ADVANCED
SPINE AND PAIN
CENTER

Date: _____ **NEW PATIENT INFORMATION**

Name: (Last, First, Middle)	☐ M ☐ F	**Home Phone**	**Cell Phone** **Consent to Text: ☐ Yes ☐ No**
Date of Birth / **Age** / **SS#**		**Driver's License #**	
Address	**City**	**State**	**Zip Code**
Email Address:	**Race:** ☐ White ☐ African American ☐ Native American/Eskimo/Aleut ☐ Asian/Pacific Islander ☐ Other/Specify: ☐ Unknown		
Preferred Language:	**Ethnicity:** ☐ Hispanic or Latino/Spanish ☐ Not Hispanic or Latino/Spanish ☐ Other/Specify: ☐ Unknown		
Marital status	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Employment Status	☐ Full Time ☐ Part Time ☐ Self-Employed ☐ Unemployed ☐ Active Military ☐ Retired ☐ Student (Full/Part-time)		
Name of Patient Employer	**Occupation**	**Employer Telephone #**	
Patient Employer Address	**City**	**State**	**Zip Code**
Do you receive health care benefits from employers plan? ☐ Yes ☐ No **Does this plan pay you before Medicare?** ☐ Yes ☐ No **Is your condition a result of an accident or personal injury?** ☐ Yes ☐ No **Date of Accident/Injury:**_____ **Is your condition covered under a Workmen's Comp claim?** ☐ Yes ☐ No			
If your condition is a result of a Worker's Comp/Accident/Personal Injury, Please Provide:			
Claim Adjuster Name	**Claim #**	**Telephone #**	
Nature of Injury			
Are you involved in a pain related legal case? ☐ Yes ☐ No **If Yes, Please Provide:**			
Name of Attorney	**Telephone #**		
Attorney Address	**City**	**State**	**Zip Code**
Emergency Contact Name	**Emergency Contact #**		**Relationship**
Emergency Contact Address	**City**	**State**	**Zip Code**
Primary Insurance Information: ☐ Group/Medical ☐ Worker's Comp ☐ Auto			
Insurance Company Name	**Owner of Insurance Policy (Last, First, Middle)**	**DOB**	**Insurance ID#**
Secondary Insurance Information: ☐ Group/Medical ☐ Worker's Comp ☐ Auto			
Insurance Company Name	**Owner of Insurance Policy (Last, First, Middle)**	**DOB**	**Insurance ID#**

