PATIENT INTAKE FORM

DIAGNOSTIC PAIN CENTER

Your completed intake paperwork helps our providers get to know you and your medical history. We rely on its accuracy and completeness to provide you with the best care possible. Please take your time and inquire at our front desk or call (512) 981-7246 if you have any questions or are unsure how to complete any section of this form.

Today's Date _____

Patient Information

Name: _____ Social Security Number: _____

Street Address: _____ Date of Birth: _____ Age: _____

City/State/Zip: _____ Height: _____ Weight: _____ lbs

Email: _____ Gender: □ Male □Female

Physical Address Same as Mailing? □ Yes □ No If not: _____

Preferred Phone: _____ □Home □ Mobile □ Work

Secondary Phone: _____ □Home □ Mobile □ Work

Email: _____ Driver's License#/State: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Marital Status: □ Married □ Single □Divorced □ Widowed □ Other _____

Primary Care Doctor: _____

Race (Question required by Affordable Care Act): □ American Indian or Alaskan Native
□ Asian or Pacific Islander □ African American □ Caucasian □ Refuse to Report

Ethnicity (Question required by Affordable Care Act): □ Hispanic □ Non-Hispanic □ Refuse to Report

Primary Language: □ English □ Spanish □ Other

Have you **ever** had a Worker's Compensation Claim? (If yes, contact our staff) □ Yes □ No

Referral

Who can we thank for referring you to our clinic? _____

If you were not referred, how did you hear about us? □ Insurance Company □ Family □ Friend □ PCP
□Facebook □Twitter □Google □Yelp □Healthgrades □Yellow Pages □Other: _____

Preferred Pharmacy

Pharmacy Name: _____ Phone Number: _____

Street Address: _____ City/State/Zip: _____

Primary Insurance Plan

Payer (e.g. BC/BS): _____ Plan: _____

Policy/I.D. Number: _____ Group Number: _____

Complete this box if you are *not* the policy holder for your primary insurance

Insurance policy holder: □ Self □Spouse □ Child □ Other: _____

Policy Holder Name: _____ Policy Holder Gender: □ Female □ Male

Date of Birth: _____ Social Security Number: _____

Secondary Insurance Plan (if any)

Payer (e.g. BC/BS): _____ Plan: _____

Policy/I.D. Number: _____ Group Number: _____

Complete this box if you are *not* the policy holder for your secondary insurance

Insurance policy holder: □ Self □Spouse □ Child □ Other: _____

Policy Holder Name: _____ Policy Holder Gender: □ Female □ Male

Date of Birth: _____ Social Security Number: _____

Law Firm (if applicable)

Complete this section only if your visit today is related to a personal injury legal claim

Law Firm: _____ Lawyer Name: _____

Phone Number: _____ Paralegal/Representative: _____

Fax Number: _____ Date of initial injury: _____

Authorization to Leave Messages Concerning Your Care

You may leave messages on my answering machine for the following: (Please check all that apply)

□ Confirming appointments □ Scheduling procedure information □ Message to return call

Please list (s) of persons you authorize to take a message from our staff regarding your care:

Name: _____ Phone: _____

Name: _____ Phone: _____

Medical History, Consent for Treatment, and Assignment of Benefits

I certify that the information that I provided in this document is accurate, complete and true.

I authorize Diagnostic Pain Center (DPC) and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness. Additionally, I acknowledge that DPC will access the Texas DPS website in regards to prescription medications. I give my consent for Diagnostic Pain Center to retrieve and review my medication history. I understand this will become part of my medical record.

