MY HEALTHCARE OFFICE: HOGAN SPINE & REHABILITATION CENTER

PERSONAL INFORMATION:

First Name: _____ Last Name: _____

Social Security #: _____ Birth Date: _____

Gender: ☐Male ☐Female

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____. Status: ☐Married ☐ Divorced ☐Widowed ☐Other

Age: _____ Height: _____ Weight: _____

Occupation: _____ Employer: _____

Work Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Relationship: _____

Contact Number: _____

How did you first hear about us? ☐Physician referral ☐Online Search ☐Facebook ☐Instagram ☐Yelp

☐ Friend/Family Member ☐Insurance ☐Magazine ☐Direct Mail ☐Other: _____

Pharmacy Name: _____ Pharmacy Number: _____

Primary Care Provider: _____

INSURANCE: Please provide a copy of your insurance card. If your plan requires a referral, please provide a copy.

Primary Insurance: _____

Subscriber Name: _____ DOB: _____

ID #: _____ Group #: _____

AUTHORIZATION & ASSIGNMENT:

I authorize the release of any and all records to **MY HEALTHCARE OFFICE** or Spine & Rehabilitation Affiliates, PLLC as requested. I authorize payment of any benefits to be paid directly to this facility. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am responsible for all costs of services rendered, regardless of insurance coverage. I understand if I have an unpaid balance to **MY HEALTHCARE OFFICE** and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts. I also understand regardless of scheduled future care, any fees for all services will be immediately due and payable. I understand it is my responsibility to consult with my primary care physician to rule out any underlying medical condition not related to my musculoskeletal condition, and/or symptoms presented.

_____ _____

Signature of Patient or Guardian Date

_____

Printed Name of Patient or Guardian

MY HEALTHCARE OFFICE: HOGAN SPINE & REHABILITATION CENTER

ALLERGIES:

Please circle ◯ all that apply:

None	Sulfa Drugs	Latex
Adhesive	Xylocaine	Penicillin
Dairy Products	Codeine	Tetracycline
Iodine	Eggs	
Novocain	Environmental (dust, pollen, etc.)	

Please list any additional allergies and your symptoms/reaction: _____

_____

_____

SOCIAL HISTORY:

Please circle ◯ all that apply:

Alcohol Use - How Often?_____	Alternative Medicine Use	Financial Difficulty
Recreational Drug Use - How Often?_____	Difficulty Driving	Good Support System
Caffeine Use	Disability	

Tobacco Use: Chewing Tobacco Cigar Pipe Previous Smoker Never Smoked

Cigarettes: # Packs Per Day? _____ How old were you when you started? _____

Sleep Habits: Less than 6 hours a night 7-9 hours a night More than 9 hours

Abdominal Surgery	Medical Spine Procedure	Back Surgery: _____
Amputation	Pacemaker Implant	Cervical Fusion: _____
Artificial Joint: _____	Post or Prolonged Bleeding	Neck Surgery
Fracture Repair: _____	Removal of Abdominal Adhesions	Other:
Laminectomy: Level_____	Anesthetic Complications	_____

Please list any major accidents, type and year: _____

Hogan Spine & Rehabilitation Center

MY HEALTHCARE OFFICE: HOGAN SPINE & REHABILITATION CENTER

PAST MEDICAL HISTORY:

Please check all that apply.

- ☐ Alcoholism
- ☐ Angina
- ☐ Asthma
- ☐ Ankylosing Spondylosis
- ☐ Back Injury/Pain
- ☐ Blood Transfusion
- ☐ Bowel Problems
- ☐ Cancer: Location
- ☐ C.O.P.D.
- ☐ Coagulopathy
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Hemophilia
- ☐ Hypertension
- ☐ Joint Sprain: Location
- ☐ Musculoskeletal Problems
- ☐ Neck Pain
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Phlebitis
- ☐ Shoulder Dislocations
- ☐ Sleep Apnea
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Syncope/Fainting Spells
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Heart Attack (MI)
- ☐ Fibromyalgia
- ☐ CHF
- ☐ Sleep Apnea
- ☐ Arthritis
- ☐ Hyperlipidemia
- ☐ HIV
- ☐ Other: _____

REVIEW OF SYMPTOMS:

Please check all that apply.

