TEXAS PAIN & SPINE INSTITUTE
Pain is Inevitable...Suffering is Optional.

ACUTE & CHRONIC PAIN AND SPINE CENTER

PHONE (806) 353-6100 EXT 118-DIANNA
FAX (806) 353-8130

Dear Patient,

Dr. Daneshfar and his staff at the Texas Pain & Spine Institute are looking forward to having you as a patient. You are important to us and it is our pledge to provide you with the best of high quality medical care and pain treatment. *Please fill in the new patient paperwork **completely** in **blue or black ink** before your appointment.*

***** No Checks Please *****

We do accept Visa, MasterCard, Discover, Care Credit & Cash

WE ARE NOT MEDICAID PROVIDERS

PRIVATE PAY ARE ASKED TO BRING IN $400.OO FOR THE FIRST VISIT

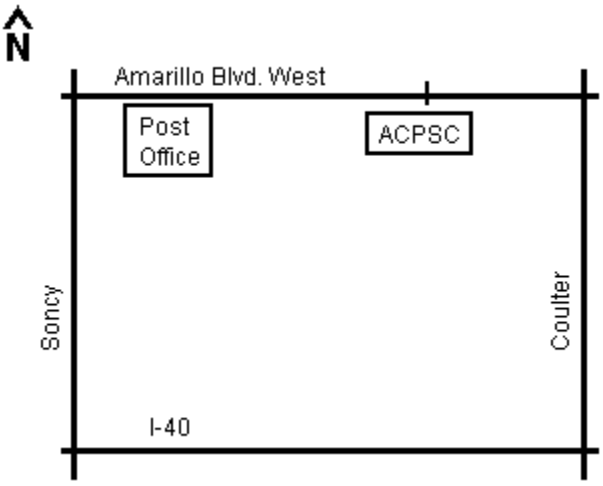
Date of appointment: _____ **Check in time: _____**

Appointment time: _____

Please plan on being in our office for about 2 hours

*Please bring or deliver any diagnostic studies you have had (I.e. MRI disks and reports, X-ray disks and reports, medical records) from previous physicians from the last six months and current medications.

Please Read This Carefully: Many people are in severe pain and are waiting to get in to see us. Please, if you cannot make our appointment, call us immediately in order for the next patient to have your appointed time. Due to your kindness and compassion, someone in a considerable amount of pain will be taken care of quickly. We will make every effort to give a quick alternate time for your evaluation if you cannot make your original appointment. If you do not want to come at all, as you may have changed your mind, we will be available to serve you if and when you come in at a future date, but please take the time to cancel your appointment. **Thank you!**



Directions: Take I-40 west and exit Soncy. Turn right on Soncy. Turn right on Amarillo Blvd. Our clinic is the third building after the Post Office on the right hand side, in Legacy Square. It is the 1st building on the right. #24 CARE CIRCLE

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AUTHORIZATION FORM
RELEASE OF MEDICAL RECORDS

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 (45 CPR.164.508).

I authorize **TP&SI/ACPSC** to disclose my individually identifiable health information stated below.

I understand that by disclosing my medical records, **TP&SI/ACPSC** cannot guarantee the recipient will use or disclose information in accordance with the Privacy Rules.

Under the Privacy Rules, I have the right to revoke this authorization at any time, and **TP&SI/ACPSC** must cease using this authorization. However, **TP&SI/ACPSC** may complete any actions it initiated prior to my revocation.

I must revoke this consent (in writing) at any time and send the revocation to **TP&SI/ACPSC**, 24 Care Circle, Amarillo, Texas 79124. This consent will expire 180 days after the date of my signature unless otherwise specified.

I must complete a separate medical records release if I wish to have any psychotherapy notes released.

The information authorized for release may include records which may indicate the presence of a communicable and/ or non communicable disease.

Patient's Name: _____SS#:_____DOB:_____

Address: _____Phone Number:_____

Information to be released TO:
_____
_____
_____
_____

From: **TP&SI/ACPSC**
24 Care Circle
Amarillo, Texas 79124
806-353-6100

Information to be released:
_____ X-ray Reports, Radiology Reports, etc
_____ Office Notes
_____ OP Reports
_____ Treatment and/or Treatment Plans
_____ History and Physical Examination
_____ All records relating to treatment rendered to the above listed patient

Reason or Purpose for Release: (Check the appropriate category)
_____ Continued Patient Care
_____ Insurance Claim/Application
_____ Attorney/Legal
_____ Personal Use
_____ Disability Determination/Social Security
_____ Other (Specify) _____

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____For Office use only_____
Records picked up _____ Records Mailed _____Date _____Initials_____

TPSI/ACPSC NEW PATIENT INFORMATION

Date_____

PATIENT'S NAME (PLEASE PRINT)	S.S.#	MARITAL STATUS					SEX		BIRTHDATE	AGE	RELIGION
		S	M	W	D	SEP	M	F			
MAILING ADDRESS	CITY AND STATE								ZIP CODE	HOME PHONE#	
PATIENT'S OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)								HOW LONG EMPLOYED	BUS. PHONE# EXT#	
EMPLOYER'S STREET ADDRESS	CITY AND STATE									ZIP CODE	
DRUG ALLEGIES, IF ANY											
SPOUSE OR PARENT'S NAME	S.S.#	BIRTHDATE									
SPOUSE OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)								HOW LONG EMPLOYED	BUS PHONE#	
EMPLOYER'S STREET ADDRESS	CITY AND STATE									ZIP CODE	
NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU									PHONE#		

PERSON RESPONSIBLE FOR PAYMENT, IF NOT ABOVE	STREET ADDRESS, CITY, STATE		ZIP CODE	HOME PHONE#
NAME OF INSURANCE	EFF DATE	POLICY #	GROUP#	PRIMARY OR SECONDARY?
NAME OF INSURANCE	EFF DATE	POLICY #	GROUP#	PRIMARY OR SECONDARY?
WERE YOU INJURED ON THE JOB? YES ☐ NO ☐	DATE OF INJURY	WHERE DID YOU WORK AT THE TIME OF INJURY?	INDUSTRIAL CLAIM#	
WAS AN AUTOMOBILE INVOLVED? YES ☐ NO ☐	DATE OF ACCIDENT	WHERE DID THE ACCIDENT OCCUR?	NAME OF ATTORNEY	
WERE X-RAYS TAKEN OF THIS INJURY OR PROBLEM? YES ☐ NO ☐	IF YES, WHERE WERE X-RAYS TAKEN? (HOSPITAL, ETC.)			DATE X-RAYS TAKEN
HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY BEEN TREATED BY OUR PHYSICIAN(S) BEFORE? INCLUDE NAME OF PHYSICIAN AND FAMILY MEMBER.				
REFERRED BY	STREET ADDRESS, CITY, STATE		ZIP CODE	PHONE#

The insurance information furnished here represents a full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose precertification/second opinion requirements for any and all plans to which I subscribe, may cause me to incur full liability for professional charges, as a result of non-payment by any carrier.