I acknowledge that I have had the opportunity to review Diagnostic Pain Center's Notice of Privacy Practices which is displayed for public inspection at its facility and online. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

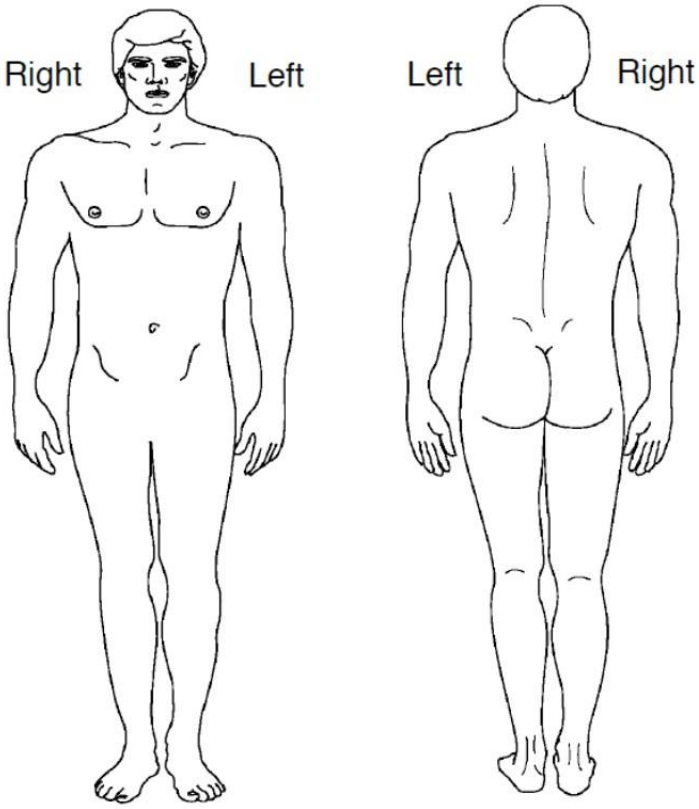
I authorize the Diagnostic Pain Center to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, physicians involved in my care, and any physician(s) to whom I may be referred. I also authorize Diagnostic Pain Center to release any information required in obtaining procedure authorization or the processing of any payment claims. Diagnostic Pain Center will not release my Protected Health Information to any other (including family) without my completing a written "Patient Authorization for Use and Disclosure of protected Health Information" form, available at its facility and online.

I hereby assign any/all medical and/or surgical benefits to which I am entitled through Medicare, Medicaid, Worker's Compensation, Letter of Protection or any other governmental or private insurance or health plans to Diagnostic Pain Center. This assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as the original. I understand that I am solely responsible for obtaining any/all referrals required by my insurance carrier in order to see Dr. Robert Marks and/or his associate(s) at Diagnostic Pain Center under the coverage of my insurance carrier(s). I also understand that if I fail to obtain the proper referral and my insurance declines to cover any date of service, if my insurance declines to cover any date of service for any reason, and/or if I fail to provide complete and accurate insurance information on this form, I am financially responsible for all affected date(s) of service and agree to promptly pay any fees due for those dates of service.

Signed: _____ Date: _____

Use this diagram to indicate the location of your pain. Mark the drawing with the following letters that best describe your symptoms:

"N" = Numbness
"S" = Stabbing
"B" = Burning
"P" = Pins and needles
"A" = Aching



Where is your worst pain located? _____

Does this pain radiate? If so, where? _____

Please list any additional areas of pain: _____

Onset of Symptoms

Approximately when did this pain begin? _____

What caused your current pain episode? _____

Is your pain the result of a Motor Vehicle Accident or Personal Injury (legal term describing injury sustained to your person by negligence of another) □ Yes □No

How did your current pain episode begin? □ Gradually □Suddenly

Since your pain began, how has it changed? □ Decreased □ Increased □Stayed the same

In the past three months have you developed any new:

□ Balance Problems □ Bladder incontinence □ Bowel incontinence □ Chills
□ Difficulty Walking □ Fevers □ Nausea □ Vomiting
□ Loss of Sensation – Where? _____ □ Loss of Strength – Where? _____
□ I HAVE NOT RECENTLY DEVELOPED ANY OF THE ABOVE CONDITIONS.

What aspects of your life are affected by your pain? (Check All That Apply)?

