Functional Recovery Associates PLLC

PRIDE

GETTING TO KNOW YOU

We'd like to help you get the most out of your first visit with your doctor. Your time with your doctor is valuable and we have a few suggestions to help you make the most of your visit. During this first appointment, you will be asked to provide a brief medical history and discuss any current health concerns you may have related to your injury.

To begin with, we ask that you complete the New Patient Information Packet that is included with this welcome kit. Please make sure you:

- Complete all Forms
- Sign all of the notices

If you have questions or would like assistance in completing any of these forms, please call the number on the brochure.

Talk about your medications. It's very important that you tell your doctor about all the medications you use including prescriptions, homeopathic and over the counter remedies. It is also important to let them know about any adverse or allergic reactions you have ever had to common medications.

Don't be afraid to ask questions. Your doctor or nurse is a valuable resource for health information and advice. If you are concerned about any information you receive, please talk to your nurse about it.

Thank you!

7929 Broookriver Dr., Ste. 400
Dallas, Texas 75247

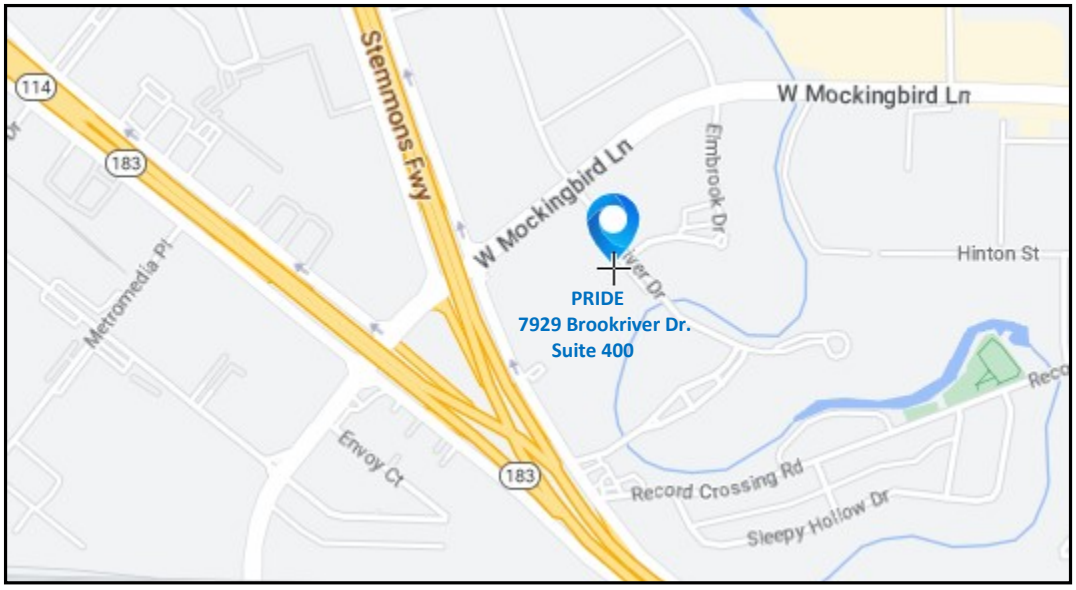
CARF

Centers Excellence AMERICAN PAIN SOCIETY Award Recipient 2008

(214) 351-6600
Fax (214) 351-6453

www.pridedallas.com

Facility Location



PRIDE is located at 7929 Brookriver Dr., Suite 400 in Dallas.

From North of Dallas: Take I–35 south and exit Mockingbird Ln and take a left on Mockingbird Ln. Take a right on Brookriver Dr. Office Building is on your right - Suite 400

From South of Dallas: Take I–35 north and exit Mockingbird Ln and take a right on Mockingbird Ln. Take a right on Brookriver Dr. Office Building is on your right - Suite 400

From East of Dallas: Take I–30 to I-35 north and exit Mockingbird Ln and take a right on Mockingbird Ln. Take a right on Brookriver Dr. Office Building is on your right - Suite 400

From West of Dallas: Take I–30 to I-35 north and exit Mockingbird Ln. and take a right on Mockingbird Ln. or take 183 and merge to I-35 south and exit Mockingbird Ln. and take a left on Mockingbird Ln. Take a right on Brookriver Dr. Office Building is on your right - Suite 400

7929 Brookriver Dr., Suite 400 ♦ Dallas, TX 75247
214-351-6600 ♦ www.pridedallas.com

Please give 24 hours notice of cancellation to avoid a service charge

Thank you!

H=_____ W=_____
P=_____ R=_____

PATIENT ASSESSMENT FORM - Non WC
Rev. Date 12/2021

PATIENT'S NAME: _____
Last First Middle
Age:_____ **Gender:** F M

Race: Caucasian African-Amer. Hispanic Asian Other:_____

Birthdate:_____ **Social Security #:_____**

Address:_____ **Home Phone#:_____**
Number & Street City/State/Zip Area Code Number

Cell Phone#:_____ **Email:_____** **Work Phone#:_____**

Name of Spouse/Partner:_____ **Emergency Contact#:_____**

Insurance Type (circle all that apply): Group Health Medicare TWS Self-Pay

Ins. Co: _____ **Group #:_____** **Policy#**:_____

***Medicare #:_____** **TWS Counselor:_____**
*Note: This facility does not accept assignment

Who is your treating physician? _____

Who referred you to us?_____

Purpose of Visit: (circle) Rehab Counseling Physical Therapy Hand Therapy Pain Management
Work Capacity Eval Other: _____

What are your worst painful (or problem) body parts (in order of severity)?
1) _____ 2) _____ 3) _____
4) _____ 5) _____ 6) _____
7) _____ 8) _____ 9) _____

