Do you have:  Localized Weakness  bowel incontinence  bladder incontinence

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

MRI  CT  X-ray \_\_\_\_\_  EMG/Name Test \_\_\_\_\_

Previous Meds:  Anti-Inflammatory  Muscle Relaxers  Neuropathic  Opioids  Other \_\_\_\_\_

List Prior Tried Medications: See Chart on next page \_\_\_\_\_

Injections \_\_\_\_\_  Epidural  mbb/RFA

Chiropractic Treatment \_\_\_\_\_  Brace

Acupuncture \_\_\_\_\_  TENS

Physical Therapy \_\_\_\_\_

Massage Therapy \_\_\_\_\_  Cognitive Behavioral Therapy

Other \_\_\_\_\_

Please list any chronic illness/medical conditions: \_\_\_\_\_

Please list any prior surgeries & date: \_\_\_\_\_

Do you have a family history of any kind of illness? Family History:  DM  Cardiac  Stroke  Other \_\_\_\_\_

Are you allergic to:  Tape  IV Iodine  Latex  Topical Iodine  Shellfish Your reaction: \_\_\_\_\_

Please list any medication allergies and reactions: \_\_\_\_\_

Current Pharmacy: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

**CURRENT MEDICATIONS** **ADDITIONAL MEDICATION LIST: YES NO (Circle one)**

\*List pain medications and blood thinners first. Check boxes below of current medications \*If you need more space, request RX sheet.

<u>Medication (ex. Ibuprofen)</u>	<u>Dosage (ex. 400 mg)</u>	<u>Frequency (ex. three times a day)</u>

<b>PLEASE CHECK <input checked="" type="checkbox"/> ALL PREVIOUSLY TRIED MEDICATIONS</b>	Amitriptyline	Lyrica	Celebrex	Tylenol	Flexeril
	Effexor/Venlafaxine	Gabapentin	Ibuprofen	Codeine	Robaxin
Other:	Topamax	Naproxen	Nucynta	Tizanidine	
Other:	Cymbalta	Meloxicam	Tramadol	Hydrocodone	

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? \_\_\_\_\_

**FEMALE PATIENTS ONLY**

I am **NOT** pregnant  I am \_\_\_\_\_ weeks pregnant Name of OB/GYN \_\_\_\_\_

**REVIEW OF SYSTEMS**  **CHECK ALL that you have experienced in the last month**

- General:**  Fever  Chills  Weight Loss  Weight Gain  Recent Infections
- Eyes/ENT:**  Blurred Vision  Double Vision  Decreased Hearing  Difficulty Swallowing
- Cardiovascular:**  Chest pain  Palpitations  Fainting  Peripheral edema
- Respiratory:**  Cough  Shortness of breath
- Gastro:**  Constipation  Abdominal pain  Bowel incontinence  Nausea  Vomiting
- Genitourinary:**  Bladder incontinence  Difficulty with Urination
- Musc-skeletal:**  Joint pain  Swelling  Spasms  Cramps
- Skin:**  Rash  Open Sores/Wound
- Heme/lymph:**  Bleeding  Easy Bruising
- Neurological:**  Falls  Tremors  Limb Weakness  Loss of balance
- Psychiatric:**  Untreated Depression  Uncontrolled Anxiety  Hallucination  Suicidal Thoughts
- Immunologic:**  Hives  Persistent infections  Covid

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