Please provide your email address_____@_____

OFFICE EVALUATION NOTE

PATIENT NAME:_____ Date:_____

DOB: _____, AGE:____, SEX: male____ female____, DOI:_____
__Right handed __Left-handed, Height: ___ft ___in, Weight_____lbs.,
Race: W___ B___ H ___Other _____, Level of Education: 1-12___ College___ Other_____
Degree: _____

Referring physician:_____
If not your physician, then who referred you?_____
Doctors that we need to send reports to:_____
_____

Other doctors treating you now (what are they treating you for) _____
_____

Chief complaint: What problem(s) brings you to see us today?
1)_____ rank __/ 10

2)_____rank__/ 10

3)_____rank__/ 10

HPI:
When did this problem start? (mm/dd/yy) _____
Since it began has it : worsened__, bettered__, or stayed the same__.
What caused the problem? _____
Did your pain begin:
From an accident at work:__, at work but no accident:__, an accident at home:__,
pain just began for no reason:__, gradually started____, suddenly started___, constant pain____, from a motor vehicle accident (MVA):__, following surgery (describe):_____
are you able to work now____ other:_____
If your pain began at work, list where?_____
Date of Injury (DOI)_____ mm/dd/yy
How long have you been employed there:_____mm/yy
Type of work (Include details)_____
If injured at work, how?_____
Lifting__, Fall__, Pushing___, Struck by falling object____
Please describe the situation_____
_____
Was your injury caused from repetitive activities (list)_____
Other_____

Initials_____ Date_____

OFFICE EVALUATION NOTE CONTINUED

Occupation:_____, Are you presently able to work? Yes___, No___, Part-time___, Full-time___, without restriction___, with restriction__, light duty___, retired___, Student ___, Are you able to perform the duties your job requires____,

If injury from motor vehicle accident, were you the driver___, passenger___, pedestrian___, automobile___, truck___, motorcycle___, describe in detail the events of the accident_____
_____
_____

Are you able to care for yourself?_____ Can you do your daily activities?____
Are you able to sleep well?_____, How many hours of sleep per night?_____

Have you before or are you now involved in a lawsuit because of your injuries or pain? _____ Please give the name and phone number of your attorney _____
If not presently involved in a lawsuit, do you plan to sue? _____ Who? _____

Please **circle** all the words that best describe and/or are associated with your pain:
Constant, radiating, mild, hot, intermittent, not radiating, intense, burning, transient, annoying, severe, sore, excruciating, stabbing, brief, tight, intolerable, dull, occasional, heavy, sharp, cold, tingling, aching pins and needle sensation, shooting, numb, jabbing, pulling, throbbing, pressure, catching, stinging weakness, increased sweating, locking, muscle spasm, skin discoloration(purple, red, white, blotchiness), pulsating, paralyzing, straining, cramping, crushing, drawing, electric shock, tender, squeezing, there has been a change of bowel or bladder habits (describe)_____
_____

Please describe what makes your pain worse or better
(Indicate by **W** for worse, **B** for better, **NC** for no change)
stress_____, coughing_____, sneezing_____, sitting_____, standing_____, lying down_____, walking_____, stooping_____, leaning_____, driving_____, physical activity_____, relaxation_____, sexual activity_____, bowel movements_____, eating_____, bending_____, weather changes_____, stretching_____, being tired_____, turning_____, dampness_____, cold_____, cold packs_____,
hot packs_____, hot shower_____, hot tub_____, loud noises_____, bright lights_____, alcohol_____, Advil/Tylenol/ibuprofen_____, narcotic medications_____, coffee/tea/caffeine_____.

What studies (lab tests, x-rays, cat scans, MRIs, etc.) have you had so far? Where were they done?
_____
_____

What have you had so far for the treatment of your pain? Please check or list:
Medications _____
Physical therapy_____
Occupational therapy_____
Procedures (including operations)_____
Injections (list by whom and when) _____
Chiropractic _____ When_____ How long did it work?_____

List any medical equipment you currently use (with a C) or have used in the past (with a P):
TENS unit_____ Back brace_____ Chair support_____ Moist heating pad_____
Cane_____ Cold pack_____ Other_____

OFFICE EVALUATION NOTE CONTINUED

Other pertinent information:

_____

_____

_____

_____

_____

Social History

A. Occupation_____
B. Marital status: Single Married Divorced Widowed
C. Number of children and ages_____
D. Do you smoke now? ____Yes ____No _____#packs/day _____#years
E. Did you smoke? _____Yes _____No _____#packs/day _____#years
F. Do you drink alcohol? _____Yes _____No How often_____ How much_____
G. Do you have a history of substance abuse problems with drugs or alcohol? ____Yes ____No
   When and explain:_____
   _____
H. Do you attend: AA_____ NA_____ Al-Anon_____ Other support group_____
I. Have you ever been convicted of illegal drug use, illegal possession, or selling drugs?_____
J. Have you ever been convicted of DWI/DUI? _____ Felony?_____
   When and explain: _____
   _____
K. Working Now: ____Yes ____No # of hours per week_____
   If no, what is the last day you worked_____
L. Do you drink cokes, coffee or any other caffeine products? _____
   Type_____ Amount per day_____

Current Prescription Medications:

Medication Name	Strength	Date Started	How often per day.

Over-the-counter (OTC) issues:

Please check all products that you use occasionally or regularly. Check all that apply.