□ Performing activities of daily living □ Engaging in a normal lifestyle
□ Performing work-related activities □ Achieving adequate sleep

Pain Description

Check all of the following that describe of your pain:

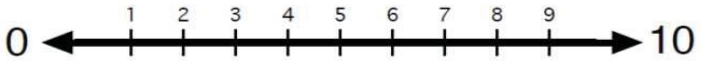
□ Aching	□ Hot/Burning	□ Shooting	□ Stabbing/Sharp
□ Cramping	□ Numbness	□ Spasms	□ Throbbing
□ Dull	□ Shock-like	□ Squeezing	□ Tingling
□ Pins & Needles	□ Constant dull/aching background pain with exacerbations as checked above		

What word best describes the frequency of your pain? □ Constant □ Intermittent

When is your pain at its worst? □ Mornings □ During the day □ Evenings □ Middle of the night
□ Progressively worsens throughout the day □ No changes – it's inconsistent or always the same

Use the pain scale described below to rate your pain for the questions below:

0 – Pain-free
1 – Very minor annoyance, occasional minor twinges
2 – Minor annoyance, occasional strong twinges
3 – Annoying enough to be distracting
4 – Can be ignored if you are really involved in your work/task, but still distracting
5 – Cannot be ignored for more than 30 minutes
6 – Cannot be ignored for any length of time, but you can still go to work and participate in social activities
7 – Makes it difficult to concentrate, interferes with sleep, but you can still function with effort
8 – Physical activity is severely limited. You can read and talk with effort. Pain causes Nausea and dizziness
9 – Unable to speak, crying out or moaning uncontrollably, near delirium
10 – Unconscious, pain makes you pass out



_____ What number on the pain scale (0-10) best describes your **CURRENT pain**?

_____ What number on the pain scale (0-10) best describes your **LEAST pain**?

_____ What number on the pain scale (0-10) best describes your **WORST pain**?

_____ What number on the pain scale (0-10) best describes your **AVERAGE pain**?

What Makes Your Pain Worse? (Check All That Apply)

□ Bending/Stooping	□ Coughing/Sneezing	□ Driving	□ Lifting
□ Lying FLAT	□ Lying SIDEWAYS	□ Physical Activity	□ Sexual Intercourse
□ Prolonged Sitting	□ Prolonged Standing	□ Straining	□ Stress/Anxiety
□ Twisting	□ Walking	□ Walking UP Stairs	□ Walking DOWN Stairs
□ Looking UP	□ Looking DOWN	□ Looking LEFT	□ Looking RIGHT

Diagnostic Tests and Imaging

Mark all of the following tests you have had that are related to your current pain complaints:

□ MRI of the_____ Date:_____ Facility: _____

□ X-ray of the_____ Date:_____ Facility: _____

□ CT scan of the_____ Date:_____ Facility: _____

□ EMG/NCV study of the_____ Date:_____ Facility: _____

□ Other diagnostic testing: _____

□ I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS.

Past Medication Treatments: Which medications have you tried? (Check all that apply)

Anti-Inflammatories:

□ Naproxen (Aleve, Naprosyn) □ Zipreant □ Ibuprofen (Advil, Motrin) □ Meloxicam (Mobic)
□ Celecoxib (Celebrex) □ Rofecoxib (Vioxx) □ Valdecoxib (Bextra) □ Sulindac (Clinoril)
□ Diclofenac (Arthrotec, Voltaren, Voltaren Gel) □ Etodolac (Lodine) □ Flector patch
□ Indomethacin (Indocin) □ Nabumetone (Relafen) □ Oxaprozin (Daypro) □ Aspirin
□ Steroids (Medrol Dose-Pak, Prednisone, Methylprednisolone) □ Other: _____

Antidepressants/Anxiolytics:

□ Amitriptyline (Elavil) □ Nortriptyline (Pamelor, Aventyl) □ Duloxetine (Cymbalta)
□ Bupropion (Wellbutrin) □ Citalopram (Celexa) □ Effexor □ Imipramine □ Escitalopram (Lexapro)
□ Fluoxetine (Prozac) □ Paxil □ Pristiq □ Remeron □ Sertraline (Zoloft) □ Serzone □ Trazodone
□ Other: _____

Beta Blockers (For Pain/Headache Purposes):

□ Blocadren (Timolol) □ Inderal (Propranolol) □ Tenormin (Atenolol) □ Toprol (Metoprolol)
□ Corgard (Nadolol)

