THE PAIN RELIEF CENTER | MICROSURGERY SPINE AND PAIN INSTITUTE | WELLNESS CENTER | MIGRAINE INSTITUTE | STEMCELL INSTITUTE

PLEASE PRINT AND COMPLETE ALL SECTIONS

Is your condition the result of a work injury? Yes ☐ No ☐ If yes, please provide the following:

Case Manager Name: _____ Case Manager Phone: ( )____-_____

Case #: _____ Date of Injury: _____

Is your condition the result of an auto accident? Yes ☐ No ☐ If yes, please list:

Attorney name: _____ Attorney phone: _____

PATIENT INFORMATION

Name: _____ Email: _____

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

Home Phone: ( )____-____ Work Phone: ( )____-____ Cell Phone: ( )____-____

Date of Birth: _____ Age: _____ SSN: ____-____-____

Driver's License State: _____ Driver's License Number: _____

Employer Name: _____ Employer Phone: ( )____-____

Employer Address: _____ City: _____ State: _____

Zip: _____ Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse Name: _____ Spouse Date of Birth: _____

Spouse SSN: ____-____-____ Spouse Phone: ( )____-____

Spouse Employer: _____ Spouse Work Phone: ( )____-____

Emergency Contact: _____ Relationship: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( )____-____ Work Phone: ( )____-____ Mobile Phone: ( )____-____

REFERRAL INFORMATION

Referring Physician Name and Address: _____

PCP Name and Address (if different from referring physician): _____

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PAST MEDICAL HISTORY – Please check all that apply

Head:
- ☐ Trauma

Eyes:
- ☐ Blindness
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Wear glasses/contacts

Ears:
- ☐ Hearing aids

Nose/Sinuses:
- ☐ Allergic rhinitis
- ☐ Sinus infections

Mouth/Throat/Teeth:
- ☐ Dentures

Cardiovascular:
- ☐ Aneurysm
- ☐ Angina
- ☐ DVT
- ☐ Dysrhythmia
- ☐ Hypertension (HTN)
- ☐ Murmur
- ☐ Myocardial infarction (heart attack)
- ☐ Heart Failure (CHF)
- ☐ Other heart disease

Respiratory:
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Pleuritis
- ☐ Pneumonia
- ☐ Lung disease

Gastrointestinal:
- ☐ Cirrhosis
- ☐ Gallbladder disease
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hiatal hernia
- ☐ Jaundice
- ☐ Stomach Ulcer

Genitourinary:
- ☐ Hernia
- ☐ Incontinence
- ☐ Nephrolithiasis
- ☐ Other kidney disease
- ☐ Liver disease
- ☐ Hepatitis
- ☐ STDs
- ☐ UTI(s)

Musculoskeletal:
- ☐ Arthritis
- ☐ Gout
- ☐ M/S injury
- ☐ Ankylosing Spondylitis
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Osteoporosis

Skin:
- ☐ Dermatitis
- ☐ Mole(s)
- ☐ Other skin condition(s)
- ☐ Psoriasis

Neurological:
- ☐ Epilepsy
- ☐ Seizures
- ☐ Severe headaches, migraines
- ☐ Stroke
- ☐ TIA
- ☐ Alzheimer's

Psychiatric:
- ☐ Bipolar disorder
- ☐ Depression
- ☐ Hallucinations, delusions
- ☐ Suicidal ideation
- ☐ Suicide attempts

Endocrine:
- ☐ Goiter
- ☐ Hyperlipidemia (high cholesterol)
- ☐ Hypothyroidism
- ☐ Thyroid disease
- ☐ Thyroiditis
- ☐ Type I Diabetes
- ☐ Type II Diabetes

Heme/Onc:
- ☐ Anemia
- ☐ Cancer
- ☐ Bleeding disorder
- ☐ Bleeds easily
- ☐ Blood clots

Infectious:
- ☐ HIV
- ☐ STDs
- ☐ Tuberculosis (dz)
- ☐ Tuberculosis (exposure)
- ☐ AIDS

Other:
- ☐ Alcoholism
- ☐ Anxiety
- ☐ Mental illness
- ☐ Fibromyalgia
- ☐ Other: _____

