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□ Collect Payment: $_____
□ Collect Insurance/Photo ID

RETURNING PATIENT INTAKE

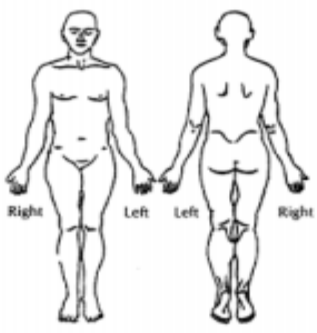
Patient's Name:_____ Date of Birth:_____
Date of Visit:_____ Primary Care Physician:_____

Please take a few minutes to fill out this medical intake to facilitate your appointment today.

About your Pain:

Chief Complaint:_____
Where are you feeling pain today?_____
Describe your pain (aching, burning, cramping, etc.)_____
Is the pain constant? □ Yes | □ No | □ N/A How long have you had the pain?_____
If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?
Right Now_____ The Best It Gets_____ The Worst It Gets_____
What makes your pain worse?_____
What makes your pain better?_____

Pain is (circle one): Constant / Intermittent
Pain is worse (circle one): Morning / Afternoon / Night
Does your pain interfere with sleep? Yes / No
Have you used a TENS unit? Yes / No
Last Physical Therapy:_____
With who?_____



Highlight PINK for pain & BLUE for numbness

Medical History

Have you ever had: □ Diabetes | □ Hypertension | □ Cancer| □ Other_____
Have you ever had surgery? □ Back Surgery □ Neck Surgery
Are you a smoker? □ Yes | □ No
Are you employed? □ Yes | □ No

Review of Systems

Are you having any gastrointestinal symptoms? □ Constipation | □ Nausea | □ Other | □ None
Are you having any psychological symptoms? □ Depression| □ Sleep Disturbance | □ Other | □ None
Any neurological symptoms? □ Loss of Bladder/Bowel Control | □ Weakness | □ Other | □ None

Any other symptoms?_____

Current Pharmacy:_____
Have you had any falls in the last year? □ Yes □ No If yes, WITH / WITHOUT injury?
Have you seen another physician since your last visit with Dr. Shaw? □ Yes □ No

TO BE COMPLETED BY OFFICE PERSONNEL

Vitals

BP:_____/_____ P:_____ Ht:_____ Wt:_____ BMI:_____

Allergies:_____

Current Medications:_____

_____

_____

Last O/V:_____ Type of O/V:_____ Today VAS:_____ Last VAS:_____

Last Procedure:_____ Type of Procedure:_____ % of Relief:_____

Provider Notes

Plan/Orders

_____
J. Kaleb Shaw, MD

_____
Date

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name:_____ Date of Birth:_____

- I authorization **Shaw Pain Clinic, PLLC** to release information from my medical record, as described in this form.
- Many of our patients allow family members to call and discuss medical information, request prescription refills, medical records, results of tests, pick up forms, etc. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have any of your medical information released to family members, you must sign this form. Signing this form will only give consent to release said information to the individuals indicated below.

_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number

Check all that apply to the above names:

□ Regarding appointment, time & date □ Discuss lab results □ Discuss imaging results
□ Pick up prescriptions □ Pick up forms □ Discuss medical care
□ Discuss billing information

RIGHT TO REVOKE: *I understand that I can withdraw at any time by giving written notice stating my intent to TERMINATE this authorization to* ***Shaw Pain Clinic, PLLC 503 E FM 1431, Ste 201 Marble Falls TX, 78654.*** *I understand that prior actions taken in reliance on this authorization by entities that had permission to access my Medical Record 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 release of Medical Record 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 released 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.*

_____	_____
Patient Signature	Date
_____	_____
Legally Authorized Representative	Relationship to Patient
_____	_____
Witness	Date

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FINANCIAL POLICY

Patient's Name:_____ Date of Birth:_____

Thank you for choosing **Shaw Pain Clinic, PLLC** as your health care provider. The following is our Financial Policy. If you have any questions or concerns about our payment policies, please do not hesitate to ask our front office personnel. We ask that all patients read and sign our Financial Policy prior to seeing a medical care provider.