CONSTITUTIONAL:

- ☐ Fever
- ☐ Weight Loss
- ☐ Obesity
- ☐ Loss of Appetite
- ☐ Fatigue
- ☐ Anxiety
- ☐ Allergies

MUSCULOSKELETAL:

- ☐ Back Pain
- ☐ Headaches
- ☐ Extremity Pain
- ☐ Bone Demineralization
- ☐ Unstable Fracture
- ☐ Spinal Infection
- ☐ Spinal Bone Tumors

NEUROLOGICAL:

- ☐ Sudden Numbness
- ☐ Sudden Headaches
- ☐ Loss of Sensation
- ☐ Confusion
- ☐ Dizziness
- ☐ Slurred Speech
- ☐ Loss of Balance

CARDIOVASCULAR:

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Arterial Aneurysm
- ☐ Angina
- ☐ Irregular Heart Beat
- ☐ Bleeding Disorder
- ☐ Heart Attack

RESPIRATORY:

- ☐ Asthma
- ☐ COPD
- ☐ Common Cold
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Cancer
- ☐ Pneumothorax

EYES:

- ☐ Hearing Loss
- ☐ Tinnitus
- ☐ Vertigo
- ☐ Nose Bleed
- ☐ Dry Mouth
- ☐ Change of Taste
- ☐ Bleeding Gums

E,N,M,T:

- ☐ Kidney Infection
- ☐ Loss Bladder Control
- ☐ Urine Color Change
- ☐ Painful Urination
- ☐ Urine Leakage
- ☐ Urgency
- ☐ Blood in Urine

GASTROINTESTINAL:

- ☐ Diarrhea
- ☐ Blood in Stool
- ☐ Abdominal Pain
- ☐ Liver/Gall Condition
- ☐ Nausea/Heartburn
- ☐ Loss Bowel Control
- ☐ Prostate Problems

MY HEALTHCARE OFFICE: HOGAN SPINE & REHABILITATION CENTER

PATIENT ACKNOWLEDGMENT OF BILLING PRACTICES:

Houston Spine & Rehabilitation Centers and/or Houston Spine & Rehabilitation Affiliates have many facets to care for patients and their healthcare needs.

A patient may be treating with the professionals and clinicians in one or more of the facets of Houston Spine & Rehabilitation Centers and/or Houston Spine & Rehabilitation Affiliates. The treating doctors, physical therapists and clinicians include, but are not limited to:

Dr. Jeffrey Hogan, DC
Dr. Zachary Benson, DC
Dr. Jason Schell, DC
Dr. James Joseph, DPT
Dr. Jerry Gentry, MD
Dr. Mark Yezak, DC
Dr. Scott Neuburger, DC
Dr. Brett Baer, DPT
Dr. Lenny Jue, MD

Due to the multiple disciplines utilized for patient care, **MY HEALTHCARE OFFICE** and Spine & Rehabilitation Affiliates, PLLC are under the direction of Medical Director, **Dr. Jerry Gentry, MD**.

All claims for patient care are submitted to insurance companies under the direction of our Medical Director, **Dr. Jerry Gentry, MD**. Our Medical Director is in-network with most major medical insurance plans and his name will appear on all explanation of benefits and correspondence from the insurance company.

During patient care, the benefit levels that will be utilized on insurance plans are the specialist and physical therapy benefits.

By signing this acknowledgment, the patient understands the billing practices of MY HEALTHCARE OFFICE and Spine & Rehabilitation Affiliates, PLLC. If there are any questions, please contact our office.