Advanced Spine and Pain Center

New Patient Questionnaire

Date: _____

Last Name	First Name	Middle Initial

☐ M ☐ F | Date of Birth: / /

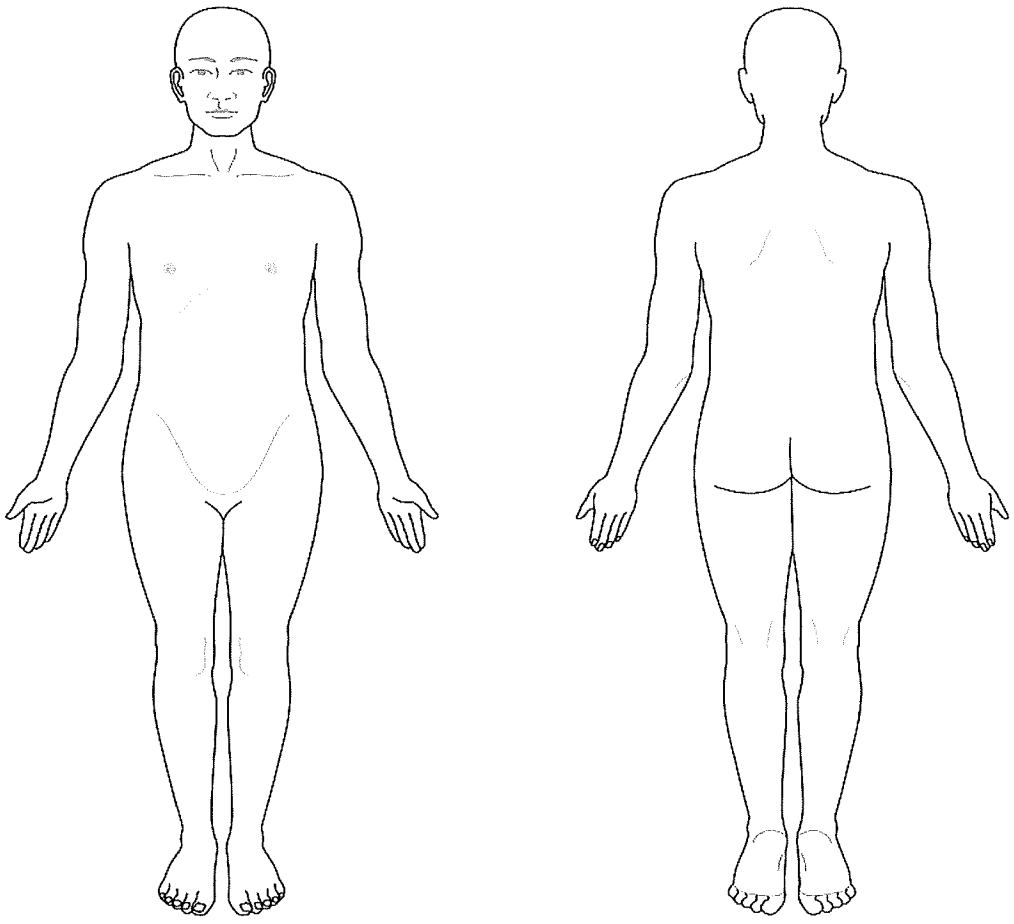
Reason For Physician Office Visit (Please Describe as accurate as possible)
Is this a Chronic Pain Condition? ☐ Yes ☐ No
Date symptom(s) and problem(s) began: / /
How did the pain start or what may have been the cause:
Does the pain radiate to any other part of your body? ☐ Yes ☐ No Where?
Can you please describe your pain? ☐ Sharp ☐ Electric ☐ Shooting ☐ Burning ☐ Tearing ☐ Ache ☐ Throbbing ☐ Other
Do you have any numbness or tingling? ☐ Yes ☐ No Where?
Is this Injury from an accident? ☐ Yes ☐ No Is this a work related injury? ☐ Yes ☐ No
Are you actively working? ☐ Yes ☐ No If No, how long?_____Weeks_____Months_____Years
Worker's Compensation? ☐ Yes ☐ No Occupation:
Have you had a physician consultation recently for this condition? ☐ Yes ☐ No
If Yes, Name of Physician: Date of consultation: / /
Have you been treated for this condition? ☐ Yes ☐ No
Describe treatment (such as epidural injections, spinal cord stimulators, physical therapy, etc.):
Date of Last Treatment: / /

Please indicate any activities that make the pain worse:
Please indicate anything that reduces the pain:
Please circle a number below to indicate your pain level right now:
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain Possible)

PLEASE MARK THE AREAS BELOW, USING THE APPROPRIATE SYMBOLS FOR PAIN AND NUMBNESS.

PAIN "PINK"

NUMBNESS AND TINGLING "BLUE"



MEDICAL HISTORY

Are you allergic to any medications? ☐ **Yes** ☐ **No**	
List each allergy:	**Reaction:**
Do you smoke? ☐ **Yes** ☐ **No** **How Often?**	**Do you Drink?** ☐ **Yes** ☐ **No** **How Often?**
Any illicit drug use? ☐ **Yes** ☐ **No** **If so, what?**	
Marital status	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Do you have any children? ☐ **Yes** ☐ **No**	**Are you pregnant?** ☐ **Yes** ☐ **No**
Do you have any of the following medical conditions? (Please check all applicable below)	
☐ Anemia/Blood Disorders ☐ Gout ☐ Kidney Problems ☐ High Blood Pressure ☐ Lung Disease ☐ Diabetes ☐ Epilepsy/Seizure Disorder Problems or Ulcers ☐ Sexual Difficulties ☐ Bowel or Bladder Problems ☐ Weight Loss ☐ Other Health or Medical Problems: _____ _____ _____	☐ Arthritis ☐ Fibromyalgia ☐ Heart Disease/Heart Attack ☐ Asthma ☐ Stomach Problems, Gastrointestinal Problems ☐ Cancer, what type?_____ ☐ Thyroid Problems ☐ Heart Disease/Heart Attack ☐ Lung Disease
Please list and date any or all minor or major surgeries:	
Is there a family history for any of the above medical conditions (mother, father, siblings, and/or grandparents)? ☐ **Yes** ☐ **No**	
Please identify which medical condition(s) and which family member(s):	
Mother's Date of Birth:	**Deceased?** ☐ **Yes** ☐ **No**
Father's Date of Birth:	**Deceased?** ☐ **Yes** ☐ **No**