___ Pain Reliever
___ Aspirin
___ Acetaminophen (example: Tylenol®)
___ Ibuprofen (example: Motrin IB®)
___ Naproxen (example: Aleve®)
___ Ketoprofen (example: Orudis KT®)
___ Cough suppressant (example: Robitussin DM®)
___ Antihistamine product (example: Chlor-Trimeton®)
___ Decongestant product (example: Sudafed ®)
___ Combination product (cough+cold reliever)(example: Triaminic DM®)
___ Sleep aids (examples: Excedrin PC®, Unisom®, Someone®, Natal®)
___ Antidiarrheals (examples:Imodium®, Pepto Bismol®, Kaopectate®)
___ Laxatives/stool softeners (examples: Doxidan®, Correctol®, etc.)
___ Diet aids/weight loss products (example: Dexatril®)
___ Antacids (examples: Maalox®, Mylanta®)
___ Acid blockers (examples: Tagamet HB®, Pepcid C®, Zantac 75®)
___ Other (please list)_____
_____

Initials_____ Date_____

OFFICE EVALUATION NOTE CONTINUED

Nutritional/Natural Supplements: Please identify and list the products you are using:

☐ Vitamins (examples: multiple or single vitamins such as B complex, E, C, beta carotene)
☐ Minerals (examples: calcium, magnesium, chromium, colloidal minerals, various single minerals)
☐ Herbs (examples:Ginseng,Ginkgo,Biloba,Echinacea,other herbal medicinal teas,tinctures,remedies,etc.)
☐ Enzymes (examples: digestive formulas, papaya, bromelain, CoEnzyme Q10, etc.)
☐ Nutrition/protein supplements (examples: shark cartilage, protein powers, amino acids, fish oils, etc.)
☐ Others (glucosamine, etc.)_____

Allergies: Please check all that apply.

___penicillin ___morphine ___dye allergies ___pet allergies
___codeine ___aspirin ___nitrate allergy ___sulfa drug
___food allergies ___no known allergies ___seasonal (pollen) allergies
other:_____

Please describe the allergic reaction you experienced and when it occurred?

_____
_____
_____
_____

Hospitalization & Surgery
Please list all surgery and any periods of hospitalization (give dates).

Date	

Family History: Has anyone in your immediate family (mother, father, sisters, brothers, children, or grandparents) had the following(please list relationship):

Condition	Who?	Condition	Who?
Heart Disease		Epilepsy	
Hypertension		Glaucoma	
Stroke		Bleeding Disorders	
Cancer		Kidney Disease	
Diabetes		Thyroid Disease	

Psychosocial status: The following indications are present or suspected during the patient evaluation as appropriately marked below:

[No/Yes] seems/reports depressed [No/Yes] seems/reports stress
[No/Yes] seems/reports anxious [No/Yes] seems/reports agitated
[No/Yes] increased family discord secondary to injury
[No/Yes] suspicion of malingering or symptom magnification due to primary or secondary gain
[No/Yes] observed presence of mental disorder and/or clinical signs of significant mental stress

Initials_____ Date_____

OFFICE EVALUATION NOTE CONTINUED

ROS: Circle symptoms that you have and cross out those symptoms you do not have from the list below:

Severe Headaches/Migraines	Dizziness/Fainting	Visual Problems
Hearing Problems	Seizures/Epilepsy	Alcohol or Drug Problems
Depression	Psychiatric/Mental Illness	Fatigue
Anxiety	Heart Attacks/MI	Arrhythmias
Angina/Chest Pain	Stroke	Heart Palpitations
Heart Murmur	Congenital Heart Disease	Mitral Valve Prolapse
Bypass/Pacemaker/ICD	CHF	CirculatoryProblems
Hypertension	Bleeding Disorder	Hyperlipidemia
Anemia	Rheumatic Fever	Asthma
Bronchitis	Shortness of Breath	Pneumonia
COPD/Emphysema	Ulcers/GI Bleeding	Irritable Bowel Syndrome
Spastic Colon	Hemorrhoids/Rectal Bleeding	GERD/Reflux Disorder
Digestive Problems	Constipation	Renal Disease/Kidney
Liver Disease	Hepatitis/Type_____	Endocrine Problems
Hypothyroid/Cold Intolerance	Hyperthyroid/Heat Intolerance	Diabetes/Type_____
Sexual Dysfunction	Urinary or Genital Problems	Menstrual Dysfunction
Fibrocystic Breast Disease	Uterine Fibroids	Ovarian Cysts
Venereal Disease/STDS	HIV/AIDS	Gout
Fibromyalgia	Arthritis/Rheumatism	Skin Rash
Fibrocystic Disease	Intermittent Claudication/Cramps	Herpes Zoster/Shingles
Chronic Fatigue Syndrome	Tuberculosis	Allergies/Hay Fever
Cancer (type) _____	Scarlet Fever	

Females Only:
Are you able to have children: _____ If no, why: _____
Are you now or could you be pregnant:_____
Last period: _____ Normal?: _____ If not explain: _____
_____
Have you had a bone density done? _____When: _____

Males Only:
Have you had your PSA (prostate specfic antigen) checked: _____ When: _____
Have you had a bone density done?_____ When: _____

Initials_____ Date_____

OFFICE EVALUATION NOTE CONTINUED

Pain Diagram:

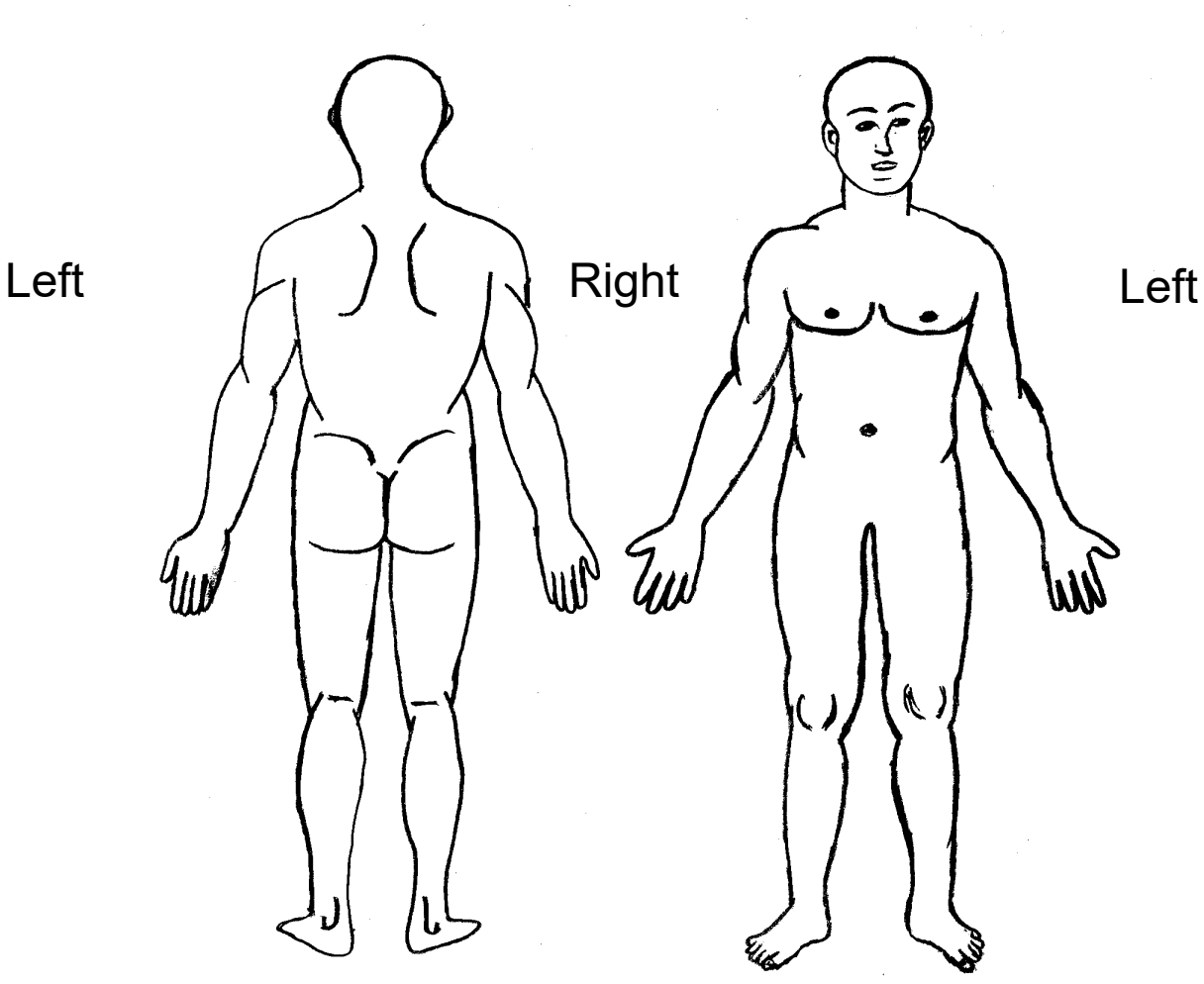
Please read these instructions carefully. We want you to give an accurate location and description of your pain. Mark your pain using the diagram.

+ + + + Burning //// Stabbing ….. Pins & Needles - - - - Numbness

e e e e External pain ¡¡¡¡ Internal pain

Show where the pain starts. Show if the pain radiates or travels with an arrow (↓). Circle the areas (if more than one area) of your pain and rate on a scale of 1 to 10 with 1 being a mild or just feeling of discomfort and 10 being pain that is excruciating or unbearable.

Area 1 Pain is (1 – 10) ____ Area 2 Pain is (1 – 10) _____ Area 3 Pain is (1 – 10) _____



Initials_____ Date_____

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PATIENTS APPROVAL TO RELEASE MEDICAL INFORMATION

With my signature on this form, I hereby give my consent to the Doctors and Staff of the Texas Pain & Spine Institute/ACPSC to discuss my medical condition with the person(s) listed below. I fully understand that I need not be present during any means of communication with Texas Pain & Spine Institute representatives and the person(s) listed below. I also acknowledge that communication with the person(s) listed below is my idea and carried out by request. I state here and now that at no time will Texas Pain & Spine Institute be held liable by me or any other party(s) for disclosing medical information, medical documents, x-rays, labs, etc. to the people listed below. I am aware of the HIPPA Privacy Act and it is my good and honest intent to have this agreement supersede it. The permission I am giving via this form to any representative of Texas Pain & Spine Institute will remain in effect with no expiration date until I have given notice in writing to Texas Pain & Spine Institute.

_____ _____
Patient's Signature Date

Please release information to the following **friends or family**:

_____
Print clearly please

_____
Print clearly please

_____
Print clearly please

_____
Print clearly please

Acknowledgment of Review of Notice of Privacy Practices

I have reviewed the Notice of Privacy Practices which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative Authority

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ASSIGNMENT OF BENEFITS FORM

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of services, unless other arrangements have been made in advance with our practice financial counselor. Necessary forms will be completed to help expedite insurance carrier payments. **However, you are responsible for all fees, regardless of insurance coverage.**

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled, I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan to issue payment check(s) directly to TP&SI and Dr. Daneshfar for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize TP&SI and Dr. Daneshfar to furnish and/or release any information necessary to insurance carriers concerning my illness and treatments, to process my insurance claim acquired in the course of my examination or treatment, to allow a photocopy of my signature to be used to process my insurance claim for the period of lifetime claims. This order will remain in effect until revoked by me in writing.

I have requested medical services from Dr. Daneshfar on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this agreement is to be considered as valid as the original.

_____ _____

Patient/Responsible Party Signature **Date**

_____ _____

Witness Date

_____ _____

Please Print Patient Name Date

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INFORMATION REGARDING BILLING

Thank you for choosing the Texas Pain & Spine Institute for your healthcare needs. We understand that you have a choice, and we appreciate you choosing us. We are providing the following information regarding billing because of several uncertainties in insurance reimbursements.

You will be billed for the professional service of Dr. Daneshfar. This will include the office visits and the fee(s) for the procedure(s). Most of these charges should be taken care of (taking into consideration any deductibles, co-insurance, or co-pays) by your insurance company, because Dr. Daneshfar is a network provider with most insurance plans.

The second charge will be for the use of the facility, equipment, supplies and nursing care. This will be billed as a "facility fee". By signing below you are indicating that you are requesting to use our Ambulatory Surgery Center which is **NOT IN NETWORK WITH MOST INSURANCE PLANS**. Please understand your plan and benefits for using an out-of-network facility. By using our facility, we not only make it more convenient for both you and your physician, but we also believe we can provide better care in our ambulatory surgery center.

Once again, we want to thank you for choosing our facility. Please feel free to contact my office manager, Michael Zamora or myself with any questions or concerns you may have.

Sincerely,

B. J. Daneshfar, M.D., F.I.P.P
DABA, DCERA, DAAPM, DABPM
Medical Director

_____ _____

Patient Signature **Date**

MEDICAL RECORDS

The first copy of your medical records at this facility will be provided at your request with at least 14 working days written notice. A fee of $25.00 for the first 25 pages then a fee $.50 cents per page thereafter will be charged.