Calcium Channel Blockers (For Pain/Headache Purposes):

□ Verapamil

Muscle Relaxants:

□ Baclofen □ Carisoprodol (Soma) □ Cyclobenzaprine (Flexeril, Amrix) □ Metaxalone (Skelaxin)
□ Methocarbamol (Robaxin) □ Tizanidine (Zanaflex) □ Other: _____

Opioids:

□ Buprenorphine (Butrans Patch, Belbuca, Suboxone, Subutex) □ Codeine □ Demerol □ Cinnysola
□ Fentanyl (Actiq, Duragesic Patch, Fentora) □ Hydrocodone (Lortab, Norco, Vicodin, Vicoprofen, Zohydro)
□ Hydromorphone (Dilaudid, Exalgo) □ Methadone □ Morphine (Avinza, Embeda, Kadian, MS Contin)
□ Oxycodone (Oxycontin, Percocet) □ Oxymorphone (Opana, Opana ER) □ Propoxyphene (Darvocet, Darvon)
□ Tapentadol (Nucynta) □ Tramadol (Ultram, Ultram ER) □ Other: _____

Triptans:

□ Axert (Almotriptan) □ Frova (Frovatriptan) □ Imitrex (Sumatriptan) □ Maxalt (Rizatriptan)
□ Relpax (Eletriptan) □ Zomig (Zolmitriptan) □ Other: _____

Other:

□ Acetaminophen (Tylenol) □ Depakote (Divalproex) □ Depakene (Valproic Acid) □ Gabapentin (Neurontin)
□ Lidocaine Patch (Lidoderm) □ Lyrica (Pregabalin) □ Tegretol (Carbamazepine) □ Topamax (Topiramate)

□ Topical Pain Cream (which one, if known?): _____

□ Other: _____

Pain Treatment History

HOW DO THE FOLLOWING TREATMENTS IMPACT YOUR PAIN?

*** IF YOU HAVEN'T TRIED IT, LEAVE THE ROW BLANK ***

TREATMENT	No Relief	Temporary Relief	Excellent Relief	DATE(S)? (ok to approximate)
Acupuncture				
Botox Injections				
Chiropractic				
Epidural Steroid Injection: Circle: Cervical / Thoracic / Lumbar				
Facet Joint Injection / Medial Branch Block: Circle: Cervical / Thoracic / Lumbar				
Heat (Heating Pad; Hot Bath)				
Ice Packs				
Joint Injections: Which joint(s)_____				
Massage				
Nerve Blocks: Which nerve(s)_____				
Physical Therapy				
Podiatrist Treatment				
Psychotherapy				
Radiofrequency Ablation (AKA "nerve burning"): Location: _____				
Spinal Cord Stimulator: Circle: Trial / Permanent Implant				
Stretching				
Surgery Details:_____				
TENS Unit				
Traction				
Trigger Point Injection(s) Where:_____				
Vertebroplasty/Kyphoplasty				

Please describe any further details regarding previous pain treatments: _____

_____

_____

What **positions** make your pain **better** (i.e., sitting in a recliner, bending forward, etc.): _____

What other specialists have you seen regarding your pain? _____

□ I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS.

Anesthesia History

Have **you** ever had any adverse reactions to anesthesia? □ Yes □No

If yes, which type of anesthesia did you have problems with? (Please check all that apply)

□ Local anesthesia □ Epidural □ General Anesthesia □IV Sedation

Has a **family member** ever had any adverse reactions to anesthesia? □ Yes □No

If yes, which type of anesthesia did they have problems with? (Please check all that apply)

□ Local anesthesia □ Epidural □ General Anesthesia □IV Sedation

Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the date, type, and any pertinent details.