Weakness? Arm: R L Leg: R L
Numbness? Arm: R L Leg: R L

I lose control of my…Urine...how often per mo.? _____Stool…how often per mo.?_____

Which injured joint buckles, gives way or pops?_____

Does your painful area have (circle all applicable):

Unusual tenderness Swelling Temperature change Color Change Hair loss Dry skin Thinner skin

When pain began (mo/yr)**?**_____ **Injury Date** (if any)…(mo/yr)?_____ **Pain Cause**: Injury Illness

If injured, describe how accident happened?: _____

_____

How did accident cause injury: _____

Injury Diag.: Sprain/Strain Fracture/Dislocation/Disc Problem Concussion Hernia Amputation Nerve Problem

If not injured, when did pain become constant (mo/yr)?_____
When did pain become disabling from work or home activities (mo/yr)? _____

Current or most recent employer:_____ **JobTitle:**_____

Address:_____ **Business Telephone#**:_____

Number/Street City/State/Zip Code Area Code Telephone

Started Job (Mo/Yr)**:**_____ **Yrs. with emp**:_____

Which body part(s) involved in your pain has been hurt before?

Injury Date (mo/yr)	Body part(s)	# of Surgeries?	Work Lost Time (mo)
1.			
2.			
3.			
4.			

Did any of these injuries happen on the job? Y N

Which ones?_____

Years in school?: _____yrs. Degree: H.S. Diploma GED Associate BA/BS MA/MS
Other:_____

Country of Origin: _____ **If not US, Years in US:** _____

Have you had surgery related to <u>your current illness, injury or painful condition</u>?

Date (mo/yr)	Operation Name	Surgeon Name
1.		
2.		
3.		
4.		
5.		

Have you had therapeutic injections since <u>this</u> pain? Y N **Did they improve your pain** Y N

Date (mo/yr)	Injection (Type/Location)	Doctor
1.		
2.		
3.		
4.		

What diagnostic tests do you remember having done to each injured body part?

Test	**Date**	**Body Part Tested**	**Results (if you know)**
X-Ray			
CT Scan			
MRI			
Myelogram: Neck Back			
EMG/Nerve Conduction		Arms: R or L	Legs: R or L
Discogram			
Bone Scan			
Blood Tests			

Have you seen other consultant doctors? Y N

	Date	Doctor's Name	Specialty	Opinion
1.				
2.				
3.				

Has your doctor recommended surgery for you at this time? Y N
What type?_____

How do you feel about surgery at this time? (Circle applicable)
Don't need it Scared of Complications Want it but doctors don't agree

What non-operative treatment have you had for this pain problem? (circle all applicable)
Manipulation Hot/cold TENS Stretch/strengthen Aqua therapy Speech/Hearing

Cognitive Work conditioning Work hardening Counseling/biofeedback Pain clinic

Other:_____

Daily therapy_____ Therapy 3x/week_____ Therapy 2x/week_____ Therapy 1x/week _____

Are you allergic to any medication? Y N
If yes, list medication(s

_____
_____

What medication are you currently taking, including OTC medication (Refer to Medication History list)?

	Name	Reason taking	Dose	# per day	Since when
1.					
2.					
3.					
4.					
5.					
6.					
7.					

What medications have you tried that failed for your painful condition(s)?

_____

_____

Pain level with medication (10 is worst possible pain) _____ 0-10

What activities make the pain worse? (Circle applicable)**:**
Lifting Pushing/Pulling Reaching Bending Forward/Backward Coughing/Sneezing Standing

Sitting Climbing Squatting Kneeling During Exercise All Activities

What reduces your pain? (Circle applicable)
Lying down Manipulation Ice Heat Physical therapy Sitting Standing Walking

Medications Nothing Other: _____

Have any of these problems caused stress for you since the pain began? (Circle all applicable):
None Finances Family relations Work Physical ability Family role Weight gain (____lbs)

Interest in sex Hobbies Lost social contacts

What are your goals? (Circle all applicable):

None Reduce pain Return to Work Retrain for other jobs Reduce Medication Prepare for surgery

Avoid surgery Feel less stress and frustration School for new career Learn techniques for pain control

Be able to participate in family/recreational activities

Other: a)_____
b)_____

Persons you live with: None Spouse Fiancée Friends

#Children____ **Age**: Youngest____ Oldest_____

Are you: Married Single Divorced Since when (mo/yr)?:_____

Do you smoke? Y N **Do you vape?** Y N **How much per day?_____**

Do you drink alcoholic beverages? Y N **How much per day?_____**

What is the heaviest thing you lifted this week? _____

Please indicate the activities that you are no longer able to do as a result of your pain. (Circle applicable):
Dressing Exercise Yard work Walking Shopping Sitting work Driving Housework
All Activities

How many hours out of 24 do you spend reclining (including sleep)?_____

Have you been in the hospital with other medical problems? Y N Number of times_____
Please describe:_____

Any surgeries (unrelated to current problem)?

	Date (mo/yr)	Surgery (Type and Body Part)
1.		
2.		
3.		
4.		

Please check any type of the following medical problems that you have been taking medications for:

_____ Allergies	_____Heart Murmurs	_____Diabetes
_____ Loss of hearing	_____Angina	_____Thyroid Disorders
_____ Vision problems, glaucoma	_____Heart Failure	_____Anemia
_____ Respiratory Disorders (Ie. Asthma, COPD, etc.)	_____High Cholesterol	_____Eczema
_____ Kidney Disease	_____High Blood Pressure	_____Cancer
_____ Prostatitis	_____Arthritis/Rheumatism	_____Sleep Apnea
_____ Colitis	_____Loss of consciousness	
_____V.D.		
_____ Hepatitis/Jaundice, liver problems	_____Frequent headaches/migraines	_____HIV
_____ Pancreatitis	_____Concussion/Head Injury	_____Arthritis
_____ Stomach disorders, ulcers, vomiting blood	_____Convulsions/Seizures	_____Other
_____ Heart Attack	_____Stroke	

List medications used to control the above medical problems:

_____

_____

Do you wear a medical alert bracelet? (Diabetes, Seizures, DNR, other) Y N
If yes to the above, specify what type and explain:

_____

_____

Please fill in your family history.