Please list all medications, dose, and how taken, including over the counter medications:		
Medication	**Dose**	**How Taken**

Referring Physician Name	**Referring Physician Phone #**		
Address	**City**	**State**	**Zip Code**
Primary Care Physician Name (If different than above)	**Primary Care Physician Phone #**		
Address	**City**	**State**	**Zip Code**
Preferred Pharmacy Name	**Preferred Pharmacy Phone #**		
Address	**City**	**State**	**Zip Code**

Have you had any imaging done for the condition? ☐ **Yes** ☐ **No** **If Yes, please specify below:**

Type	Body Part	Where	Date
☐ **MRI**			
☐ **CT**			
☐ **X-RAY**			
☐ **Other:**_____			

REVIEWS OF SYSTEMS: PLEASE CIRCLE ANY SYMPTOMS THAT YOU ARE CURRENTLY EXPERIENCING:

CONSTITUTIONAL SYMPTOMS: |WEIGHT GAIN| |WEIGHT LOSS| |LOSS OF APPETITE| |FEVER| |FUSSY| |DIMINISHED ACTIVITY| |FATIGUE| |CHILLS|

EYE SYMPTOMS: |EYE PAIN| |BLURRY VISION| |EYE REDNESS| |EYE ITCHINESS| |EYE SWELLING| |EYE DISCHARGE| |VISION CHANGE|

CARDIOVASCULAR SYMPTOMS: |CHEST PAIN| |RAPID HEART RATE| |SHORTNESS OF BREATH| |PALPITATIONS-IRREGULAR HEART BEAT|

GASTROINTESTINAL SYMPTOMS: |ABDOMINAL PAIN| |NAUSEA| |VOMITTING| |DIARREHA| |CONSTIPATION| |HEART BURN|

GENITOURINARY SYMPTOMS: |BLOOD IN URINE| |PAIN WITH URINATION| |INCREASED URINARY FREQUENCY| |PELVIC PAIN| |BLADDER INCONTINENCE|

MUSCULOSKELETAL SYMPTOMS: |JOINT SWELLING| |LIMITED MOTION| |MUSCLE SPASMS| |NECK PAIN| |ARM PAIN| |BACK PAIN| |JOINT PAIN|

SKIN PROBLEMS: |DRY SKIN| |FLAKING| |REDNESS| |RASH| |HIVES| |ECZEMA| |INCREASED SWEATING| |SWELLING|

NEUROLOGICAL SYMPTOMS: |NUMBNESS| |TINGLING| |WEAKNESS| |SHOOTING PAIN| |ELECTRIC| |BURNING| |HEADACHE| |CONFUSION|

PSYCHIATRIC SYMPTOMS: |DEPRESSION| |ANXIETY| |INSOMNIA| |STRESS| |LOSS OF INTEREST| |SUICIDAL THOUGHTS|

HEMATOLOGIC SYMPTOMS: |ANEMIA| |EASY BRUISING| |EASY BLEEDING|

ADVANCED
SPINE AND PAIN
CENTER

INFORMED CONSENT AND PAIN MEDICINE AGREEMENT

AS REQUIRED BY THE TEXAS MEDICAL BOARD

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

5th Edition: Developed by the Texas Pain Society, January 2021 (www.texaspain.org)

NAME OF PATIENT: _____ DATE: _____

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

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician (name at bottom of agreement) to treat my condition of chronic pain, which is a state of pain that persists beyond the usual course of an acute disease or healing of an injury. I hereby authorize and give my voluntary consent for my physician to administer or write prescription(s) for dangerous and/or controlled drugs (medications) as a part of the treatment of my chronic pain.