Abdominal Surgery

□ Gallbladder removal _____

□ Appendectomy _____

□ Other _____

Female Surgeries

□ Caesarean section _____

□ Hysterectomy _____

□ Laparoscopy _____

□ Ovarian _____

□ Other _____

Heart Surgery

□ Valve replacement _____

□ Aneurysm repair _____

□ Stent placement _____

□ Other _____

Joint Surgery

□ Shoulder _____

□ Hip _____

□ Knee _____

Spine/Back Surgery

□ Discectomy (levels) _____

□ Laminectomy _____

□ Spinal fusion (levels) _____

Other Common Surgeries

□ Hemorrhoid surgery _____

□ Hernia repair _____

□ Thyroidectomy _____

□ Tonsillectomy _____

□ Vascular surgery _____

Please list any other surgeries and dates (attach an additional sheet if necessary):

□ I HAVE NEVER HAD ANY SURGICAL PROCEDURES.

Current Medications

Please indicate which (if any) of the following blood-thinners you are taking:
□ Aggrenox □ Coumadin / Warfarin □ Effient □ Lovenox □ Plavix □ Pletal □ Pradaxa □ Prasugrel
□ Ticlid □ Aspirin □ Other _____

Please list *all* medications you are currently taking. Attach an additional sheet, if required.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

Allergies

Do you have any known drug allergies? □ Yes □ No

If so, please list all medications you are allergic to.

Medication Name	**Allergic Reaction Type**

Topical Allergies: □ Iodine □ Latex □ Tape Are you allergic to shellfish? □ Yes □ No

Family History

Mark all appropriate diagnoses as they pertain to your biological *MOTHER AND FATHER* only.

	Arthritis	Cancer	Diabetes	Headaches	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Problems	Liver Problems	Osteoporosis	Rheumatoid Arthritis	Seizure	Stroke
Mother													
Father													

Other medical problems: _____

□ I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY. □ I AM ADOPTED (No Medical History Available).

Social History

Are you capable of becoming pregnant? □ Yes □ No *If so*, are you currently pregnant? □ Yes □ No

Highest level of education: □ Grammar school □ High School □ College □ Post-graduate

Alcohol Use: □ Daily Limited Use □ History of Alcoholism □ Current
□ Never Drinks Alcohol □ Drinks Alcohol Socially

Tobacco Use: □ Current Tobacco User □ Former Tobacco User □ Has Never Used Tobacco

Illegal Drug Use: □ Denies Any Illegal Drug Use □ Currently Using Illegal Drugs (Which:_____)
□ Formerly Used Illegal Drugs (not currently using) (Which:_____)
□ Currently Using Someone Else's Prescription Medications

Have you ever abused narcotic or prescription medications? □ Yes □ No (Which:_____)

Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

General Medical
- □ Cancer – Type _____
- □ Diabetes – Type _____
- □ HIV/AIDS

Head/Eyes/Ears/Nose/Throat
- □ Headaches
- □ Migraines
- □ Head Injury
- □ Hyperthyroidism
- □ Hypothyroidism
- □ Glaucoma

Cardiovascular/Hematologic
- □ Anemia
- □ Bleeding Disorders
- □ Heart Attack
- □ High Blood Pressure
- □ High Cholesterol
- □ Mitral Valve Prolapse
- □ Murmur
- □ Phlebitis
- □ Poor Circulation
- □ Stroke
- □ Coronary Artery Disease

Respiratory
- □ Asthma
- □ Bronchitis
- □ Emphysema/COPD
- □ Pneumonia
- □ Tuberculosis
- □ Valley Fever

Gastrointestinal
- □ Bowel Incontinence
- □ GERD (Acid Reflux)
- □ Gastrointestinal Bleeding
- □ Constipation

Musculoskeletal
- □ Amputation
- □ Bursitis
- □ Carpal Tunnel Syndrome
- □ Chronic Low Back Pain
- □ Chronic Neck Pain
- □ Chronic Joint Pain
- □ Fibromyalgia
- □ Joint Injury
- □ Osteoarthritis
- □ Osteoporosis
- □ Phantom Limb Pain
- □ Rheumatoid arthritis
- □ Tennis Elbow
- □ Vertebral Compression Fracture

Genitourinary/Nephrology
- □ Bladder Infection(s)
- □ Dialysis
- □ Kidney Infection(s)
- □ Kidney Stones
- □ Urinary Incontinence