	Relation Age	Age at Death	Name of Diseases
Mother			
Father			
Brother(s)			
Sister(s)			
Grandmothers			
Grandfathers			

Do you currently have any problems in the following areas? Please Check.

General: Fever, weight loss, weight gain, unusually tired, etc.	**Yes**	**No**	Explain:
Ears, Nose, Throat: Hard of hearing, stuffy nose, ear pain, buzzing ears, cough, dry mouth, etc.			
Cardiovascular: High blood pressure, low blood pressure, racing pulse, chest pain, etc.			
Respiratory: Congestion, wheezing, short of breath, cough, asthma, COPD, etc.			
Gastrointestinal: Stomach upset, diarrhea, constipation, hernia, ulcers, pain/cramps, acid reflux, etc.			
Genital, Kidney, Bladder: Painful urination, frequent urination, burning sensation, impotence, incontinence, infection, etc.			
Muscle, Bones, Joints: Muscle pain/cramps, joint pain swelling, stiffness, etc.			
Skin: Itching, rash, infection, ulcer, tumor/growths, warts, excessive dryness, etc.			
Neurological: Numbness, weakness, headaches, paralysis, seizures, tremors, tingling, etc.			
Mood: Depression, anxiety, mood swings, insomnia, psychosis, disorientation, etc.			
Endocrine: Diabetes, thyroid problems, fatigue, hair loss, hot/cold intolerance, etc.			
Blood/Lymph: Anemia, blood disorders, prolonged bleeding, frequent nose bleeds, bruise easily, high cholesterol			
Allergic/Immunologic: Recurrent infections, hay fever, food allergies, drug sensitivity, hives, redness, itching, etc.			

Your Signature: _____ Date: _____

CURRENT MEDICATION HISTORY

Please complete the following information about ALL mediations you are currently taking.

Name:	**Date of Birth:**
Allergies:	

Start Date	**Medication Name**	**Dose**	**Frequency**	**Prescribing Practitioner**	**Reason for Medication**	**End Date**

Rev. 6/2023

MEDICATION HISTORY
(Please circle any medications you have *ever* taken)

Patient Name:_____ Date:_____

STIMULANTS
Ritalin, Concerta (methylphenidate)
Cylert (pemoline)
Dexedrine, Adderall (dextroamphetamine)
Provigil (modafanil)
Fastin/Adipex (phentermine)
Ephedra/Ephedrine
Daytrana
Strattera (atomoxetine)
Vyvanse

ANTIDEPRESSANTS
Viibryd
Trimipramine
Pristiq
Savella
Cymbalta (duloxetine)
Anafranil (clomipramine)
Asendin (amoxapine)
Celexa (citalopram)
Desyrel (trazodone)
Effexor (venlafaxine)
Elavil (amitriptyline)
Lexapro (escitalopram)
Ludiomil (maprotiline)
Luvox (fluvoxamine)
Nardil (phenelzine)/Marplan
Norpramin (desipramine)
Pamelor (nortriptyline)
Paxil (paroxetine)
Prozac (fluoxetine)
Parnate (tranylcypromine)
Remeron (mirtazapine)
Serzone (nefazodone)
Sinequan (doxepin)
Tofranil (imipramine)
Wellbutrin (bupropion)
Zoloft (sertaline)
Lithobid/Eskalith/Lithonate (lithium)
EMSAM/Eldepryl (selegiline)/DLPA
St.John's Wort
Inositol / Omega 3 Fatty Acids/SAM-E
Vivactil (protriptyline)

ANTI-NAUSEANTS
Vistaril, Atarax (hydroxyzine)
Zofran (ondansetron)/Kytril
Tigan (trimethobenzamide)
Phenergan (promethazine)
Marinol (dronabinol)
Compazine (prochlorperazine)
Reglan (metoclopramide)
Emetrol

ANTI-ANXIETY
Ativan (lorazepam)
Klonopin (clonazapam)
Librium (chlordiazepoxide)/Librax
Serax (oxazepam)
Valium (diazepam)
Xanax (alprazolam)
Tranxene (chlorazepate)
Buspar (buspirone)
Valerian
Kava
Phenobarbital
Meprobamate

MUSCLE RELAXERS
Dantrolene
Flexeril (cyclobenzaprine)
Lioresal (baclofen)
Norflex (orphenadrine)
Norgesic (corphenadrine/caffeine/aspirin)
Parafon Forte/Lorzone (chlorzoxazone)
Robaxin (methocarbamol)
Skelaxin (metaxalone)
Soma (carisoprodol)
Zanaflex (tizanidine)
Botox

CENTRAL NERVOUS SYSTEM
Artane (trihexyphenidyl)
Cogentin (benztropine)
Eldepryl, Deprenyl (selegiline)
Symmetrel (amantidine)
Parlodel (bromocryptine)
Permax (pergolide)
Sinemet (levodopa/carbidopa)
Mirapex (pramipexole)
Requip (ropinerole)
Mysoline
Inderal (propranolol)
Tenormin (atenolol)
Visken (pindolol)
Dostinex
Prazosin
Terazosin
Dibenzyline