Patient's portion of payment, including co-pay, deductible, and/or balance on account is due at the time services are rendered unless prior arrangements have been made with the office. We accept assignment with most major insurance companies and participating provider plans. However, you must understand that:

___ 1. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance carrier. We verify your benefits as a courtesy and do not guarantee coverage or payment.
___ 2. All charges are your responsibility whether your insurance company pays or not.
___ 3. Fees for services, along with unpaid deductibles and co-payments, are due at the time of treatment.
___ 4. If the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier to request prompt payment. Please inform our office of the carrier's response.
___ 5. Returned checks will be subject to a $25.00 collection charge. If the check is not picked up within 10 days, the check may be turned over to law enforcement.
___ 6. Completion of forms is subject to a $25.00 charge.
___ 7. No show or cancellations without 24 hour notice are subject to a $50.00 charge. **Appointment will not be allowed to reschedule until this charge is paid in full.**
___ 8. Unpaid balances over 90 days may be subject to collections via small claims court, attorney, and/or collection agency with applicable collection fees. All collection fees are the responsibility of the patient.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Authorization to Release and Assign Insurance Benefits: I authorize release of **ANY** medical information, including substance abuse, mental health, and HIV/AIDS records, required to act on **ANY** medical insurance claim and permit photographic or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to **Shaw Pain Clinic, PLLC** the medical and/or surgical benefits I am entitled from my insurance company(s) and/or Medicare.

This authorization is in effect for all future claims, until I choose to revoke it in writing. I, the undersigned, understand and agree to the above Financial Policy. I understand that I am financially responsible for all charges incurred for my medical treatment. I have had the opportunity to ask and have my questions answered to my satisfaction.
I have received or been offered and declined a copy of the Privacy Practices. I have had the opportunity to have any questions answered to my satisfaction regarding the privacy practices of the clinic.

Patient Signature_____ Date_____

Printed Name_____

Relationship to patient_____ Authorized Witness_____

SHAW PAIN
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GENERAL CONSENT FOR CARE AND TREATMENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). The consent will remain fully effective until it is revoked in writing.

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. You have the right at any time to discontinue services.

I voluntarily request a Shaw Pain Clinic physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at Shaw Pain Clinic, PLLC. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Signature of Patient Date

_____ _____

Printed name of Patient Date

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INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT
AS REQUIRED BY THE TEXAS MEDICAL BOARD
REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9 CHAPTER 170
4th Edition: Developed by the Texas Pain Society, August 2017 (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 therapy to be used, so that you may make the informed decision whether or not to take the drug(s) 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 purposed 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 (name at bottom of agreement) to treat my condition which has been explained to me as chronic pain. 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 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).

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 (urine, blood, saliva, or any other testing 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 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 judgement, 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 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 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 medication(s) 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.

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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:

____ I am aware that all controlled substance prescriptions are now being monitored by the Texas State Board of Pharmacy and that information will be accessed by my physician each time a prescription is written.
____ 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 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 medication(s).
____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
____ My pain management physician will manage the chronic pain symptoms. All other health related issues must be managed by my primary care physician.
____ I understand that my medication(s) will be refilled on a regular basis, 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 controlled substance 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.

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____ 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 substances(s), such as marijuana, speed, cocaine, etc., 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 specialized 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 give my pain physician permission to obtain any and all medical records necessary to diagnose and treat my painful conditions.

____ 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 treatment.

____ I just **keep all follow-up appointments** as recommended by my physician or my treatment may be discontinued.

____ I understand many prescription medication for chronic pain produce serious side effects including drowsiness, dizziness, and confusion. Alcohol will enhance all of these side effects and should be discontinued before starting these medications.

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 realized 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 management agreement supersedes any other agreement that I may have signed in the past.

_____

Name and contact information for pharmacy

_____ _____

Patient Signature Physician Signature (*or Appropriately Authorized Assistant*)

_____

Date