Hepatic
- □ Hepatitis A (active/inactive/unsure)
- □ Hepatitis B (active/inactive/unsure)
- □ Hepatitis C (active/inactive/unsure)

Neuropsychological
- □ Alcohol Abuse
- □ Alzheimer Disease
- □ Bipolar Disorder
- □ Depression
- □ Epilepsy
- □ Prescription Drug Abuse
- □ Multiple Sclerosis
- □ Paralysis
- □ Peripheral Neuropathy
- □ Schizophrenia
- □ Seizures
- □ Reflex Sympathetic Dystrophy/CRPS
- □ Other Diagnosed Conditions

_____

Review of Systems

Mark the following symptoms that you currently suffer from. *Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.*

Constitutional:
- □ Chills
- □ Difficulty Sleeping
- □ Easy Bruising
- □ Excessive Sweating
- □ Excessive Thirst
- □ Fatigue
- □ Fevers
- □ Insomnia
- □ Low Sex Drive
- □ Night Sweats
- □ Tremors
- □ Unexplained Weight Gain
- □ Unexplained Weight Loss

Eyes:
- □ Recent Visual Changes
- □ Vision Loss

Ears/Nose/Throat/Neck:
- □ Dental Problems
- □ Earaches
- □ Hearing Problems
- □ Nosebleeds
- □ Recurrent Sore Throats
- □ Ringing in the Ears
- □ Sinus Problems

Cardiovascular: □ Bleeding Disorder □ Chest Pain □ Deep Vein Thrombosis
□ Fainting □ High Blood Pressure □ Irregular Heartbeat □ Lightheadedness
□ Shortness of Breath During Sleep □ Swelling in the Feet

Respiratory: □ Cough □ Wheezing □ Pulmonary Embolism
□ Shortness of Breath on Exertion/Effort □ Shortness of Breath at Rest

Gastrointestinal: □ Abdominal Cramps □ Acid Reflux □ Constipation
□ Coffee Ground Appearance in Vomit □ Dark and Tarry Stools □ Diarrhea
□ Hernia □ Vomiting

Musculoskeletal: □ Back Pain □ Joint Pain □ Joint Stiffness
□ Joint Swelling □ Muscle Spasms □ Neck Pain

Genitourinary/Nephrology: □ Blood in Urine □ Painful Urination
□ Decreased Urine Flow/Frequency/Volume □ Flank Pain

Neurological: □ Tremors □ Dizziness □ Headaches
□ Numbness/Tingling □ Seizures

Psychiatric: □ Depressed Mood □ Feeling Anxious □ Stress Problems
□ Suicidal Thoughts □ Suicidal Planning

DIAGNOSTIC PAIN CENTER

Robert S. Marks, M.D.
Board Certified in Pain Management and Anesthesiology
Fellowship-Trained Interventional Pain Specialist

EXCHANGE OF INFORMATION:

I authorize DPC to disclose to, or obtain from, to the extent allowed by law, my medical and financial record to: (a) any insurance company, attorney, insurance adjuster, employer, or their representatives, agents, or employees that may be responsible for all or part of the payments due for services rendered to the patient; (b) any physician, clinic, hospital, or other healthcare provider who has provided services for me in the past or who may be providing future services (e.g. a consulting physician or a facility at which a procedure is to be performed); (c) the Centers for Medicare and Medicaid Services or any other government agency as required by local, state, or federal law; (d) any person or entity to provide quality and/or utilization review. This authorization can be revoked by submitting a request in writing to Diagnostic Pain Center, 12176 N. Mopac Expy, Ste D, Austin, Texas 78758.