HYPNOTICS
Ambien/Intermezzo (zolpidem)
Dalmane (flurazepam)
Doral (quazepam)
Halcion (triazolam)
Noctec, Somnote (chloral hydrate)
Prosom (estazolam)
Restoril (temazepam)
Seconal (secobarbital)
Sonata (zaleplon)
Melatonin
Xyrem (GHB)
Lunesta (eszopiclone)
Rozerem (ramelteon)

NEUROLEPTICS
Abilify(aripiprazole)
Geodon (ziprasidone)
Risperdal (risperidone)
Seroquel (quetiapine)
Zyprexa (olanzapine)
Clozaril
Haldol (haloperidol)
Loxitane (loxapine)
Mellaril (thioridazine)
Moban (molindone)
Navane (thiothixene)
Stelazine (trifluoperazine)
Thorazine (chlorpromazine)
Trilafon (perphenazine)
Thorazine (chlorpromazine)
Methotrimprazine
Symbyax/ (Zyprexa-Prozac)
Invega (palloperidone)
Limbitrol
Saphris
Latuda
Fanapt

TOPICAL
EMLA Cream (lidocaine prilocaine)
Lidoderm (lidocaine patch)
Zonalon Cream (doxepin)
Capsaicin lotion
Ketamine gel/cream
Biofreeze
Salicylate/Menthol
Volran gel / Flector patch
Ketprofen gel
Clonidine gel
Gabapentin gel
Morphine gel
Amitriptyline gel
Qutenza

OPIOIDS

Fioricet/ Fiorinal with codeine
Tylenol with codeine , #2, #3,#4
Soma compound with codeine
Duragesic Patch (fentanyl)
Actiq Lozenge (fentanyl)
Nucynta (tapentadol)
Lorcet,Lortab,Norco,Vicodin,Zydone,Xodol (hydrocodone/acetominophen)
Vicoprofen (hydrocodone/ibuprofen)
Opana (oxymorhone)
Exalgo, Dilaudid (hydromorphone)
Levo-Dromoran (levorphanol)
Demerol/Mepergan Fortis (meperidine)
Dolophine (Methadone)
Darvon/Darvocet (propoxyphene)
Avinza,MS-Contin,Oramorph,Kadian (morphine)
Oxycontin, OxyIR/Roxicodone (oxycodone)
Percocet/Tylox/Endocet (oxycodone/acetaminophen)
Percodan (oxycodone/aspirin)
Buprenex /Suboxone/Subutex /Butrans(buprenorphine)
Nubain (nalbuphine)
Stadol (butorphanol)
Talwin NX (pentazocine/naltrexone)
Delsym/Dexalone (dextromethorphan)

HEADACHE MEDICATIONS

Relpax (eletriptan)
Amerge (naratriptan)
Axert (almotriptan)
Maxalt (rizatriptan)
Imitrex tablet/injection/spray (sumatriptan)
Zomig (zolmitriptan)
Frova (frovatriptan)
Bellergal (ergotamine tartrate, belladonna alkaloids, Phenobarbital)
Cafergot, Wigraine (ergotamine tartrate, caffeine)/ Methergine
D. H. E. 45 (dihydroergotamine mesylate)
Migranal nasal spray (dihydroergotamine)
Midrin (isometheptene, acetaminophen, dichloralphenazone)
Petadolex (butterbur)
Periactin (cyproheptadine)
Sansert (methysergide)
Esgic, Fioiricet (butalbitol/acetominophen/caffeine)
Fiorinal (butalbital/aspirin/caffeine)
Nimotop (nimodipene)
Calan (verapamil)
Inderal (propranolol)/ Tenormin (atenolol)
Botox
Feverfew
Magnesium/Coenzyme Q10
Lidocaine drops

ADDICTION MEDICATIONS

Revia/Trexan (naltrexone)
Catapres (clonidine)
Antabuse (disulfuram)
Ibogaine
Methadone/LAAM
Suboxone/Subutex (buprenorphine)
Campral (acamprosate)
Chantix
Prometa

NON-OPIOID PAINKILLERS

Ultram/Ultracet (tramadol)
Tylenol (acetaminophen)
Advil, Motrin, Nuprin (ibuprofen)
Aleve, Anaprox, Naprelan, Naprosyn (naproxen)
Ansaid (flubiprofen)
Arthrotec (diclotenac/ misoprostol)
Aspirin (acetylsalicylic acid)
Voltaren (diclofenac)
Celebrex (celecoxib)
Clinoril (sulindac)
Daypro (oxaprozine)
Dolobid (diflunisal)
Feldene (piroxicam)
Indocin (indomethacin)
Lodine (etodolac)
Mobic (meloxicam)
Nalfon (fenoprofen)
Orudis, Oruvail (ketoprofen)
Relafen (nabumetone)
Trilisate (choline magnesium trisalicylate)
Toradol (ketorolac)
Vioxx (rofecoxib)
Bextra (valdecoxib)
MSM (methylsufonylmethane)
Chondroitin/Glucosamine
Enbrel/ /Remicade/Humira/Methotrexate
Prialt (ziconotide)
Intravenous Lidocaine/Ketamine
Nuedexta

COGNITIVE ENHANCERS

Hydergine (ergoloid mesylates)
Aricept (donepezil)
Exelon (rivastigmine)
Piracetam
Vinpocetine
Razadyne (galantamine)
Cognex (tacrine)
Ginko Biloba
Eldepryl/Deprenyl (selegiline)
DMAE/Choline/Phosphatadiylcholine
Namenda (memantine)
Vayacog