PHARMACOLOGY THERAPY CONTRACT

It is necessary for the patient to sign a pharmacological therapy contract with this office prior to receiving any prescribed narcotic medications.

We request that all patients be compliant and follow the directions given by the office staff and instructions given by their evaluating physician. The instructions given are necessary for smooth conduct of the office activities, which involves your care as well as the best outcome possible as we treat your condition. We thank you in advance for your cooperation and understanding in these matters. We seek to serve you and will treat you as family.

Patient Signature _____ Date_____

Physician Assistant

Consent For Treatment

24 Care Circle
Amarillo, TX 79124

This facility has on staff a physician assistant to assist in the delivery of medical care.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the State Medical Board. Under the supervision of a physician, a physician assistant can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care.

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

A physician assistant may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulation of a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting at surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

I have read the above, and hereby consent to services of a physician assistant for my health care needs.

I understand that at any time I can refuse to see the physician assistant and request to see a physician.

Name:	Date
Signature:	Witness: (optional)

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Controlled Substance Agreement and Informed Consent Form

Evidence of medication hoarding; increasing the amount of medication without communication to B. J. Daneshfar, M.D. and/or his appropriately authorized assistant(s); refilling my prescription too frequently; getting the medication from multiple physicians; increasing the amount of the medication despite significant side effects; altering prescriptions; selling, trading, or giving away medication; unapproved use of other drugs (alcohol, sedatives, or using non-prescription medications inconsistent with drug labeling) during narcotic analgesic treatment; or other unacceptable behavior will result in tapering and discontinuing of narcotic maintenance therapy.

I certify and agree to the following:

I am not currently abusing illicit or prescription drug(s), and I am not undergoing treatment for substance dependence or abuse;

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

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 I would otherwise continue to have chronic pain.

I have received the Narcotic Information Sheet reviewing the side effects of the narcotics that may be used in the treatment of my chronic pain. I fully understand the explanations regarding the benefits and the risks of this method. I agree to the use of narcotic medication(s) in the treatment of my chronic pain.

_____ _____
Patient's Signature Date

_____ _____
Physician and/or Appropriately Authorized Assistant(s) signature Date

_____ _____
Family Member or Significant Other's Signature Date

_____ _____
Witness's Signature Date

To all patients regarding our ambulatory surgical center (ASC) please make sure that you have read and understand the following statement prior to scheduling your next procedure:

Unfortunately our ambulatory surgical center is not in network with several insurance companies. If you have decided to have a procedure performed in our facility, you will need to contact your insurance company. It is your responsibility to determine whether or not you have out of network benefits, and to determine what percentage of the cost your insurance company will cover. As a courtesy to you our insurance department will call on your behalf to pre-authorize or approve your procedure; *however this is not a guarantee of payment from the insurance company*. **Please be aware that you are responsible for any and all charges that are not covered by your insurance company.** If you have any questions or concerns please feel free to contact our billing department at (806)353-6100 or your insurance company for further details.

Thank you,

ACPSC Management

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TO ALL PATIENTS REGARDING CARE

Please be advised that the medical care you will receive at Texas Pain & Spine Institute/Acute & Chronic Pain & Spine Center will be done as a team involving all physicians, practitioners, and staff of the clinic, including you, the patient. In certain cases, with your consent when necessary, your family members may need to be involved in the care given. First and foremost you, the patient, will be required to take responsibility in your own care. We have found that this is the first requirement in good response and outcome of our care given to you.

Consent to Treatment:

I give permission to the physicians, physician's assistants, nurses, etc. of B.J. Daneshfar, M.D. and Texas Pain & Spine Institute, to examine me and prescribe such treatments as he/she deems necessary or advisable.

Our Financial Policy:

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at anytime. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility with regards to both.

1. All patients must complete our "Patient Information Form" before seeing the doctor.
2. We will file your insurance, but we must have information prior to your appointment so that we may pre-verify your coverage. You must also bring a completed claim form with you on the first visit if you want us to file your insurance.
3. You will be responsible for the deductible and co-insurance payments at the time of service. We will give you an estimate of what this amount will be after you schedule your appointment.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

The following is a list of guidelines that you must follow.

1. If you are a new patient, it is necessary to come one hour prior to your evaluation (check with the receptionist to see if you were given your check in time or you appointment time). This time is needed to complete the necessary documentation and questionnaire that the physicians and other practitioners must have for the evaluation. Please remember to bring all of your x-rays and medical records. When x-rays and tests are done at other locations, these may be delivered to the office directly by that institution. However, it is important to note that there is a time delay, as they have schedules also and your x-rays and medical records may not be delivered in time prior to your evaluation. Sometimes these are not delivered at all. This creates a real set back for the physician at the time of evaluation. We therefore recommend that you bring your x-rays and medical records with you at the time of evaluation.
2. All appointments given to you by this office must be kept. We have a very busy clinic and appointments are limited by number. When appointments are not kept, this wastes the time set aside for your care as well as denying access to other patients who are waiting to be seen and could not come in because of the appointment time given to you. There are those times when you may not be able to keep your appointments because of unforeseen circumstances. In this situation we would appreciate a 3 working day notice before your appointment time. In case of an emergency, a minimum of 24 hours notice is

required. This will give us the opportunity to give your appointment time to someone else as well as schedule a new appointment for you. If a 24 hour notice is not given, the patient will be charged $100.00 for an office visit and $ 500.00 for a procedure appointment. We request that you come to the office at least 10 minutes before your routine office visit.