It has been explained to me that these medication(s) include opioid/narcotic drug(s). I have discussed with my Pain Medicine Physician the risks and benefits of the use of controlled substances for the treatment of chronic pain, including an explanation of the following: (a) diagnosis; (b) treatment plan; (c) anticipated therapeutic results, including realistic expectations for sustained pain relief, improved functioning and possibilities for lack of pain relief; (d) therapies in addition to or instead of drug therapy, including physical therapy or psychological techniques; (e) potential side effects and how to manage them; (f) adverse effects, including the potential for dependence, addiction, tolerance, and withdrawal; and (g) potential complications and impairment of judgment and motor skills. 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 accidental overdose, injury and death are also possibilities as a result of taking these medication(s).

I understand that concurrently consuming sedating substances like alcohol, or taking additional types of sedating controlled medications, such as benzodiazepines, along with opioids increases my chance for accidental overdose, injury, and death. If in the unusual situation it is medically indicated for me to receive multiple types of controlled substances, I understand that I will require close supervision of medical specialists to maximize my safety. I agree to follow their direction on the proper use of these medications. Deviation from using medications as directed is grounds for discontinuation of pain therapy.

THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT HAVE BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT (THIS IS SOMETIMES REFERRED TO AS "OFF-LABEL" PRESCRIBING). MY DOCTOR WILL EXPLAIN HIS TREATMENT PLAN(S) FOR ME AND DOCUMENT IT IN MY MEDICAL CHART.

I HAVE BEEN INFORMED AND UNDERSTAND THAT I WILL UNDERGO MEDICAL TESTS AND EXAMINATIONS BEFORE AND DURING MY TREATMENT. Those tests include random unannounced checks for drugs (urine, blood, saliva or any other testing indicated and deemed necessary by my physician at any time) and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances or absence of authorized substances may result in my being discharged from my Pain Medicine Physician's care.

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension(low blood pressure), arrhythmias(irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction times might still be slowed. Such activities include but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself.

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

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

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

For female patients only:

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

_____If I am not pregnant, I will take appropriate precautions to avoid pregnancy during my course of treatment. I accept that it is **my responsibility** to inform my physician immediately if I become pregnant.

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

I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo, fetus, or baby.

PAIN MEDICINE AGREEMENT:

I UNDERSTAND AND AGREE TO THE FOLLOWING:

That this pain medicine agreement relates to my use of any and all medication(s) called dangerous drugs and/or controlled substances (i.e., opioids, also called narcotics or painkillers, and other prescription medications) for chronic pain prescribed by my physician. I understand that there are many strict federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). **Therefore, medication(s) will only be provided so long as I follow the rules specified in this Agreement.**

The term "Pain Medicine Physician" below means your primary Pain Medicine Physician or your physician who is managing your pain, or that physician's Physician Assistant or Nurse Practitioner, or another physician covering for your primary Pain Medicine Physician.

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

(***Patient Shall Acknowledge All Provisions by Initialing***)

_____ I am aware that all controlled substance prescriptions are now being monitored by the Texas State Board of Pharmacy and that information must be accessed by my Pain Medicine Physician every time a prescription is written, and by my pharmacist every time before my prescription is dispensed.

_____ I will not consume alcohol or use any illegal substances (such as marijuana, heroin, cocaine, methamphetamines, etc.) while being prescribed dangerous and controlled substances for the treatment of chronic pain.

_____I agree to submit to laboratory tests for drug levels upon request, including urine and/or blood screens, to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for alcohol or illegal substance(s), treatment for chronic pain may be terminated. Also, a consult with, or referral to, an expert may be necessary, such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an addictionologist or a physician who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.

_____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. My Pain Medicine Physician may limit the number and frequency of prescription refills.

_____ I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money**. If either are lost or stolen, they may not be replaced. But if my medications were stolen and I provide my Pain Medicine Physician with a copy of the police report, my Pain Medicine Physician after carefully reviewing my situation, may issue an early refill.**

_____ My Pain Medicine Physician will manage all of my chronic pain symptoms**. Only my Pain Medicine Physician may prescribe Dangerous Drugs and Controlled Substances for the treatment of chronic pain**. I will receive controlled substance medication(s) **only from ONE Pain Medicine Physician,** unless it is for an emergency **or** the medication(s) that is being prescribed by another physician is approved by my Pain Medicine Physician. Information that I have been receiving medication(s) prescribed by other physicians that has not been approved by my Pain Medicine Physician may lead to a discontinuation of medication(s) and treatment. All other health related issues must be managed by my primary care physician and my other specialists.