ANTICONVULSANTS/ NERVE PAIN

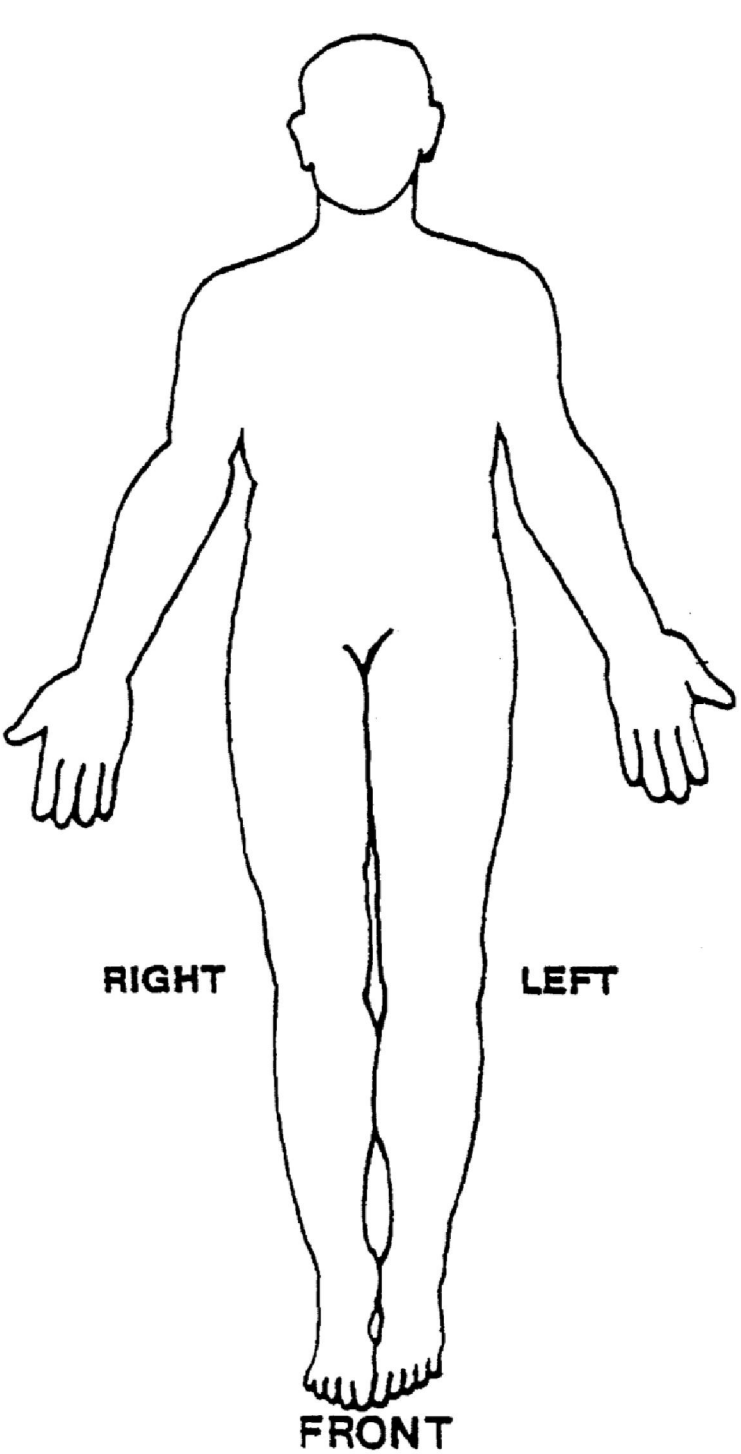
Mexitil (mexiletine)
Carbatrol, Tegretol (carbamazepine)
Depakote/ Depakene (valproic acid)
Dilantin (phenytoin)
Gabitril (tiagabine)
Klonopin (clonazepam)
Lamictal (lamotrigine)
Neurontin (gabapentin)
Lyrica (pregabalin)
Keppra (levetiracetam)
Topamax (topiramate)
Trileptal (oxcarbazepine)
Felbatol (felbamate)
Zonegran (zonisamide)
Ketamine
Tambocor (tocainamide)
Namenda (memantine)
Vimpat (lacosamide)