PAST SURGICAL HISTORY – Please check all that apply

Common Surgeries:
- ☐ Aneurysm repair
- ☐ Appendectomy
- ☐ Back surgery
- ☐ Bariatric surgery/gastric bypass
- ☐ Bilateral tubal ligation
- ☐ Breast resection/mastectomy
- ☐ CABG
- ☐ Carotid endarterectomy/stent
- ☐ Carpal tunnel release surgery
- ☐ Cataract/lens surgery
- ☐ Cesarean section
- ☐ Cholystectomy/bile duct surgery
- ☐ Dilation & curettage
- ☐ Hemorrhoid surgery
- ☐ Hip arthroplasty
- ☐ Hip replacement
- ☐ Hysterectomy
- ☐ Inguinal hernia repair
- ☐ Knee arthroplasty
- ☐ LASIK
- ☐ Laminectomy
- ☐ Nasal surgery
- ☐ PTCA/PCI
- ☐ Pacemaker/ defibrillator
- ☐ Prostate surgery
- ☐ Prostatectomy
- ☐ Rotator cuff surgery
- ☐ Sinus surgery
- ☐ Skin cancer excision
- ☐ Spinal fusion
- ☐ TAH-BSO
- ☐ TURP
- ☐ Tonsillectomy/ adenoidectomy
- ☐ Vasectomy

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FAMILY HISTORY – Please check all that apply

Mother	Father	Brother(s)	Sister(s)
☐ No Health Concern	☐ No Health Concern	☐ No Health Concern	☐ No Health Concern
☐ Arthritis	☐ Arthritis	☐ Arthritis	☐ Arthritis
☐ Asthma	☐ Asthma	☐ Asthma	☐ Asthma
☐ Bleeding disorder	☐ Bleeding disorder	☐ Bleeding disorder	☐ Bleeding disorder
☐ Coronary artery disease < age 55	☐ Coronary artery disease < age 55	☐ Coronary artery disease < age 55	☐ Coronary artery disease < age 55
☐ COPD	☐ COPD	☐ COPD	☐ COPD
☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes
☐ Heart attack	☐ Heart attack	☐ Heart attack	☐ Heart attack
☐ Heart disease	☐ Heart disease	☐ Heart disease	☐ Heart disease
☐ High cholesterol	☐ High cholesterol	☐ High cholesterol	☐ High cholesterol
☐ Hypertension	☐ Hypertension	☐ Hypertension	☐ Hypertension
☐ Mental illness	☐ Mental illness	☐ Mental illness	☐ Mental illness
☐ Osteoporosis	☐ Osteoporosis	☐ Osteoporosis	☐ Osteoporosis
☐ Stroke	☐ Stroke	☐ Stroke	☐ Stroke
☐ Cancer (please specify):_____	☐ Cancer (please specify):_____	☐ Cancer (please specify):_____	☐ Cancer (please specify):_____
☐ Deceased	☐ Deceased	☐ Deceased	☐ Deceased
☐ Unknown	☐ Unknown	☐ Unknown	☐ Unknown
		☐ N/A	☐ N/A

SOCIAL HISTORY– Please check all that apply

Tobacco:
- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Heavy tobacco smoker
- ☐ Light tobacco smoker
- ☐ Never smoker
- ☐ Smoker, current status unknown
- ☐ Unknown if ever smoked

Alcohol:
- ☐ Do not drink
- ☐ Drink daily
- ☐ Frequently drink
- ☐ Occasional drink
- ☐ History of alcoholism

Drug Abuse:
- ☐ Intravenous drug use
- ☐ Illicit drug use
- ☐ No illicit drug use

Cardiovascular:
- ☐ Eat healthy meals
- ☐ Regular exercise
- ☐ Take daily aspirin

Safety:
- ☐ Household Smoke detector
- ☐ Keep Firearms in home
- ☐ Wear seatbelts

Sexual Activity:
- ☐ Exposure to STI
- ☐ Homosexual encounters
- ☐ Not sexually active
- ☐ Safe sex practices
- ☐ Sexually active

Custom Items:
- ☐ Caffeine Usage

Height:_____

Weight:_____

Patient Signature: _____ Date: _____

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PAIN QUESTIONNAIRE

Current Medications (please list all medications/vitamins including dosage and frequency): ☐ None

**If you need additional space to document medications, please attach a medication list to paperwork.*

Allergies (please list allergen, reaction, severity and date of onset): ☐ No known allergies