3. When you come for your scheduled appointment, it is absolutely important, that you inform the staff of any medication refill if warranted. Please also inform the staff of medications that you are having trouble with, not helping, too strong, or you cannot tolerate. If your medication issues are not addressed at the time of your office visit with the physician, it will be difficult to address them by telephone. **All medication changes either in dosage or type will require an office evaluation by nursing staff and ultimately your physician.** If medications refills are needed, the best time to have these refilled is again at the time of you visit with your doctor. To call in after the office visit with your doctor for refills that were not taken care of during that office visit and evaluation may delay the receiving of your medications. This may cause you to run out of your medications, which is not advisable. It is important to note that this office is quite busy and we receive multiple calls for medication refills. **Medication refills, when requested by telephone to this office, require a minimum of 3 business days notice.** Most medication refills will be done in 2 working days. A working day is when the office is open and staff is working. All attempts will be made to refill your medications as soon as possible by the staff. For those prescriptions that are given with multiple refills, it is important for you to keep track of the number of refills that you have left at the pharmacy where the medication was filled first time. The number of refills that you have at your pharmacy is indicated on your medication bottles.
4. All triplicate prescriptions for medications will need to be picked up by the patient. These cannot be given to anyone else unless you have signed a written consent form or made other arrangements with our office.
5. It is our duty to answer all of your questions completely and in a timely manner. Please write down your questions and ask them at the time of the office visit. This office does take questions by telephone from our patients however these call are answered by their priority. Because of the number of call received, generally only emergency telephone calls are answered. In case of an emergency, the office will return your call. However there may be a time delay, which is determined based on how busy the office is at that time. Please note the staff members can only discuss patient issues with the patient only. These issues cannot be discussed with family members, which includes the patient's spouse (see No. 6)
6. Patient information may not be given to a family member unless by written patient consent or special existing circumstances. This is due to patient confidentiality issues.
7. All x-rays and tests that are ordered by your physician from this clinic can be delivered to this office. You must request their delivery from the institution where they were done. However, again because of their time schedule and number of patients, there is a time delay and these x-rays may not be delivered to us prior to the time of your evaluation or office visit. It is generally best for you to pick up and bring these x-rays with you at the time of your office visit. All radiology images are digitally recorded and kept at this facility. In order to provide you copies of the studies done here, we will need at least 14 business days notice. A business day is when the clinic is open and the staff is here. This time is required to gather the data and print the image so that you may have them. We understand that it is often necessary for these images to be provided to other physicians who may also evaluate you. The written radiology reports done at this facility can be provided to you with two working days notice.

Controlled Substance Agreement and Informed Consent Form

This contract outlines some important requirements that I must fulfill in order to participate in the Chronic Pain Treatment Program. This agreement relates to my use of any controlled substance(s) (i.e. narcotics, painkillers, and prescription medications) for chronic pain prescribed by B.J. Daneshfar, M.D. and/or any appropriately authorized assistant(s) at Texas Pain & Spine Institute. I understand that there are federal, state, and Texas Pain & Spine Institute policies regarding the use and prescribing of controlled substance(s). The Texas Intractable Pain Treatment Act, the Texas State Board of Medical Examiners, and the Texas State Board of Pharmacy all have specific requirements for the use of controlled substance(s) for the treatment of chronic pain. Therefore, controlled substance(s) will only be provided so long as I am actively participating in this Chronic Pain Treatment Program and adhere to the following rules or regulations.

B.J. Daneshfar, M.D., and/or any appropriately authorized assistant(s) may at any time discontinue the narcotic prescription(s) at his/her discretion. My progress will be periodically reviewed and, if the narcotics are not **improving my quality of life**, the narcotics will be discontinued.

I hereby authorize and give my voluntary consent to B.J. Daneshfar, M.D., Director of the Texas Pain & Spine Institute, and/or any appropriately authorized assistant(s), to administer or prescribe prescription(s), controlled substance(s), or narcotic medication(s) as an element in the treatment of my chronic, intractable pain.

The therapies necessary to treat my chronic pain have been explained to me and I understand that the therapies will involve my taking daily dosage(s) of narcotic(s), which will help to control my chronic, intractable pain.

It has been explained to me that these medication(s) include narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) are addictive and may, like other drugs used in the practice of medicine, produce adverse affects or results. (See attached Narcotic Information Sheet.) 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).

MOST COMMON SIDE EFFECTS: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention, 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.

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 narcotic(s) for the treatment of my chronic, intractable 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 have a permanent disability and there is no cure but the goal of taking narcotic(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. An appropriate treatment goal may even mean the eventual withdrawal from the use of all narcotic(s). I realize that the treatment for some will require prolonged or continuous use of controlled medication(s) and that my condition will be evaluated on an individual basis.

I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time, and I will be afforded detoxification under medical supervision.

I will use the medication(s) exactly as directed by B.J. Daneshfar, M.D. and/or his appropriately authorized assistant(s).

Controlled Substance Agreement and Informed Consent Form Continued

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 **WILL NOT BE REPLACED** unless I file a police report and bring B.J. Daneshfar, M.D., a copy of the report. Otherwise, I will need to wait until my next scheduled refill.

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.

All requests for medication(s) or refill(s) must be made by the patient directly not by family members or friends.

I will receive controlled substance(s) or medication(s) **only** from B.J. Daneshfar, M.D. and/or his appropriately authorized assistant(s) at Texas Pain & Spine Institute unless it is for an emergency or the controlled substance(s) that are being prescribed by another physician are approved by B.J. Daneshfar, M.D. Information that I have been receiving medication(s) prescribed by other doctors, and that B.J. Daneshfar, M.D. has not approved of these, may lead to a discontinuation of medication(s) and treatment.

Until B.J. Daneshfar, M.D. and/or his appropriately authorized assistant(s) have gotten to know me and my medical history well, I understand that prescription(s) for larger quantities of medication(s) to cover me while I am out of town will not be given. Later, depending on my compliance, B.J. Daneshfar, M.D. and/or his appropriately authorized assistant(s) may modify this.

A record of my medication(s) and pain diary may be required to document my progress and compliance. These dairies must be filled out in their entirety and returned at my next scheduled visit. Failure to do so will be considered noncompliance with medical treatment.

If it appears to B.J. Daneshfar, M.D. and/or his appropriately authorized assistant(s) that there are no **demonstrable benefits to my daily function or quality of life** from the controlled substance(s), then B.J. Daneshfar, M.D. and/or his appropriately authorized assistant(s) may try alternative medication(s) and/or B.J. Daneshfar, M.D. and/or his appropriately authorized assistant(s) may taper me off of all narcotic(s). I will not hold B.J. Daneshfar, M.D., and/or his appropriately authorized assistant(s), and/or any other employees, or members of Texas Pain & Spine Institute/Acute & Chronic Pain and Spine Center liable for problems caused by the discontinuance of controlled substance(s).

I agree to submit to urine and 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 will be terminated and can only be restarted if I am evaluated and treated by an Addictionologist and the Addictionologist recommends continued treatment for chronic pain.

I recognize that my chronic pain represents a complex problem, which may benefit from physical therapy, psychotherapy, and behavioral medicine strategies. 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 to secure increased functioning and improved coping with my condition.