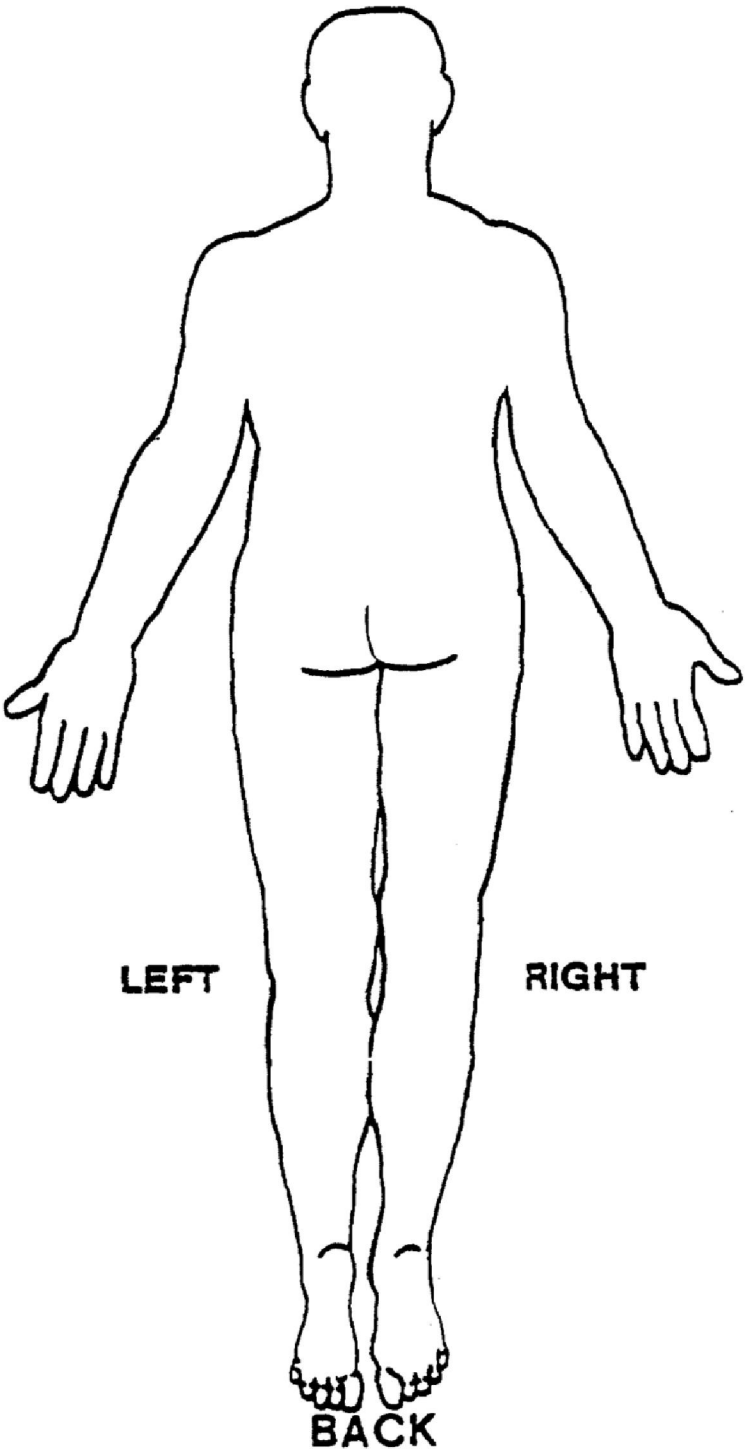
Name: _____ Date: _____

DALLAS PAIN DRAWING GRID ASSESSMENT

THINKING ABOUT ALL YOUR PAIN IN THE LAST 7 DAYS:

Mark the location of your pain on the body outlines.





Indicate how bad your pain is.

NO PAIN WORST POSSIBLE PAIN

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT

AS REQUIRED BY THE TEXAS MEDICAL BOARD

REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9, CHAPTER 170

Developed by the Texas Pain Society, September 2007 (www.texaspain.org)

NAME OF PATIENT: _____ DATE: _____

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to use the drug(s) recommended to you by me, as your physician. For the purpose of this agreement the use of the word "physician" is defined to include not only my physician but also my physician's authorized associates, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat my condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician (name at bottom of agreement) to treat my condition which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent to administer or prescribe the prescription(s) for dangerous and/or controlled drugs (medications) as an element in the treatment of my chronic pain.

It has been explained to me that these medication(s) include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

I HAVE BEEN INFORMED AND understand that I will undergo medical tests and examinations before and during my treatment. Those tests include random unannounced checks for drugs and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances may result in my being discharged from your care.

For female patients only:

To the best of my knowledge **I am NOT pregnant.**

If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment. I accept that it is **MY responsibility** to inform my physician immediately if I become pregnant.

If I am pregnant or am uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY.

All of the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo/ fetus / baby.

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension(low blood pressure), arrhythmias(irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medication(s) for the treatment of my chronic pain.

The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and active life. I realize that I may have a chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored specifically for me. I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time and that I will notify my physician of any discontinued use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

I have been informed that the drug therapy that my physician may prescribe for me may involve using a drug that the Federal Food and Drug Administration may not have been asked by the manufacturer to review for safety for effectiveness for my condition. Current medical literature shows that such “off label” use may be beneficial to some patients and I understand that recommended dosages for treating chronic pain are often exceeded in order to balance the benefit and risk to the patient.

I understand that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of medications to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

PAIN MANAGEMENT AGREEMENT:

I UNDERSTAND AND AGREE TO THE FOLLOWING:
That this pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called 'narcotics, painkillers', and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). **Therefore, medication(s) will only be provided so long as I follow the rules specified in this Agreement.**

My physician may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior:

- My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the **medication(s) may be discontinued**.
- I will **disclose** to my physician **all medication(s)** that I take at any time, prescribed by any physician.
- I will use the medication(s) **exactly as directed by my physician**.
- I agree **not to** share, sell or otherwise permit others, including my family and friends, to have access to these medications.
- I will **not allow or assist in the misuse/diversion of my medication**; **nor will I give or sell them** to anyone else.
- All medication(s) must be obtained at **one pharmacy, where possible**. Should the need arise to change pharmacies, my physician must be informed. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my physician to release my medical records to my pharmacist as needed.
- I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money**. If either are lost or stolen, they may NOT BE REPLACED.**
- Refill(s) **will not be ordered before the scheduled refill date**. However, early refill(s) are allowed when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.
- I will receive medication(s) **only from ONE physician** unless it is for an emergency **or** the medication(s) that is being prescribed by another physician is approved by my physician. Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.
- If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then **my physician may try alternative medication(s) or may taper me off all medication(s**). I will not hold my physician liable for problems caused by the discontinuance of medication(s).
- I **agree to submit to urine and/or blood screens** to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), treatment for chronic pain may be terminated. Also, a consult with, or referral to, an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an addictionologist or a physician who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.

- I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize **that my active participation** in the management of my pain is extremely important. I agree to **actively participate in all aspects of the pain management program** recommended by my physician to achieve increased function and improved quality of life.
- I agree that I **shall inform any doctor** who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.
- I hereby give my physician **permission to** discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).
- I must take the medication(s) as instructed by my physician. **Any unauthorized increase** in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.
- I must **keep all follow-up appointments** as recommended by my physician or my treatment may be discontinued.

I certify and agree to the following:

1) I am **not currently using illegal drugs or abusing prescription medication**(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

2) I have **never been involved** in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.)