**If you need additional space to document allergies, please attach an allergy list to paperwork.*

REVIEW OF SYSTEMS – Are you currently or have you ever had problems with the following

Immune System	☐ Yes ☐ No	Describe:
Cardiovascular	☐ Yes ☐ No	Describe:
Constitutional (chills, weight gain/loss)	☐ Yes ☐ No	Describe:
Endocrine (temperature sensitivity)	☐ Yes ☐ No	Describe:
Ears, Nose, Throat	☐ Yes ☐ No	Describe:
Eyes/Vision	☐ Yes ☐ No	Describe:
GI (abdominal pain, bladder, bowel)	☐ Yes ☐ No	Describe:
GU (painful urination, incontinence)	☐ Yes ☐ No	Describe:
Hema/Lymphs (easy bleeding)	☐ Yes ☐ No	Describe:
Integumentary (brittle hair, nails)	☐ Yes ☐ No	Describe:
Musculoskeletal	☐ Yes ☐ No	Describe:
Neurological (dizziness, weakness, gait)	☐ Yes ☐ No	Describe:
Psychiatric (anxiety, depression)	☐ Yes ☐ No	Describe:
Reproductive	☐ Yes ☐ No	Describe:
Respiratory	☐ Yes ☐ No	Describe:

Please describe any other issues not listed above: _____

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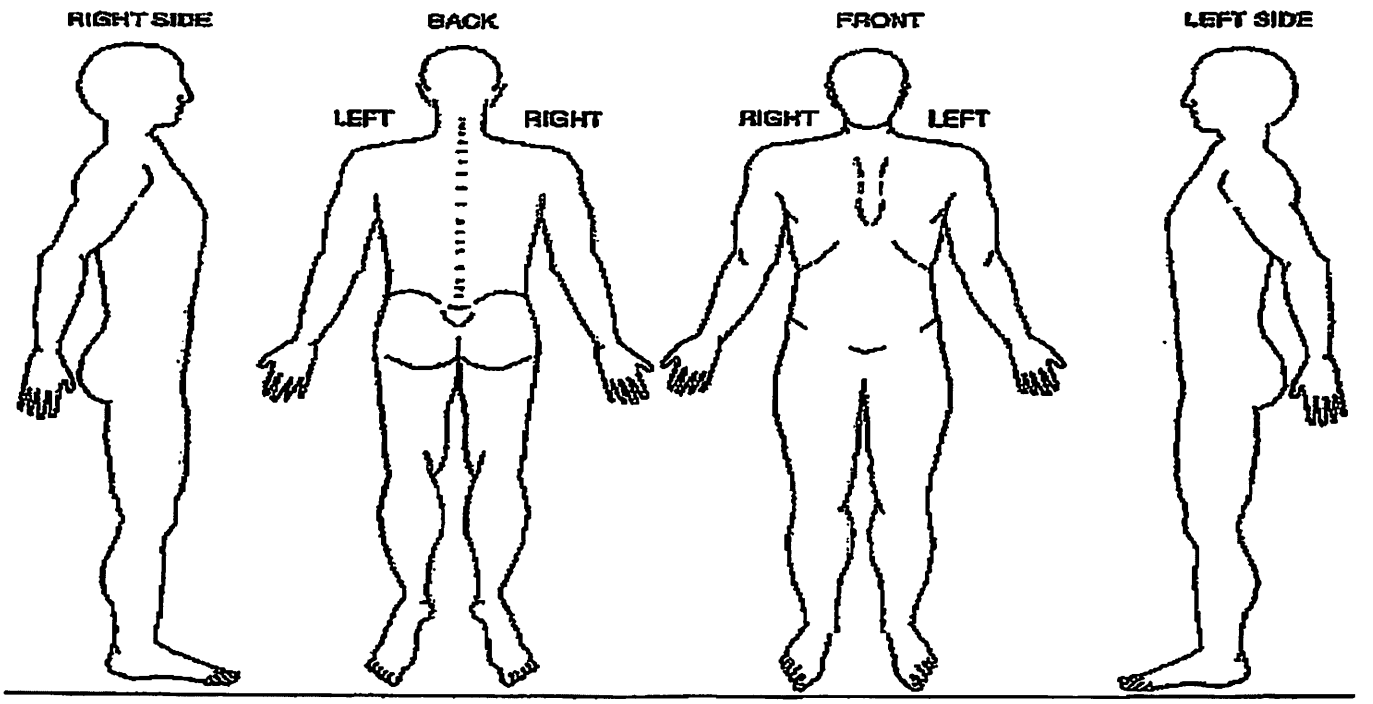
PAIN DIAGRAM