_____I agree that I **will inform any physician** who may treat me for any other medical problem(s) that I am enrolled in a pain medicine program and have signed this Pain Medicine Agreement.

_____I hereby give my Pain Medicine Physician **permission to** discuss all diagnostic and treatment details with my other physician(s) and my pharmacist(s) regarding my use of medications prescribed by my other physician(s). I give my Pain Medicine Physician permission to obtain any and all medical records necessary to diagnose and treat my painful conditions.

_____ I will use the medication(s) **exactly as directed by my Pain Medicine Physician**. **Any unauthorized increase** in the dose of medication(s) may cause the discontinuation of my pain treatment(s).

_____ If anyone other than my Pain Medicine Physician prescribes me medication(s) to treat acute, post-surgical or chronic pain, then I will **disclose** this information to my Pain Medicine Physician at or before my next date of service, which must include, at a minimum, the name and contact information for the person who issued the prescription, the date of the prescription, the name and quantity of the drug prescribed, and the pharmacy that dispensed the medication.

____I will alert my physician if I receive a prescription for Naloxone or any opioid antagonist which are designed to reverse the effects of an accidental or intentional overdose of pain medication.

_____ All medication(s) must be obtained at **one pharmacy designated by me**, with exception for those circumstances for which I have no control or responsibility, that prevent me from obtaining prescribed medications at my designated pharmacy. Should the need arise to change pharmacies, my Pain Medicine

Physician must be informed at or before my next date of service regarding the circumstances and the identity of the pharmacy. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my Pain Medicine Physician to release my medical records to my pharmacist as needed.

_____ My progress will be periodically reviewed and, if the medication(s) are not improving my function and quality of life, the **medication(s) may be discontinued**.

_____ I must **keep all follow-up appointments** as recommended by my Pain Medicine Physician or my treatment may be discontinued.

_____ I agree **not to** share, sell or otherwise permit others, including my family and friends, to have access to my medications.

_____ I will **not use any cannabidiol (CBD) products unless one of my physicians has prescribed me Epidiolex, and I will immediately provide you with that physician's name and lab work so that I can make sure it is not causing problems with my current medications. I understand that the use of over-the-counter CBD products increases my risk of failing a urine drug test because of the presence of illegal substances present in many over-the-counter CBD products.**

_____ I agree to be seen in **in-person office visits** because in Texas it is illegal to use Telehealth for the treatment of chronic pain with controlled substances.

_____If it appears to my Pain Medicine Physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then **my Pain Medicine Physician may try alternative medication(s) or may taper me off all medication(s)**. I will not hold my Pain Medicine Physician liable for problems caused by the discontinuance of medication(s).

_____ I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, interventional pain medicine (e.g. steroid injections, nerve ablations, implants to relieve pain, etc.) etc. I also recognize **that my active participation** in the management of my pain is extremely important. I agree to **actively participate in all aspects of the pain medicine program** recommended by my Pain Medicine Physician to achieve increased function and improved quality of life.

_____ I understand many prescription medications for chronic pain produce serious side effects including drowsiness, dizziness, and confusion. Alcohol will enhance all of these side effects and I will discontinue it before starting these medications.

I certify and agree to the following (*Patient Shall Acknowledge All Provisions by Initialing*):

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

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

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

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

_____ 5) If I become a patient in this clinic and receive controlled substances to control my pain, this Pain Medicine Agreement supersedes any other pain management agreement that I may have signed in the past.

_____

Name and contact information for pharmacy

Ellen Liu MD

_____ _____

Patient Printed Name Physician Printed Name

_____ _____

Patient Signature Physician Signature

Patient Name: DOB:

FINANCIAL POLICY

Because of our commitment to provide you with the highest standard of medical care, we want you to be aware of our policies concerning payment of your medical expenses.

At the initial visit and all visits, the patient is responsible for co-payment/co-insurance amount, plus any deductible. **If our office cannot verify insurance benefits, payment is due in full.**

If your insurance carrier sends payment directly to you, then payment in full is due at each visit. Should an overpayment occur on the deductible or percentage amounts charged, we will apply a credit to your account. A refund is available upon request.