3) **No guarantee or assurance has been made** as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life.

4) I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain. **I fully understand the explanations regarding the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.**

_____

Patient Signature

_____

_____

Name and contact information for pharmacy

Functional Recovery Associates PLLC

PRIDE

Conquering Pain thru Function

Financial Policy and Payment Agreement

PRIDE and the physicians named above are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive the maximum allowable benefits. In order to achieve these goals, however, we need your assistance and your understanding of our financial payment policy.

I. Financial Policy.

a. Self-pay patients are expected to pay for services received in full at the time of service. Any financial arrangements must be made before you see the physician. We accept the following forms of payment: Cash, MasterCard and Visa.

b. As a courtesy to you, we will file your insurance claim form for reimbursement. However, in order to do this, we must have current insurance information for each visit. Charges not paid by your insurance company within 90 days will become due and payable by you. Patients who do not provide current insurance information will be treated as self pay (see above). **We make every attempt to obtain correct reimbursement information from your insurance carrier, however, the amount paid at the time of the visit is an estimate only and upon receipt of payment and the explanation of benefits (EOB) from your carrier, you may owe additional monies or be due a refund.** If you dispute the information provided on your EOB, it is your responsibility to contact your carrier (member phone number is on the back of your card) to resolve any issues. We are obligated to obey the EOB sent to us.

c. If your insurance plan requires a referral or authorization from your primary care physician, we will need to receive the authorization before you see our physician. If you have not received an authorization prior to your arrival at our office, we have a telephone available for you to call your primary care physician or insurance company to get the required authorization.

d. In the event your insurance company determines a service to be "not covered," you will be responsible for payment. We try to inform patients when services may not be covered; however, it is the patient's responsibility to understand their health insurance limitations.

e. We will bill for Workers' Compensation services that have been pre-authorized by your employer or Workers' Compensation insurance carrier.

f. **Appointment No-Show Fee:** We understand that sometimes appointments must either be cancelled or rescheduled. Because we provide specialized services, we ask that you provide at least a 24 hour prior notice for cancellations or rescheduled appointments. Your failure to provide us the requested 24 hour notice will result in a No-Show fee; this fee will be due at the time of your next appointment.

No Show Fees:

- $75.00 – New evaluation appointment No-Show
- $50.00 – Re-check appointment No-Show

g. **Additional Fees:** We charge additional fees as outlined below

- $50.00 - Non-emergency After Hours Call
- $50.00 - Prescription pick – up
- $50.00 - $175.00 - Completion of Forms/Paperwork– completed during separate appointment.

*** ***Please be aware that any balance on your account over 90 days is subject to intensive collection procedures and may result in denial of future care until overdue balances are paid in full.***

II. <u>Payment Agreement.</u>

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account. I accept full responsibility for any and all charges related to diagnosis and treatment, whether or not my insurance covers these services. I agree that my physician is not ultimately responsible for collection from my insurance company. I understand that my physician cannot file Medicaid, Managed Care Medicare or Secondary Insurances. Office policy is to collect all Co-pays, Coinsurance, and Deductibles due at the time of service. I agree to pay IN FULL within 30 days of receipt of notice all balances due such as non-covered services, coinsurances, deductibles and co-payments not paid by my insurance company in addition to any fees charged against my account. **Assignment of Benefits:** I authorize my insurance carrier to pay benefits directly to my physician on any unpaid services on my behalf.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ, OR HAS BEEN READ, THE FOREGOING; UNDERSTANDS THE FOREGOING; HAS RECEIVED A COPY THEREOF; HAS BEEN GIVEN THE OPPORTUNITY TO ASK ANY QUESTIONS THEY MAY HAVE CONCERNING THE FOREGOING; AND THAT HE/SHE IS THE PATIENT OR DULY AUTHORIZED REPRESENTATIVE OF THE PATIENT. THE UNDERSIGNED, HAVING READ AND UNDERSTOOD THE AGREEMENT, ACCEPTS THIS FINANCIAL POLICY AND PAYMENT AGREEMENT.

Patient Name (Please Print) _____

Patient's Signature /Date _____ **Date:** _____

_____

Responsible/Authorized Representative (Guarantor) Relationship to Patient

_____ **Date:** _____

Guarantor Signature/ Date

Functional Recovery Associates PLLC

PRIDE

MEDICAL AUTHORIZATION TO TREAT AND OBTAIN CONFIDENTIAL INFORMATION FROM MEDICAL RECORDS

NAME:_____ **DOB:**_____**SS#:** _____

I, the undersigned, hereby authorize the physicians and their staff and/or PRIDE, to evaluate and treat me pursuant to standards of medical and therapy practice. Such authorization assumes that I will receive full disclosure of potential risks and benefits of any invasive procedures to be performed upon me.

I, the undersigned, understand I have the full opportunity to ask my physician any questions about any such treatment.

I, the undersigned, hereby authorize the physicians, staff, and/or PRIDE to contact and confer with any and all licensed physicians, chiropractors, therapists, hospitals, clinics and laboratories that may have examined or treated me, and to examine and copy any and all medical reports, x-rays and records pertaining to my medical condition or relating to such examination and treatment. This will also authorize any such licensed health providers, hospitals, clinics and laboratories, or other representatives, to deliver to the physicians and staff of PRIDE, full and complete written reports, or copies thereof, of medical records, imaging and lab reports, hospital records, medical bills, and all other information relative to my physical or mental condition requested by said physician.