_____ _____
Signature of Patient or Guardian Date

_____
Printed Name of Patient or Guardian

DISCLOSURE OF PHYSICIAN OWNERSHIP INTEREST NOTICE TO PATIENTS:

Dear Patient,

Please carefully review this notice.

In order to allow you to make a fully-informed decision about your healthcare, the physicians of **MY HEALTHCARE OFFICE** (the "Practice") would like to inform you that at some point during the course of your treatment, the providers may refer you to laboratories, diagnostic imaging centers, surgical centers or hospitals to perform diagnostic studies or surgical procedures. The practice wishes to advise you that some or all of the doctors of **MY HEALTHCARE OFFICE** and/or Spine & Rehab Affiliates, PLLC have a direct ownership interest in:

Spring Imaging Center 26218 I-45 Spring, TX 77386	**Galleria MRI** 3391 Westpark Dr. Houston, TX 77005	**Upright MRI** 2655 Cordes Dr Sugar Land, TX 77479

All of the practice's physicians will make referrals to laboratories, diagnostic imaging centers, surgical centers or hospitals, based upon the best interest of a patient's health and any other factors that a patient would like his or her physicians to consider, regardless of any ownership, interest or compensation arrangement that a physician may have with a particular laboratory or other facility.

You, as a patient, have the right to choose the provider of your healthcare services and the diagnostic facilities where you receive services or treatment.

If you have any questions concerning this notice, please feel free to ask your physician or any member of our staff. We welcome you as a patient and value our relationship with you.

By signing below, you acknowledge that you have read and fully understand this notice.

_____ _____

Signature of Patient or Guardian Date

_____

Printed Name of Patient or Guardian

AUTHORIZATION FOR TELEPHONE CONTACT

I authorize the staff of **MY HEALTHCARE OFFICE** to contact me at my home, cell, or any other alternate phone number that I have listed.

Which phone number do you prefer we contact first? ☐Home ☐Work ☐Cell

_____ (Initial) I authorize **MY HEALTHCARE OFFICE** to leave a voicemail on the above phone in reference to any items that assist the practice in carrying our Treatment, Payments and Healthcare Operations (TPO), such as appointment reminders, insurance items, and any other calls pertaining to my clinical care, including lab results among others.

AUTHORIZATION FOR U.S. MAIL AND EMAIL

Consent for **MY HEALTHCARE OFFICE** to mail to my home or email any item is that assist the practice in carrying out TPO, such as appointment reminders, documentation to refer out for services, documentation requested by myself and patient statements. I understand that as with any internet service, there is a risk sending information through email. All records are kept in our Electronic Medical Record.

☐I acknowledge and consent to receive paper mail ☐I acknowledge and consent to receive email

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NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be Involved in that treatment directly and indirectly
Obtain payment from third party payers
Conduct normal healthcare operations such as quality assessments and physician certifications

I agree to receive an electronic copy of the Notice of Privacy Practices (available on our website or by contacting the office) containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request In writing that you restrict how my private Information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, that you are bound to abide by such restrictions.

By acknowledging below I give my consent for **MY HEALTHCARE OFFICE** to use and disclose my protected health information (PH) in the ways described in the Notification and to carry out treatment, payment, and healthcare operations (TPO).

_____ (Initial) I have read or been given the opportunity to read the Notification of Privacy Practices and agree as indicated above.

Due to the privacy laws mentioned above, we are unable to discuss your PHI (Including appointment information) with any family member without your expressed consent. If you would like us to be able to discuss any aspect of your PHI with a spouse, parent or other family member please list them below. For minor children we will follow any applicable state or federal laws regarding release of information .

I authorize **MY HEALTHCARE OFFICE** and all of its healthcare providers to discuss issues regarding my visits, any lab or test results, my appointments or insurance with the following people and understand that this authorization will remain In effect until I notify the office in writing of any changes.

Name of Individual to release Information to: _____ Relationship: _____

OR _____ (Initial) I do not wish to designate anyone to have access to my information.

