

PAIN MANAGEMENT CENTER OF HOUSTON
5420 West Loop South, Suite 3500
Bellaire, Texas 77401

ASSIGNMENT OF BENEFITS

In consideration of the services rendered and to be rendered, I hereby irrevocably assign and transfer to **Pain Management Center of Houston** all rights, titles and interest in all benefits payable for the health care rendered, which are provided in any and all insurance policies, employee benefit plans and / or third party plans against any other person or entity from whom my dependents or I are entitled to recover. Said irrevocable assignment and transfer shall be for the purposes of granting the provider an independent right of recovery against such responsible parties, but shall not be construed to be an obligation of the provider to pursue any such right of recovery.

I hereby authorize all responsible parties to pay directly to **Pain Management Center of Houston** benefits and amounts due for services rendered by the provider.

I understand that if the provider is not paid in full by proceeds of any benefits, then this assignment does not release my obligation and liability to the provider for payment of all services and items provided to me or below referenced patient by the provider. In the event that no benefits are paid by my insurance company or health benefit plan, then I agree to pay the provider for all charges incurred. In the event benefits are paid by my insurance company or health benefit plan, then I agree to pay for all charges in excess of the benefits paid. All payments will be made to:

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The terms and consequences of these irrevocable assignments and financial responsibilities have been fully explained to me to my understanding and I have signed this document freely and without inducement other than the rendition of services by the provider.

Name of Patient

Date

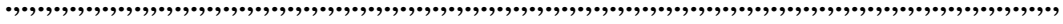
Signature of insured or authorized representative

Date

Witness or office representative

Date

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MEDICATION CONTRACT

I, _____, understand that this contract is between me and Pain Management Center of Houston. It is designed to inform me fully of the manner in which my medications, especially narcotics, will be provided. It also outlines the criteria by which the Clinic team will determine whether or not to continue to prescribe my medications.

- Pain medication, especially of a narcotic type, will be provided only after it is determined that reasonable alternatives for adequate pain control have been investigated / attempted.
- I will agree to try other approaches or techniques as felt appropriate by the team that may assist me in taking the lowest effective dose possible.
- My “pain medications” will be prescribed by one doctor and one doctor only, and filled at one pharmacy. Any attempt, successful or not, to obtain additional medications without the permission of the Medication Clinic may result in discontinuation of medication therapy.
- Medications will be given at fixed intervals, usually every two or four weeks, and only if I keep my Clinic appointments.
- I may at times, be requested to submit to a drug screen to confirm that I am taking only those medications prescribed.
- Medications will be continued as long as (a) there is associated pain relief of at least 30% to 50%, (b) my functional activity is commensurate with what would be expected, given my physical condition, and is enhanced by taking the medication, and (c) there is no evidence of physical tolerance as suggested by the need for increasing medicine.
- Evidence of hoarding or other mismanagement of my pain medication may result in discontinuation of Clinic services.
- “Flare-ups” or exacerbations of my pain symptoms will be handled by other therapies, such as TENS, exercise, icing, heat, relaxation, or non-habit forming preparations. Only when it is determined that there is a physiological basis for the flare-up and additional medicine is required, a brief increase or “rescue dose” will be considered.
- If it is determined that the situation may be out of control, I will agree to be hospitalized where medications and other therapies can be provided in a controlled fashion.
- I understand that there are risks with medications that will be given to me including constipation, decreased appetite, confusion, loss of balance, breathing difficulty, physical dependence, psychological dependence and tolerance. I am willing to take these risks.

I have read and understand each of the above statements. I realize that the Medication Clinic will assume the responsibility of assisting me in my therapy as long as long as I comply with the above.