I further authorize the physicians and their staff and/or PRIDE to use my records to compile research data for the use of scientific publications/presentations, guideline development and the like, without using any of my identifying information (name, SS# etc…)

I further authorize the physician and his/her employees, in accordance with the laws of the State of Texas, to furnish authorized employers, insurance carriers, attorneys, or state administrators, or to any agent or representative who is identified by this party, with all necessary information which this party should request from the medical records compiled by the physicians, staff, and/or PRIDE in his/her office during my course of treatment for my work-related injury. The medical records from which this information may be obtained includes any and all records produced under the direction of the physician, staff, and/or PRIDE, or any other health provider's office, clinic, hospital, or laboratory at which evaluations or procedures may be performed. I authorize the physicians and their staff and/or PRIDE to release medical information that may be necessary to request reimbursement from insurance companies to whom I have submitted a claim.

I assume personal responsibility for any valuables I bring to this facility. PRIDE or the physicians will not be responsible for lost valuables of any kind.

Date_____ Patient's Signature_____

PATIENTS WITH PERSONAL INJURIES

I hereby authorize and direct that payment be made directly to my physicians and/or PRIDE such sums as may be due and owing for medical services rendered me both by reason of this accident and by reason of any other bills that are due and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect my physicians and/or PRIDE. And I hereby further give a Lien on my case to my physicians and/or PRIDE against any and all proceeds of my settlement, judgment or verdict which may be paid to myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

All physician and/or PRIDE bills for treatment rendered to me shall become my responsibility and shall be paid from any settlement funds rendered to me with regard to my injury if not satisfied from this lien.

Date_____ Patient's Signature_____

REQUEST FOR MEDICAL REIMBURSEMENT FOR PATIENTS NOT COVERED BY WORKER' COMPENSATION INSURANCE

I assign medical benefits, to include major benefits to which I am entitled, to the above. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. **I understand that I am financially responsible for all charges whether or not paid by said insurance**. (This assignment is not applicable to workers' compensation.)

Date_____ Patient's Signature_____

Functional Recovery Associates PLLC

PRIDE

Conquering Pain thru Function

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION FROM MEDICAL RECORDS

NAME:_____ **DOB:**_____
SS#: _____

I, the undersigned, hereby authorize the physicians and their agents and employees of PRIDE, in accordance with the laws of the State of Texas, to furnish to any insurance carrier, attorney, employer, or State/Federal Agency, or any agent or representative who is identified by the organization, with all necessary information which this party should request from the medical records compiled by the above named doctor in his office during the course of my treatment with my physician and with PRIDE, for the purpose of evaluating and treating my medical condition.

The medical records from which this information may be obtained includes but is not limited to: 1) office records; 2) laboratory reports; 3) x-rays and interpretive reports; 4) nurses and therapists notes; 5) physician order sheets; 6) medication charts; and 7) any other reports kept for clinical purposes as part of normal medical practice and business activities of the physician's office and PRIDE.

I hereby authorize the release of this information for the purposes of: 1) obtaining payment on the account of the above named physician whose services were provided to me; 2) medical audit, utilization review, or quality assurance review, which may be the objective of the release of this information for which purposes my insurance company may wish to review these record.

Date_____ Patient's Signature_____

Functional Recovery Associates PLLC

PRIDE

Authorization for Release of Information to Family Members

Patient Name_____ Date of Birth_____

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize P.R.I.D.E. and/or my physician to release my medical and/or billing information to the following individual(s):

1._____ Relation to Patient:_____

2._____ Relation to Patient:_____

3._____ Relation to Patient:_____

Patient Information
I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to being disclosured by the above recipient.

You have the right to revoke this consent in writing.

Signature: _____ Date:_____

PRIDE

Conquering Pain thru Function

NOTICE OF PRIVACY PRACTICES

Effective Date: 03/10/2014

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY AND PROTECTION OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practice, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect immediately and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make these changes and make the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

Treatment/Payment/Healthcare Operations: We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

- **Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
- **Payment:** We may use and disclose your health information to obtain payment for services we provide to you.
- **Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluation practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make

reasonable influences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your specific health information for marketing communications without your written authorization.

Required by Law: We will use or disclose your health information when we are required to do so by law.

Psychotherapy Notes: We may only use or disclose your psychotherapy notes if we have your prior authorization or as required by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Workers' Compensation: We may release your health information for workers' compensation or similar programs, but only as authorized by and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to the authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health, information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

INDIVIDUAL RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure).

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information for treatment, payment, and health care operations, but we may not agree to the restriction. Under Federal Law, we must agree to your request to restrict disclosures of health information if:

- The disclosures are for purposes of payment or health care operations and are not otherwise required by law, and
- The medical information pertains solely to health care items or services for which you, or another person on your behalf (other than PRIDE), has paid in full.

If we agree to your request, we must follow your restrictions, except if the information is necessary for emergency treatment. You may cancel the restrictions at any time by writing to us. In addition, we may cancel a restriction at any times as long as we notify you of the cancellation and continue to apply the restriction to information collected before the cancellation.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended). We may deny your request under certain circumstances.

Fundraising Communication: You have the right to request that we or our authorized agents do not contact you for fundraising activities.

Breach Notification: In the event of a breach of your protected health information, we will provide you with notification of such a breach as required by law or where we otherwise deem appropriate.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you believe your privacy rights have been violated, you may file a written complaint either with PRIDE or with the Federal Government.

We support your right to the privacy of your health information. We will not take any action against you or change the treatment of you in any way if you file a complaint with us or with the U.S. Department of Health and Human Services.

To file a written complaint or request more information, please contact us at:

PRIDE
Attn: Privacy and Security Official
5701 Maple Ave., Suite 100
Dallas, TX 75235
Telephone: 214-351-6600

You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with their address to file your complaint upon request.

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I, _____ , have reviewed a copy of this office's Notice of Privacy Practices.

_____

Please print name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (please specify)

_____

_____

_____