_____ _____

Signature of Patient or Guardian Date

_____

Printed Name of Patient or Guardian

MY HEALTHCARE OFFICE: HOGAN SPINE & REHABILITATION CENTER

MY HEALTHCARE OFFICE and Spine & Rehab Affiliates, PLLC ro ders specialize in the treatment of the spine and associated pain. We perform various treatments consisting of passive modalities, therapeutic interventions and spinal manipulation. The goal of our services is to reduce and/or eliminate your pain, however, with any chiropractic and/or physical medicine services there are risks associated with the services we provide.

As your healthcare provider, we feel that it is crucial that you understand these risks. Be informing you of these risks, we are striving to move actively involve you in our care, as well as further assist you in making well informed decisions regarding your treatment options.

PASSIVE MODALITIES

Passive modalities consist of the following treatments: hot packs, cold packs, ultrasound, electrical stimulation, massage, traction and cold laser. The primary risks associated with passive modalities include skin irritation or electrical burns due to exposure to heat, cold or agents used in application or modalities (i.e. lotions and pads). If you have experienced skin sensitivity to heat, cold temperatures and/or lotions or similar products in the past, or are aware of any skin allergies, please inform our staff prior to treatment so proper precautions can be made prior to initiating treatment.

THERAPEUTIC INTERVENTIONS

Therapeutic interventions consist of the following types of treatments: stretching, flexibility exercises, strengthening exercises, joint mobilizations and myofascial release. Therapeutic interventions are generally quite safe, though there are risks associated with each of these procedures. The primary risk is potential aggravation of your current condition and/or underlying condition. As with any physical activity and/or exercise, there is also the risk of injury. Though this risk Is minimal, as you are under the direct supervision of experienced clinical staff, it may still exist. Some responses to therapeutic interventions are muscle soreness, muscle fatigue, increased discomfort, overall tiredness and/or joint stiffness and/or pain. It is important that you inform your treating staff member of any of these responses following your treatment and more importantly, it is crucial that you continue to attend your appointments as scheduled so your condition can be documented and your symptoms effectively managed.

SPINAL MANIPULATION

Spinal Manipulation consists of adjustments that seek to restore normal function to the spine and other joints. Typically, this involved applying a specific, highly controlled treatment directly to a joint or muscle. This treatment often reduces or eliminates both local and referred pain, allows muscle spasms to relax and may even release the Irritation from the nervous system, which may result in other health benefits. As with any healthcare service, there are potential reactions and risks, however as with any healthcare intervention, it is hoped that the expected benefits of spinal manipulation exceed the expected risks. These are unavoidable risks of spinal manipulation which, though rare, can occur.

DISK HERNIATION

The occurrence of disk herniation during spinal manipulation is highly unlikely. In fact, averaged disks withstand an average of 23 degrees or rotation and degenerated disks an average of 14 degrees of rotation before failure occurs. Furthermore, given the fact that during manipulation posterior facet joints limit rotation to a maximum of 23 degrees, this joint would have to fracture to allow any further rotation to occur.

CAUDA EQUINA SYNDROME

It is estimated that the rate of occurrence of the Cauda Equina Syndrome as a complication of lumbar spinal manipulation is about one case per 100 million manipulations. It Is probably higher in patients with a herniated nucleus pulposus and lower in patients without this anatomic abnormality.

VERTEBROBASILAR ARTERY COMPROMISE

Serious complications of cervical spine manipulation are also rare (none have been reported in any of the clinical trials) but appear to be more common and severe than complication of lumbar manipulation. The most serious complication of the cervical spine manipulation is related to compromise of the vertebrobasilar artery, leading to stroke or death. The risk Is higher for manipulation Involving rotation plus extension of the vertical spine than for other types of manipulation and those persons who have suffered manipulation related vertebrobasilar artery compromise due to atherosclerotic disease. The best estimate of the incidence of vertebrobasilar artery compromise related to cervical spine manipulation is that is occurs one in a million manipulations (Hurwitz, 1996; McGregor, 1955).