Patient

Spouse / Family member / Guardian

Witness

Date



Pain Management Center of Houston
(713) 664-2662 Fax: (281) 657-6859

CONSENT & DISCLOSURE

Please read before you sign

Patient Name: _____ Date: _____

Authorization to release information / Medical records: The undersigned hereby authorizes Pain Management Center of Houston to release information concerning examination, testing and treatment of the above named patient, hereafter referred to as “the patient” to any insurance company, attorney, other medical facility, or other physician requesting the same for purposes of determining eligibility for payment of insurance benefits for billing purposes, referral services or medical treatment.

Authorization to obtain information / Medical records: The undersigned hereby authorizes Pain Management Center of Houston to obtain information concerning examination, testing and treatment of the patient from any insurance company, attorney, other physician and other medical facility.

State of financial responsibility: The undersigned agrees, whether he or she signed as an agent or a patient, that in consideration of services to be rendered to the patient, he / she hereby individually obligates himself to pay the account in accordance with the regular rates charged by the provider. Should the account be referred to collections, whether it is a collection agency or an attorney, the undersigned agrees to pay the collection expense and reasonable attorney fees equal to 32% of the outstanding balance due. Should protracted litigation result, the court may set an attorney fee in excess of 32% of the outstanding balance.

Consent for treatment: The undersigned hereby consents to examination and treatment of the patient by the physicians at Pain Management Center of Houston to the performance of any surgical or diagnostic procedure deemed necessary under the circumstances. I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and or procedures. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure.

Authorization to pay insurance benefits and guarantee of payment: The undersigned hereby authorizes payment to Pain Management Center of Houston for the treatment or diagnosis conducted, any benefits specified and otherwise payable to the patient, but not to exceed the customary charges. The undersigned understands that he / she is financially responsible to Pain Management Center of Houston for charges not covered by this assignment of benefits.

Statement to permit payment of medical insurance benefits to physicians: The undersigned certifies that the information given by the patient applying for payment under Titles V, XVII, and XIX of the Social Security Act is complete and correct. He / she authorized any holder of medical or other information about the patient, to release to the Social Security Administration or its carriers any information needed for this or any related Medical Medicaid Claim. He / she requests that payment of authorized benefits be made on the patient’s behalf to Pain Management Center of Houston or its designated representative to obtain from the Social Security Administration and the agency to release any information to establish the patient’s entitlement to Medicare / Medicaid benefits.

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TERMS OF SERVICE

- I authorize payment of medical benefits to Pain Management Center of Houston for any services furnished. I authorize Pain Management Center of Houston to appeal any denied claims(s) on my behalf. I understand that I am financially responsible for any amount not covered by my insurance carrier. I authorize you to release to my insurance company or its agent information concerning healthcare, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.
- The undersigned hereby consents to examination and treatment of the patient by the physicians at Pain Management Center of Houston and to the performance of any surgical or diagnostic procedure deemed necessary under the circumstances. I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and or procedures. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure.
- I understand as the patient / guarantor that I am responsible for providing current demographic and payer information. If I fail to provide the required information, I will become financially responsible for all charges.
- I understand once my claim is processed, if there is a balance, I agree to contact Pain Management Center of Houston to make payment arrangements.
- If you need to reschedule or cancel appointment for a procedure, you must notify the office at least 72 hours in advance. There will be a \$25.00 charge for missed appointments.
- If Workers Compensation, I have given all requested information to Pain Management Center of Houston. I understand that if my injury is ruled non-compensable, I am responsible for making payment arrangements.
- Co-pays and Co-insurances will be collected at the time of service.
- There is a \$30.00 fee for returned checks.
- For release of any medical records, a signed authorization from the patient must be completed. Release of any and all medical records will be in compliance with HIPPA guidelines. Per HIPPA guidelines there is a fee for medical records.

I have read, understand and agree to the above Terms of Service.

Signature of Patient or Guarantor.

AP 3/07

Date.

REV

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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.

Pain Management Center of Houston uses health information about you for treatment to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of Greater Houston Therapeutics.

How we may use or disclose your health information

For Treatment: We may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider such as a physician, therapist, nurse or other person providing health services to you will record information in your record related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond.