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. We will not provide your medical information to your family, friends, or others not directly involved in your medical treatment unless specifically authorized by you in writing. We will not provide your name or other information for the purposes of marketing or fund raising. We strive to protect your health information, but there are situations where your medical information can be disclosed to others as determined by the Federal Government. Your health information may be provided to others for what the government calls "Treatment, Payment, and Operations." This includes sharing information with other physicians, providers, or pharmacists, reporting to your insurance company or worker's compensation carrier, Legal services, training programs, quality improvement programs, and the like. Your medical bills are sent by mail or by computer to the insurance carriers and may be reviewed by a billing company or clearinghouse before being forwarded to the insurance company. Finally, there are exceptions to the privacy agreement; your medical information may be provided to others without your consent in the following situations, as provided by law: (1) State of Texas reporting requirements, including, but not limited to, duty to warn individuals of a threat from a patient, duty to inform the Department of Public Safety after a seizure, or the duty to prevent a disaster; (2) State of Texas reporting requirements for worker's compensation claims; (3) State of Texas or local county public health activities; (4) Health oversight activities; (5) Legal proceedings; (6) Police investigations; (7) Any information needed on a deceased patient (i.e. by coroners, etc); (8) Any information needed for organ donation; (9) Certain types of research such as quality improvement initiatives (identity will be protected); (10) Any information needed by the government and not subject to privacy protection under Federal or State law. This notice is printed as required by Federal Law.

CONSENT TO TREAT:

I consent to all examination procedures and/or treatments prescribed by my physician and his/her assistant(s) or designee(s) as is necessary by his/her judgment. I recognize that refill authorizations and requests will not be handled outside of regular business hours or on weekends. A photocopy or scanned copy of this agreement shall be considered effective and valid as the original.

_____
PRINT NAME: Patient or Guarantor

_____ _____
SIGNATURE: Patient or Guarantor Date

Revised 12/30/2016

DIAGNOSTIC PAIN CENTER

Robert S. Marks, M.D.
Board Certified in Pain Management and Anesthesiology
Fellowship-Trained Interventional Pain Specialist

COMMUNICATION:
We intend to notify you of upcoming appointments or procedures. If the following methods are acceptable forms of such communication, please write the preferred contact information below. If you do not wish for us to contact you by Email or Text message, please leave the fields blank.

Email Address	Text Message	Phone Call

ASSIGNMENT OF BENEFITS:
I hereby assign to and authorize payment of all benefits due to me under any insurance policy, worker's compensation plan, auto insurance policy, Medicare, Medicaid, or any other 3rd party payor for any and all services provided by Diagnostic Pain Center ("DPC") or any of its individual practitioners directly to DPC or its individual practitioners. This assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as the original.

FINANCIAL AGREEMENT:
I understand and agree that all payments for services rendered are due at the time they are performed. I further understand and agree that I am financially responsible for all charges, including all fees assessed under this paragraph, whether or not my insurance provider accepts or denies any claim for payment, and agree to pay all sums due to DPC and/or its individual practitioners at the usual and customary charge for DPC. I understand that I am solely responsible for obtaining any/all referrals required by my insurance carrier in order to see Dr. Robert Marks and/or his associate(s) at Diagnostic Pain Center under the coverage of my insurance carrier. I also understand that if I fail to obtain the proper referral and my insurance declines to cover any date of service or if my insurance declines to cover any date of service for any reason, I am financially responsible for that date of service and agree to promptly pay any fees due for those dates of service. I understand and agree that there is a $25 fee for all missed office visits and a $100 fee for all missed surgical procedures that are not cancelled at least 24 hours in advance. I understand and agree that there is a $25 service fee for any returned checks regardless of reason. I further understand that I must leave a credit card on file with DPC if I wish to pay my bill by personal check. I authorize DPC to charge my credit card for the full balance owed plus applicable service charges if my check is returned for any reason whatsoever. I certify that I am the patient and/or I am financially responsible for the services rendered and do hereby unconditionally guarantee the full payment of the amount when and as due.

PRINT NAME: Patient or Guarantor

SIGNATURE: Patient or Guarantor

Date

Revised 12/30/2016

DIAGNOSTIC PAIN CENTER

Robert S. Marks, M.D.
North: 12176 N. Mopac Expy Ste D, Austin, Texas 78758
South: 3345 Bee Cave Rd #101, Austin, Texas 78746
www.DiagnosticPainCenter.com Phone/Fax: 512.981.7246

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: _____

{ } I authorize the release of information including the diagnosis, records, examination rendered to me, billing and claims information as requested. This information may be released to:
{ } Spouse _____
{ } Child(ren) _____
{ } Other _____
OR
{ } Information is not to be released to anyone.