PATIENT UNDERSTANDING AND ACCEPTANCE OF RISKS ASSOCIATED WITH TREATMENT

As your doctor, it is our responsibility to inform you of the potential risks and benefits of your treatment, but we also want to assure you that we strive to minimize these risks by providing thorough clinical examination and by performing diagnostics as clinically Indicated. Furthermore, we continually review medical literature pertaining to current trends within our profession as well as throughout the entire medical community to ensure the safest and most effective care.

_____ _____

Signature of Patient or Guardian Date

_____

Printed Name of Patient or Guardian

MY HEALTHCARE OFFICE: HOGAN SPINE & REHABILITATION CENTER

PATIENT HISTORY

Please help us to provide you with the best comprehensive care by completing the following questionnaire.

Date _____

First Name: _____ Last Name: _____

CHIEF COMPLAINT:

What is the reason for your visit today? _____

Please mark the severity of your complaint **right now:**

☐ No Symptoms ☐ Discomfort - Does Not Affect Activity ☐ Prevents Personal Activities

☐ Limits Work ☐ Prevents all Activity ☐ Keeps Me Bedridden

Please mark the severity of your complaint **on average:**

☐ No Symptoms ☐ Discomfort - Does Not Affect Activity ☐ Prevents Personal Activities

☐ Limits Work ☐ Prevents all Activity ☐ Keeps Me Bedridden

Please mark the severity of your complaint **at its best:**

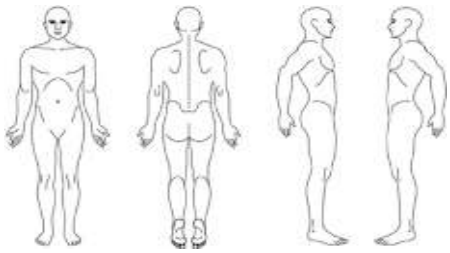
☐ No Symptoms ☐ Discomfort - Does Not Affect Activity ☐ Prevents Personal Activities

☐ Limits Work ☐ Prevents all Activity ☐ Keeps Me Bedridden

Please mark the severity of your complaint **at its worst:**

☐ No Symptoms ☐ Discomfort - Does Not Affect Activity ☐ Prevents Personal Activities

☐ Limits Work ☐ Prevents all Activity ☐ Keeps Me Bedridden



Mark the areas of your complaint on the diagrams to the left. Please include any descriptions or comments that you feel are important.

If your symptoms travel to other areas of your body, mark the diagram to reflect how the symptoms seem to move.

MY HEALTHCARE OFFICE: HOGAN SPINE & REHABILITATION CENTER

PAIN DISABILITY INDEX:

Date: _____

First Name: _____ Last Name: _____

For each of the 7 categories listed, please circle the number on the scale that best describes the level of disability you typically experience. A score of "0" means no disability at all, and a score of "10" signifies that all of these types of activities have been totally disrupted or prevented by your pain.

Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

FAMILY/HOME RESPONSIBILITY (such as house cleaning or errands):

1 2 3 4 5 6 7 8 9 10

No Disability Total Disability

RECREATION (such as sports, exercise, and other similar leisure time activities):

1 2 3 4 5 6 7 8 9 10

No Disability Total Disability

SOCIAL ACTIVITY (such as going to parties, dining out, and other social functions):

1 2 3 4 5 6 7 8 9 10

No Disability Total Disability

OCCUPATION (all activities related to one's job, including non-paying jobs):

1 2 3 4 5 6 7 8 9 10

No Disability Total Disability

SEXUAL BEHAVIOR:

1 2 3 4 5 6 7 8 9 10

No Disability Total Disability

SELF-CARE (such as bathing and dressing):

1 2 3 4 5 6 7 8 9 10

No Disability Total Disability

LIFE-SUPPORT ACTIVITY (eating, sleeping and breathing):

1 2 3 4 5 6 7 8 9 10

No Disability Total Disability

OVERALL DISABILITY SCORE (OUT OF A POSSIBLE 70): _____

Understanding Services Not Considered by Your Insurance Carrier

There are some services that are not covered by your insurance carrier. Below are the services that are not considered by your insurance carrier.