For Payment: We may use and disclose health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payer, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For Health Care Operations: We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to:

- Evaluate the performance of our staff;
- Assess the quality of care and outcomes in your case and similar cases;
- Learn how to improve our facilities and services;
- Determine how to continually improve the quality and effectiveness of the health care we provide.

Appointments: We may use your information to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Required by Law: We may use and disclose information about you as required by law. For example, we may disclose information for the following purposes:

- For judicial and administrative proceedings pursuant to legal authority;
- To report information related to victims of abuse, neglect or domestic violence;
- To assist law enforcement officials in their law enforcement duties.

Public Health: Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities. Health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law. Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Government Functions: Your health information may be disclosed for specialized government functions such as protection of public official or reporting to various branches of the armed services.

Workers' Compensation: Your health information may be used or disclosed in order to comply with laws and regulation related to Workers' Compensation.

Other uses: Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent our facility has taken in reliance on such.

Your Health Information Rights: You have the right to:

- Request a restriction on certain uses and disclosures of your information provided by 45 C.F.R. § 164.522; however, our facility is not required to agree to a requested restriction;
- Obtain a paper copy of the notice of information practices upon request;
- Inspect and obtain a copy of your health record as provided for in 45 C.F.R. § 164.524;
- Request that your health record be amended as provided in 45 C.F.R. § 164.526;
- Request communications of your health information by alternative means or at alternative locations;
- Receive an accounting of disclosures made of your health information as provided by 45 C.F.R. § 164.528.

Concerns / Complaints: You may complain to our facility and / or to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a concern. To register a concern with our facility, please contact the Administrator to complete and return a Patient Concern Form to our facility.

Our Obligations: Our facility is required by law to:

- Maintain the privacy of protected health information;
- Provide you with this notice of its legal duties and privacy practices with respect to your health information;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed;
- Accommodate reasonable request you may make to communicate health information by alternative means or at alternative locations.

This office reserves the right to change information practices and to make the new provisions effective for all protected health information it maintains. Revised notices will be made publicly available and posted at the facility.

PATIENT INFORMATION SHEET - PLEASE PRINT LEGIBLY

ALL PATIENTS MUST PROVIDE PHOTO IDENTIFICATION

Today's Date: _____

Name: Last: _____ First: _____ M.I. _____

DOB: ____/____/____ SSN: ____-____-____ D.L. & State: _____/_____

Address: _____ City: _____ State: ____ Zip: _____

E-Mail address: _____ @ _____

Phone #: Home: ____-____-____ Cell #: ____-____-____ Work #: ____-____-____
Best number to reach between 8 am to 5 pm: (circle one) Home - Cell - Work

Marital Status (circle one) Single Married Separated Divorced Widowed

Work Status: (circle one) Unemployed - Part-time - Full-Time - Self-Employed - Retired - Date retired: ____-____-____

Employers Name: _____ Work phone #: ____-____-____ Ext: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Emergency contact: Name: _____ Phone #: ____-____-____

Referring Doctors Name: _____ Phone Number: ____-____-____

Please, provide a copy of current insurance card to Pain Management Center of Houston

Primary Insurance Company: _____ I am the policy holder: (circle one) Yes - No

Secondary Insurance Company: _____ I am the policy holder: (circle one) Yes - No

If yes, skip the Policy Holder Information Section. If no, please complete Policy Holder Information Section below

POLICY HOLDER INFORMATION – If other than self

Relationship to patient: (circle one) Parent - Spouse - Self

Name: Last: _____ First: _____ M.I. _____

DOB: ____/____/____ SSN: ____-____-____

Address: _____ City: _____ State: ____ Zip: _____

Phone #: Home: ____-____-____ Cell: ____-____-____ Work: ____-____-____

Employers Name: _____ Phone #: ____-____-____

Address: _____ City: _____ State: ____ Zip: _____

If this is an HMO Policy, please provide referral form from primary care doctor