I agree that I shall inform any doctor who may treat me for any medical problem that I am enrolled in a narcotic(s) and controlled substance(s) treatment program, since the use of other drug(s) in conjunction with same may cause me harm.

I also understand that during the course of treatment, certain conditions may make it necessary to use additional or different procedures than those explained to me. I understand that these alternate procedures shall be used when is considered advisable by B.J. Daneshfar, M.D., and/or his appropriately authorized assistant(s).

I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize B. J. Daneshfar, M.D. and/or his appropriately authorized assistant(s) to release my medical records to my pharmacist at his/her discretion.

Controlled Substance Agreement and Informed Consent Form Continued

For female patients only:

To the best of my knowledge, I am not pregnant at this time and I will use appropriate contraception during my course of treatment.

Besides the possible risks involved with the long-term use of narcotic(s) and controlled substance(s), I further understand that information on the effects of narcotic(s) and controlled substance(s) on pregnant women and their unborn children is at present inadequate to guarantee that it may not produce significant or serious side effect(s).

It has been explained to me and I understand that narcotic(s) and controlled substance(s) are transmitted to the unborn child and will cause physical dependence. Thus, if I am pregnant and suddenly stop taking narcotic(s) and controlled substance(s), I or the unborn child may show signs of withdrawal, which may adversely affect my pregnancy or the child. I shall use no other drugs without B. J. Daneshfar, M.D. and/or his appropriately authorized assistant(s) approval, since these drugs, particularly as they might interact with narcotic(s) and controlled substance(s), may harm my unborn child or me. I shall inform any other doctor who sees me during my present or any future pregnancy or who sees the child after birth, of my current or past participation in a chronic pain program in order that he/she may properly take care of my child and me.

It has been explained to me that after the birth of my child I should not nurse the baby because narcotic(s) and controlled substance(s) are transmitted through the milk to the baby and this may cause physical dependence on narcotic(s) and controlled substance(s) in the child. I understand that for a brief period following birth, the child may show temporary irritability or other ill effects due to my use of narcotic(s) and controlled substance(s). It is essential for the child's physician to know of my participation in a narcotic(s) and controlled substance(s) treatment program so that he may provide appropriate medical treatment for the child.

All of the above possible effects of narcotic(s) and controlled substance(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 the drug to assure complete safety to my child. With full knowledge of this, I consent to its use and promise to inform B. J. Daneshfar, M.D. and/or his appropriately authorized assistant(s) immediately if I become pregnant in the future.

I hereby give B. J. Daneshfar, M.D. and/or his appropriately authorized assistant(s) permission to communicate with the referring physician(s) and any pharmacist(s) regarding my use of controlled substance(s).

I must take the narcotic medication(s) exactly as instructed by B. J. Daneshfar, M.D. and/or his appropriately authorized assistant(s) or in smaller doses. Any unauthorized **increase** in the dose of narcotic medication(s) may be viewed as a cause for discontinuation of the treatment with narcotic medication(s).

If I demonstrate unacceptable behavior patterns, B. J. Daneshfar, M.D. and/or his appropriately authorized assistant(s) may discontinue prescribing the narcotic medication(s) for me.

I must keep all regular follow up appointments as recommended by B. J. Daneshfar, M.D. and/or his appropriately authorized assistant(s). Failure to comply may cause discontinuation of narcotic prescription(s).

Controlled Substance Agreement and Informed Consent Form Continued

Evidence of medication hoarding; increasing the amount of medication without communication to B. J. Daneshfar, M.D. and/or his appropriately authorized assistant(s); refilling my prescription too frequently; getting the medication from multiple physicians; increasing the amount of the medication despite significant side effects; altering prescriptions; selling, trading, or giving away medication; unapproved use of other drugs (alcohol, sedatives, or using non-prescription medications inconsistent with drug labeling) during narcotic analgesic treatment; or other unacceptable behavior will result in tapering and discontinuing of narcotic maintenance therapy.

I certify and agree to the following:

I am not currently abusing illicit or prescription drug(s), and I am not undergoing treatment for substance dependence or abuse;

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

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 I would otherwise continue to have chronic pain.

I have received the Narcotic Information Sheet reviewing the side effects of the narcotics that may be used in the treatment of my chronic pain. I fully understand the explanations regarding the benefits and the risks of this method. I agree to the use of narcotic medication(s) in the treatment of my chronic pain.

Narcotic Information Sheet

Narcotic medications(s) can be an effective and a safe part of your pain treatment. It is only one part of your treatment. Your cooperation in all aspects of your prescribed pain management program is necessary and expected if you are to continue receiving narcotic medication(s).

The goals of your pain therapy include a reduction in the level of your pain and your improved ability to function on a day-to-day basis, i.e., improved quality of life. The pain relief you receive from your medication(s) should improve your ability to engage in physical and social activities, and, therefore, help you return to a more normal life style.

The following is a list of the most common side effects and complications related to use of narcotic medication(s). We have also enclosed a list of the precautions and preventive treatments for some of these patterns:

PROBLEM	**TREATMENT**
Constipation	Increase your regular exercise, fluid intake add more bulk forming food to your diet. You may need to take over the counter or prescription stool softeners.
Nausea and vomiting	Stop the medication and call the office.
Excessive drowsiness	This will usually improve as you continue the medication. DO NOT DRIVE OR OPERATE MACHINERY DURING THIS TIME. Your family should be aware of the medication you are taking and be instructed to call the office or take you to the emergency room if you become difficult to arouse. If your pain had caused you to lose sleep, you may find that you are sleeping a lot after taking the narcotic medication(s). You may simply be getting the rest you need. In this case, you are not experiencing a side effect of the drug, but a benefit of the drug.
Itching	Call our office.
Urinary Retention	Call our office. You may need temporary catheterization of your bladder to help drain the urine.
Insomnia	Call our office.
Depression	Call our office as soon as possible
Reasoning and judgment may be impaired	Call our office.