VAX-D (Spinal Decompression) | Cost: $25.00 / session _____ **(Initial)**

VAX-D is the brand name of the mechanical traction machine that performs mechanical spinal decompression. VAX-D stands for Vertebral Axial Decompression and is a service prescribed to treat specific issues for the Cervical Spine or the Lumbar Spine. You doctor will advise you if you are a candidate for this service. If you are prescribed VAX-D for either the cervical or lumbar spine, the number of visits you are prescribed will vary between 20- 25 visits. The number of visits will vary based on how your body responds to the VAX-D service. Your visits will include standard post modality care. These standard post modalities are not billed to your insurance carrier. We will not be billing VAX-D services to your insurance carrier. You have 2 options of which you can opt to pay for VAX-D sessions:

_____ Option 1: Pay for sessions per date of service without discount

_____ Option 2: Pay for sessions in advance utilizing the "Prompt Pay" 10% discount.

If you are having VAX-D therapy **in combination** with any of the other not-considered services on this list, the cost will be added to your patient responsibility. In cases where a patient has taken advantage of the "Prompt Pay" discount, the patient will be asked for payment of the other services that they have received listed on this advisement.

Functional Dry Needling (FDN) | Cost: $50.00 / session _____ **(Initial)**

Functional Dry Needling is a **short-term prescribed service** that is performed by a Licensed Physical Therapist. FON requires a short PT Evaluation with the Licensed Physical Therapist who will be performing the service. Your doctor/therapist will be setting the frequency and duration of the short-term prescribed service. In most cases, 3 - 6 sessions are prescribed.

If you are prescribed FON, the FDN service will not be billed to your insurance carrier but all standard modalities and physical therapies will be billed. The cost for the FON will be collected from you at the time of service. If the payment is not collected on the same date of service you have the FON performed, it will be collected from you at the Check In/Check Out and/or be billed to you.

Therapeutic Cupping | Cost: $25.00 / session _____ **(Initial)**

Therapeutic Cupping is a **short-term prescribed service** that is performed either by a modalities technician or a Licensed Physical Therapist. Your doctor/ therapist will be setting the frequency and duration of the short-term prescribed service. In most cases, 3 sessions are prescribed.

If you are prescribed Therapeutic Cupping, the service will not be billed to your insurance carrier, but all standard modalities and physical therapies will be billed. The cost for Therapeutic Cupping will be collected from you at the time of service. If the payment is not collected on the same date of service you have the service performed, it will be collected from you at the Check In/Check Out and/or be billed to you.

Active Release Techniques (ART) | Cost: $25.00 / session _____ **(Initial)**

ART is a **prescribed service** that is performed by your treating doctor. If you are prescribed ART in conjunction with your treatment plan, the service will not be billed to your insurance carrier, but all other therapies will be billed. The cost for ART will be collected for you at the time of service. If the payment is not collected on the same date of service you have the service performed, it will be collected from you at the Check In/Check Out and/or be billed to you.

Kinesio Taping (Taping) | Cost: $15.00 / session _____ **(Initial)**

Kinesio Taping (Taping) is a **prescribed service** that is performed either by a modalities technician or a Licensed Physical Therapist. Taping is usually prescribed once or twice during a course of treatment.

If you are prescribed Taping, the service will not be billed to your insurance carrier, but all other therapies will be billed. The cost for Therapeutic Cupping will be collected from you at the time of service. If the. payment is not collected on the same date of service you have the service performed, it will be collected from you at the Check In/Check Out and/or be billed to you.

STATE–REQUIRED ETHNICITY AND RACE QUESTIONS

BACKGROUND INFORMATION

Texas Law requires the Texas Health Care Information Council to collect information on the race/ ethnic backgrounds of medical clinic patients. Medical practices are required to ask patients to identify their own race and ethnic backgrounds.