Please indicate in the table below the percentage of pain you currently feel in your neck, arm, back and legs. Example (0%, 25%, 75%, 100%; total should equal 100%)

Neck Pain_____%	Arm Pain_____%
Back Pain_____%	Leg Pain_____%

Please mark the area of pain on the diagram below using the appropriate symbols (Location):

Pain or burning: xxxxxxx Numbness: oooooo Pins and Needles: =====



Does your pain radiate (Radiation)? ☐ No ☐ Yes If yes, please describe: _____

When did your pain begin (Onset)? Date: _____

What symptoms are you experiencing with your pain (Symptoms)? _____

Is your pain constant or intermittent (Duration)? _____

Is your pain increased by any of the following (Aggravation)?

☐ Standing ☐ Walking ☐ Bending/Twisting ☐ Sitting ☐ Laying ☐ Other: _____

Is your pain relieved by any of the following (Relief)?

☐ Sitting ☐ Laying ☐ Standing ☐ Other: _____

What is your pain intensity on a scale of 0-10 with 0= no pain and 10= the worst pain (Level)? _____

STEM CELL INSTITUTE | THE PAIN RELIEF CENTER | WELLNESS CENTER | MICROSURGERY SPINE AND PAIN INSTITUTE

FINANCIAL POLICY AND BILLING PROCEDURES

- All patients must complete our "Patient Information Sheet"
- Full payment is due at the time services are rendered unless other arrangements have previously been made and agreed upon. (e.g. credit card on file for balance)
- We accept cash, check, and all major credit cards. There will be a $30.00 fee for any returned check.
- **Referrals, if necessary, must be presented at the time of your visit. IT IS YOUR RESPONSIBILITY TO OBTAIN AND TRACK YOUR OWN REFERRAL.**

The fees we charge for services are usual and customary for this area. Your insurance policy may base its allowance on a fixed fee schedule, which may or may not coincide with our fees. You should be aware that different insurance companies can vary greatly on the types of coverage you may have. You should also be aware that your insurance carrier determines your financial responsibility, not our staff.

If you are an HMO or PPO patient, it is your responsibility to make sure all referral information from your primary care physician is in our office prior to your visit. We will require this referral authorization before we can render services to you. **If you do not provide the appropriate referral information at the time of your visit and services are rendered to you, you agree to pay our doctors their billed rate as a fee-for-service patient, foregoing any health care insurance coverage you may otherwise have had.** If you have Medicare, we will file the claim forms representing services rendered to you as "assignment accepted". If you have any secondary insurance, you agree to provide us with this information at the time of your visit so that we may file the appropriate claim forms for you.

All patients are responsible for paying their annual deductible, coinsurance and copay balances, as well as any non-covered service charges at the time of your visit. We do not accept Medicaid patients. If you are a Medicaid patient or anticipate applying for Medicaid for the payment of services rendered to you, by signing this agreement you understand that our doctor is accepting you as a private-pay patient and not as a Medicaid patient for any services rendered to you and that you will be responsible for paying for the services you receive from our doctors. We will not file a claim with Medicaid for the services provided to you.

I, _____(Patient or Legal Guardian) have read the above information and fully understand that I am responsible for the payment of all applicable charges at the time services are rendered. I authorize the release of my medical and billing information for the purpose of seeking reimbursement through my medical policy and also agree that I am financially responsible for all charges not covered by my insurance policy.

Patient Signature: _____ Date: _____

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CONTROLLED SUBSTANCES CONTRACT

- **This contract applies only if the physician or other healthcare provider prescribes controlled medications to you.**

Controlled substance medications (e.g. "narcotics", benzodiazepines, "valium" or opiates) can be useful but have high potential for misuse and abuse. They are closely controlled by local, state and federal governments. If used improperly, they may cause adverse effects, such as vomiting, severe constipation, lethargy, overdose or even death. These medications can impair the ability to drive and operate machinery. If you are prescribed controlled substance medications by a healthcare provider at The Pain Relief Center, you must agree to the following conditions:

1) I (the patient) am responsible for my controlled substance medications. If the prescription is lost, misplaced or stolen, or if I run out sooner than my healthcare provider intended, I understand that it will not be replaced.
2) I will not request or accept controlled substance medications from any other physician or individual unless prior arrangements have been made with The Pain Relief Center. Exceptions are hospital and emergency room visits, but these must be reported to the physician in a timely fashion.
3) I will follow The Pain Relief Center refill policies for controlled substance medications. Policies include:
    1) Refills are authorized only during regular business hours and require a visit with a provider in the clinic.
    2) Refill requests on Fridays and over the weekends will not be addressed until the next business day. **NO EXCEPTIONS WILL BE MADE.**
    3) Refills are not authorized if the patient "runs out early" or as an emergency if the patient suddenly realizes that he or she will "run out tomorrow". The Pain Relief Center expects patients to anticipate the next refill date.
4) I will use only one pharmacy for all my pain medications.
5) I understand that if I violate any of the above conditions or decline to take a urine test for controlled substances at my healthcare providers' request, my prescription for these medications may be ended immediately. The Pain Relief Center also reserves the right to report the specifics of the situation to my primary care physician, local medical facilities or law enforcement authorities.

Patients prescribed controlled substance medications by healthcare providers at The Pain Relief Center should also understand that tolerance (the need for more pain medication to achieve the same effect), dependence (the presence of withdrawal symptoms when abruptly ceasing the medication) and addiction (abnormal psychological dependence characterized by desire for euphoria when taking these medications) can develop while taking these medications. The main treatment goal is the improve functions, which also requires maintenance of a healthy lifestyle.

Patient Signature: _____ Date: _____

THE PAIN RELIEF CENTER

This notice is to inform you that some services provided by our office may be billed as out of network services. This may include but are not limited: laboratory services, durable medical equipment, anesthesia services. Each of these is billed by an outside company and all billing questions will need to be directed that specific company

By signing this, you acknowledge that you have been notified of the out of network services. All questions or concerns can be directed to Maya Graham, Practice Manager or you may call our main number at 214-709-1904

_____ _____

Signature Date

_____

Printed Name

Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/____

Witness:_____ Date: ____/____/____

OUT

THE PAIN RELIEF CENTER | MICROSURGERY SPINE AND PAIN INSTITUTE

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ **Date of Birth:** _____

Phone: H) _____ **Phone: W)** _____

Address: _____ **City/State/Zip:** _____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: TPRC / MSPI **Facility Phone:** 214-709-1904

Facility Address: 7709 San Jacinto Pl Suite 101 **Facility Fax:** 214-279-8969

City, ST, Zip: Plano, TX 75024

Dates and Type of information to disclose:

- ☐ Full Records
- ☐ Dates Other: _____
- ☐ Specific Information Requested: _____

The purpose of disclosure is:

- ☐ Change of Insurance or Physician
- ☐ Continuation of Care (e.g., VA Med Ctr)
- ☐ Referral
- ☐ Other _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: _____

Address: _____

City, State, Zip: _____

Fax: _____ **Phone:** _____

- ☐ **Please mail records.**
- ☐ **Please fax records.**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.**
If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X _____ _____

Signature of Patient / Parent / Guardian or Authorized Representative (Guardian or Authorized Representative must attach documentation of such status.) **Date**

_____ _____

Printed name of Authorized Representative Relationship / Capacity to patient

_____

Address and telephone number of authorized representative

THE PAIN RELIEF CENTER

DISCLOSURE OF PHYSICIAN OWNERSHIP
NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

1. Gabriel Rodriguez, M.D. has financial interest of the following companies:
    1. Dallas Anesthesia Consultants.
    2. Preferred Imaging
    3. Southwest Laboratories
    4. Preston Surgical Center THR
    5. DFW Wellness
    6. ASID surgical center
    7. My Lab, LLC
    8. Texas Rx pharmacy

    Management Company service agreements – variety of ancillary services including pharmacy, surgical kits, and laboratories.

2. You have the right to choose the provider of your health care services. Therefore, you have the option to use providers other than those in which Dr Gabriel Rodriguez has personal stake in.
3. You will not be treated differently by your physician if you choose to obtain health care services from another company.

If you have any questions concerning this notice, please feel free to ask your physician or any representative The Pain Relief Center. We welcome you as a patient and value our relationship with you.