If you are waiting for coverage to become effective or have no insurance, payment in full will be expected the day you are seen. For your convenience, we accept VISA, Master Card, Discover, American Express, cash, or check. Due to pending insurance contract status or a decision not to contract with your insurance company, out of network chargers may apply. If you do not have any out-of-network benefits, payment is due in full each visit. It is your responsibility to call your insurance company and obtain this information before receiving treatment and before filing claims for treatment.

We require that an adult (parent or legal guardian) accompany a minor patient unless prior written authorization is given to our office. The adult accompanying the minor s required to pay in accordance with our policies. We do not accept third party assignments nor do we recognize or enforce the terms of divorce or decrees.

There is a **$35.00 service fee on all returned checks in addition to the amount of the check**. NSF (non-sufficient funds) checks must be redeemed with certified funds (cashier's check, credit card, money order, certified check or cash) at or before the next office visit.

Please notify us with at least 24 hour notice if you must cancel your appointment so that we may let another patient have your appointment time. **If you do not provide at least 24 hour notice there will be a "no-show" charge for an office visit of $50.00 and a "no-show" charge for a procedure, including an injection of $100.00.**

It is your responsibility to know your coverage and benefits and if we are a preferred or assigned provider of your plan. Please be aware that some or all services provided for you may not be covered by your specific plan. In the event that your plan does not cover all services, you will be billed for the services that are not covered.

If your insurance has not paid your account in full within 120 days, you will be billed the balance. Bills that are not paid within 90 days of the first billing will be transferred to an outside collection agency unless other arrangements have been made. We will make every effort to work with you so please contact our office manager if there a need for a payment plan or there are problems prior to 90 days. If you are unable to keep your account current, we will not be able to provide additional medical services to you unless prepayment is made for services.

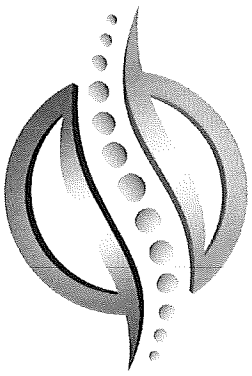
In the event that payment is not made on this account and it is placed with a licensed a collection agency, you agree to pay the fees of the collection agency equal to maximum of 40% of our outstanding balance at the time the account is placed with the collection agency interest of 40% per year will be accrued on the principal balance. Should legal action be necessary to collect the account, you agree to pay attorney fees and court cost incurred for collection.

I have read and understood the foregoing Financial Policy and agree to abide by the terms of the policy.

I hereby authorize **Advanced Spine and Pain Center** to release to my insurance company any information acquired in the course of my examination or treatment which is necessary to process claims for services rendered. I hereby authorize and direct my insurance carrier to pay directly to the Physician any benefits due me under my insurance plan. I certify that the information above is correct and I understand that any remaining balance after contractual discounts are taken into consideration will be my responsibility. **IF ANY OF THE GIVEN INFORMATION IS INACCURATE OR INCOMPLETE AND THIS CAUSES CLAIMS TO BE UNPROCESSABLE OR DENIED, I UNDERSTAND THAT THE UNPAID BALANCES ARE MY RESPONSIBILITY.**

By signing this below I have reviewed and agreed to non-covered services agreement. If I am requesting medical records for myself, I agree to pay the applicable fees for copying.

Print Name	**Signature**	**Date**
Witness Name	**Witness Signature**	**Date**



ADVANCED
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PRESCRIPTION REFILL POLICY

FOR PRESCRIPTION REFILLS PLEASE CALL YOUR PHARMACY AND REQUEST A REFILL DIRECTLY. YOUR PHARMACY WILL SUBMIT A REQUEST DIRECTLY TO THE DOCTOR.

YOU MAY ALSO REQUEST PRESCRIPTION REFILLS THROUGH YOUR PATIENT PORTAL. THIS REQUEST IS SENT DIRECTLY TO THE DOCTOR.

PLEASE ALLOW UP TO 72 HOURS TO PROCESS YOUR REFILL REQUEST.

_____ _____

Signature of Patient or Legal Representative Date

_____

Patient Name (printed)

ADVANCED
SPINE AND PAIN
CENTER

NOTICE OF PRIVACY PRACTICE

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's 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 Legal Representative

_____

Date

_____

Name of Patient of Legal Representative