The data obtained through this process will be used to assist researchers in determining whether or not all citizens of Texas are receiving adequate health care.

If a patient fails or refuses to identify their own race and ethnic backgrounds, facility staff will use its best judgment in making the identification.

QUESTIONS

Mark the box that most accurately identifies the patient's ethnic background.

The Patient Is:

- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino
- ☐ Patient refuses to answer the question

The Patient's Race Is:

- ☐ American Indian/Eskimo/Aleut
- ☐ Asian or Pacific Islander
- ☐ Black
- ☐ White
- ☐ Other (includes all other responses not listed above. Patients who consider themselves as multiracial or mixed should choose this category.
- ☐ Patient refuses to answer the question

_____ _____

Printed Name of Patient Date

_____

Signature of Patient or Guardian

PAIN MANAGEMENT PROGRAM

The following are some questions given to all patients who are taking or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

SOAPP® VERSION 1.0-SF

Please answer the questions below using the following scale:

0 = Never 1 = Seldom 2 = Sometimes 3 = Often 4 = Very Often

1. How often do you have mood swings? 0 1 2 3 4
2. How often do you smoke a cigarette within an hour after you wake up? 0 1 2 3 4
3. How often have you taken medication other than the way it was prescribed? 0 1 2 3 4
4. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years? 0 1 2 3 4
5. How often, in your lifetime, have you had legal problems or been arrested? 0 1 2 3 4

Please include any additional information you wish about the above answers. Thank you.

PAIN MANAGEMENT AGREEMENT

I understand that I have a right to comprehensive pain management. I wish to enter a treatment agreement to prevent a possible chemical addiction. I understand that failure to follow any of these agreed statements might result in Dr. Gentry not providing ongoing care for me.

I, _____, agree to undergo pain management by Dr. Gentry.

I agree to the following statements:

I will not accept any narcotic prescriptions from another doctor, including Emergency Room or Dental visits.

I will be responsible for making sure that I do not run out of my medications on weekends and holidays, because abrupt discontinuation of these medications can cause severe withdrawal syndrome.

I understand that I must keep my medications in a safe place.

I understand that Dr. Gentry will not supply additional refills for the prescriptions of medications that I may lose.

If my medications are stolen, Dr. Gentry may refill the prescription one time only if a copy of the police report of the theft is submitted to the physician's office.

I will not give my prescription to anyone else.

I will only use one pharmacy.

I will keep my scheduled appointments with Dr. Gentry unless I give notice of cancellation 24 hours in advance.

I agree to refrain from all mind/mood altering/illicit drugs including alcohol unless authorized by Dr. Gentry.

My treatment plan may change based on the outcome of therapy, especially if pain medications are ineffective. Such medications will be discontinued.

I understand that Dr. Gentry believes in the following "Patients' Bill of Rights."

- Continued on Next Page -

"Patients' Bill of Rights" includes the following:

Have your pain prevented or controlled adequately

Have your pain and medication history taken.

Have your pain questions answered.

Know what medication{s), treatment or anesthesia will be given.

Know the risks, benefits, and side effects of treatment.

Know what alternative pain treatments may be available.

Ask for changes in treatments if your pain persists.

Receive compassionate and sympathetic care.

Receive pain medication on a timely basis.

Refuse treatment without prejudice from your physician.

Include your family in decision-making.

Dr. Gentry may terminate this agreement at any time if he has caused to believe that I am not complying with the terms of this agreement, or to believe that I have made a misrepresentation or false statement concerning my pain or my compliance with the terms of this agreement.

I understand that I may terminate this agreement at any time. If the agreement is terminated, I will not be a patient of Dr. Gentry and would strongly consider treatment for chemical dependency if clinically indicated.

_____ _____

Patient Signature Date

_____ _____

Physician Signature Date

_____ _____

Witness Signature Date