PROBLEM CONT.	TREATMENT CONT.
Respiratory depression (suspect this if the patient has slow and shallow breathing or stops breathing)	This is an extremely rare but potentially serious side effect. Stop the medications. Contact our office immediately and/or take the patient to an emergency room. If respiratory depression remains undetected, there is risk of cessation of breathing and possible complications related to the lack of oxygen, including death.
Impotence	Call our office .
Tolerance (the need for an increasing amount of drug to achieve the same pain relief)	Chronic pain patients may develop tolerance to the narcotic medication(s). If tolerance develops, new medication(s) of equal strength can be substituted for the medication you have been taking.
Physical and emotional dependence on narcotic may occur " …a pharmacologic property characterized by the occurrence of an abstinence syndrome after abrupt discontinuation of the drug.."	This is not a problem. Dependence requires tapering off to avoid withdrawal. Talk to your doctor before you discontinue any medication(s).
Addiction may occur, "a chronic disorder characterized by the compulsive use of a substance resulting in physical, psychological, or social harm to the user and continued use despite that harm..." AMA Task Force TBME, Volume 15, Number 1	This problem is rare, in patients who suffer from chronic, intractable pain, but this may be the price the patient must pay when trying to achieve pain relief. Withdrawal and detoxification will be needed if an addiction occurs.

Notice of Privacy Practices

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.

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive. This notice describes our privacy practices. You can request a copy of this notice at any time. For more information about this notice or our privacy practices and policies, please contact the person listed below.

Treatment
We are permitted to use and disclose your medical information to those involved in your treatment. For example, the physician in this practice is a specialist. When we provide treatment, we may request that your primary care physician share your medical information with us. Also we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.

Payment
We are permitted to use and disclose your medical information to bill and collect payment for the services provided to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. The form will contain medical information, such as a description of the medical service provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations
We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. (For example, we may engage the services of a professional to aid this practice in its compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law.)

Disclosures That Can Be Made Without Your Authorization
There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

Public Health, Abuse or Neglect, and Health Oversight
We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to mediations, problems with products, or to notify people of recalls of products they may be using.

We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications, and inspections which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement
We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided that the information:

- Is release pursuant to legal process, such as a warrant or subpoena;
- Pertains to a victim of crime and you are incapacitated
- Pertains to a person who has died under circumstances that may be related to criminal conduct;
- About a victim of crime and we are unable to obtain the person's agreement;
- Is released because of a crime that has occurred on the premises; or
- Is released to locate a fugitive, missing person, or suspect.

We may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Workers' Compensation
We may disclose your medical information as required by the Texas workers' compensation law.

Inmates
If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National security and Intelligence Activities, Protection of the President
We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you

are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors
When a research project and its privacy protections have been approved by an institutional review board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased or a cause of death. Further, we may release medical information to a funeral director where such a disclosure is necessary for the director to carry out his duties.

Required by Law
We may release medical information where the disclosure is required by law.

Your Rights Under Federal Privacy Regulations
The United Stated Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their HIPAA rights.

Requested Restrictions
You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations. We do NOT have to agree to this restriction but if we do agree we will comply with your request except under emergency circumstances.

To request a restriction, submit the following in writing:
a. The information to be restricted
b. What kind of restriction you are requesting (i.e. on the use of information, disclosure of information or both)
c. To whom the limits apply.

Please send the request to the address and person listed below.

You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

Receiving Confidential Communications By Alternative Means
You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information
You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that request for copies be

made in writing and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed below.

We can refuse to provide some of the information you ask to inspect or ask to be copied if the information:

- Includes psychotherapy notes
- Includes the identity of a person who provided information if it was obtained under a promise of confidentiality.
- Is subject to the Clinical Laboratory Improvements Amendments of 1988
- Has been compiled in anticipation of litigation

We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make any such review.

Texas law requires that we are ready to provide copies or a narrative within 15 days of your request. We will inform you when the records are ready to pick up or if we believe access should be limited. If we deny access, we will inform you in writing.

HIPAA permits us to charge a reasonable cost base fee. The Texas State Board of Medical Examiners (TSBME) has set limits on fees for copies of medical records that under some circumstances may be lower than the charges permitted by HIPAA. In any event, the lower of the fee permitted by HIPAA or the fee permitted by the TSBME will be charged.

Amendment of medical Information

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed below. We will respond within 60 days of your request. We may refuse to allow an amendment if the information:

- Wasn't created by this practice or the physicians here in this practice.
- Is not part of the Designated Record Set.
- Is not available for inspection because of an appropriate denial.
- If the information is accurate and complete.

Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we now have the correct information.

Accounting of Certain Disclosures

The HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person listed below. Your first accounting of disclosures (within a 12 month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you and you may choose to withdraw or modify your request before any costs are incurred.

Appointment Reminders, Treatment Alternatives, and Other Health-related Benefits
We may contact you by telephone to provide appointment reminders, information reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

Complaints
If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the United States Department of health and Human Services. We will not retaliate against you for filing a complaint with the government or us. The contact information for the United States Department of Health and Human Services is:

US Department of Health and Human Services
HIPAA Compliant
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

Our Promise to You
We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

Questions and Contact Person for Requests
If you have any questions or want to make a request pursuant to the rights described above, please contact:

Michael Zamora
24 Care Circle
Amarillo, TX 79124
Phone (806) 353-6100 Fax (806) 353-8130
Email michaelzamora@acpsc.com

This notice is effective on the following date: April 14, 2003
We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.

TEXAS PAIN & SPINE INSTITUTE
Pain is Inevitable...Suffering is Optional.

ACUTE & CHRONIC PAIN AND SPINE CENTER

PATIENT QUALITY IMPROVEMENT SURVEY

In our continuing effort to provide you with the most compassionate, courteous and professional care possible, we are kindly requesting your participation. Please take a few minutes to complete the survey and return it utilizing the prepaid postage envelope.

1. How did you hear about us? (Please list name if applicable)
   ___Family_____ ___Friend_____ ___Pharmacy_____
   ___Doctor_____ ___Internet_____ ___Billboard_____
   ___Phone Book_____ ___TV_____ ___Other_____
   ___Radio_____ ___Website_____ ____Facebook_____

2. How long did you wait to get an appointment?
   ___1-3 days ___4-7 days ___8-11 days ___12-15 days ___16-19 days ___20-23 days
   ___24-30 days ___Other_____

3. Did you have any problems getting an appointment? ___Yes ___No If yes, what kind of problem did you have? _____

4. Was our receptionist courteous to you? ___Yes ___No If no, please explain? _____
   _____

Medication Log

Name_____

SS#_____

Date of Injury if W/C_____

Date of Birth_____

Address_____

Home Phone_____

Cell Phone_____

Medication Name	Dosage	Date Start	Date Stop	Prescribing Physician	Purpose