This Release of Information will remain valid and in effect through 1/1/2018.

I understand that I have a right to revoke this authorization by providing written notice to ***Diagnostic Pain Center***. However, this authorization may *not* be revoked if ***Diagnostic Pain Center's*** employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may decline by marking the Information is not to be released to anyone box. This will not affect my services.

Signature: _____ Date: _____

Print Name: _____

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof. {Power of Attorney and/or guardianship papers, etc. MUST BE PROVIDED} I am legally authorized to act on the Patient's behalf with respect to this authorization form.

Name of Legal Representative: _____ Date: _____

Signature of Legal Representative: _____

Signature of Witness: _____ Date: _____

Signature of Witness: _____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (_____)_____ **ALT. PHONE** (_____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____Fax (_____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name: Robert S. Marks, M.D. / Diagnostic Pain Center
Address: 12176 N. Mopac Expy, Suite D
City: Austin State: Texas Zip Code: 78758
Phone: (512) 981-7246 Fax: (512) 981-7246

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes)
_____ Drug, Alcohol, or Substance Abuse Records
_____ Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)). **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.

Diagnostic Pain Center, Austin, TX

Robert S. Marks, M.D.

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT

AS REQUIRED BY THE TEXAS MEDICAL BOARD

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

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 therapy to be used, so that you may make the informed decision whether or not to take the drug after 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. For the purpose of this agreement the use of the word "physician" is defined to include not only my physician but also my physician's authorized associates, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat my condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician to treat my condition which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent to administer or prescribe the prescription(s) for dangerous and/or controlled drugs (medications) as an element in the treatment of my chronic pain.

It has been explained to me that these medication(s) include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

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 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 may result in my being discharged from your care.

For female patients only:

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

If I am not pregnant, I will use appropriate contraception/birth control 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.

All of the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics 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 / baby.

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 understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.

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 active 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 for some will 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 have been informed that the drug therapy that my physician may prescribe for me may involve using a drug that the Federal Food and Drug Administration may not have been asked by the manufacturer to review for safety for effectiveness for my condition. Current medical literature shows that such “off label” use may be beneficial to some patients and I understand that recommended dosages for treating chronic pain are often exceeded in order to balance the benefit and risk to the patient.

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.

PAIN MANAGEMENT AGREEMENT:

I UNDERSTAND AND AGREE TO THE FOLLOWING:
That this pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called 'narcotics, painkillers', and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand that there are 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.**

My physician may at any time choose to discontinue the 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:

- My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the **medication(s) may be discontinued**.
- I will **disclose** to my physician **all medication(s)** that I take at any time, prescribed by any physician.
- I will use the medication(s) **exactly as directed by my physician**.
- I agree **not to** share, sell or otherwise permit others, including my family and friends, to have access to these medications.
- I will **not allow or assist in the misuse/diversion of my medication**; **nor will I give or sell them** to anyone else.
- All medication(s) must be obtained at **one pharmacy, where possible**. Should the need arise to change pharmacies, my physician must be informed. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my physician to release my medical records to my pharmacist as needed.
- 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.**
- 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.
- I will receive medication(s) **only from ONE physician** unless it is for an emergency **or** the medication(s) that is being prescribed by another physician is approved by my physician. Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.
- If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then **my physician may try alternative medication(s) or may taper me off all medication(s**). I will not hold my physician liable for problems caused by the discontinuance of medication(s).
- I **agree to submit to 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 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.

- I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, 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 management program** recommended by my physician to achieve increased function and improved quality of life.
- I agree that I **shall inform any doctor** who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.
- I hereby give my physician **permission to** discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).
- I must take the medication(s) as instructed by my physician. **Any unauthorized increase** in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.
- I must **keep all follow-up appointments** as recommended by my physician or my treatment may be discontinued.

I certify and agree to the following:

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** 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.**

_____

Patient Signature

_____

Physician Signature (or Appropriately Authorized Assistant)

_____

_____

Name and contact information for pharmacy