The PAIN RELIEF Center
Your pain stops here.

Informed Consent & Pain Management Agreement

AS REQUIRED BY THE TEXAS MEDICAL BOARD
REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9, CHAPTER 170

- 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 and/or his appropriately authorized assistant(s) 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 and/or his appropriately authorized assistant(s). 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 and/or his appropriately authorized assistant(s) or my treatment may be discontinued.
- I agree that in the event I experience suicidal or homicidal thoughts, I WILL SEEK IMMEDIATE MEDICAL HELP by calling the doctor, the therapist, or 911 and/or going to the nearest Emergency Room for an assessment and treatment.

I certify and agree to the following:

1) I am not currently using illicit 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, 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 I would otherwise continue to have chronic pain.
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's Name (Print): _____

Patient's Signature: _____

Date: _____

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PAIN MANAGEMENT /PSYCHIATRY AGREEMENT

I UNDERSTAND AND AGREE TO THE FOLLOWING: That this pain management/psychiatry 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 and/or any appropriately authorized assistant(s). 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 adhere to the rules specified in this Agreement.

My physician and/or any appropriately authorized assistant(s) may at any time discontinue the medication(s) at his/her discretion. 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 and /or his appropriately authorized assistant(s).
- I agree not to share, sell or otherwise permit others, including my family and friends, to have access to these medications.
- I will not participate in the 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 and/or his appropriately authorized assistant(s) to release my medical records to my pharmacist at his/her discretion.
- 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 and/or his appropriately authorized assistant(s) 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 and/or his appropriately authorized assistant(s) that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then my physician and/or his appropriately authorized assistant(s) may try alternative medication(s) or may taper me o_ all medication(s). I will not hold my physician or his appropriately authorized assistant(s) and/or any member of his staff liable for problems caused by the discontinuance of medication(s).

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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, orthostatic hypotension, arrhythmias, 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. An appropriate treatment goal may even mean the eventual withdrawal from the use of all medication(s). I realize that the treatment for some will require prolonged or continuous use of medication(s) and that my condition will be evaluated on an individual basis.

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 afforded detoxification if needed under medical supervision.

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 Pain Management 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.

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Which doctor are you here to see? _____

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 to the drug(s) recommended to you by me, as your physician.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician at The Pain Relief Center, and such associates, technical assistants, nurses and other health care providers as he may deem necessary or advisable, 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 scheduled 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. Presence of unauthorized substances may result in my discharge.

For female patients only: To the best of my knowledge ***I am NOT pregnant.*** Patients Initials: _____

If I am not pregnant, I will use appropriate contraception during my course of treatment. I promise and it is **MY responsibility** to inform my physician and/or his/her appropriately authorized assistant(s) immediately if I become pregnant.

If I am pregnant or am uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY. Besides the possible risks involved with the long-term use of medication(s) i.e. opioids /narcotic(s), I further understand that information on the effects of medication(s) on pregnant women and their unborn children is at present inadequate to guarantee that I and/or my unborn children may not experience significant or serious side effect(s).

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) to assure complete safety to my child. With full knowledge of this, I consent to its use and hold my physician and all staff harmless for injuries to the embryo/ fetus / baby.

New Patient Pain Form

The PAIN RELIEF Center
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Social History
Marital Status: ☐Married ☐Single ☐Separated ☐Divorced
Children (#):_____ Occupation: _____

Smoking: ☐YES ☐NO or ☐Quit, when?_____ Pack per day:_____ How long have you smoked?_____
Alcohol Use: ☐Never ☐Occasionally ☐Frequently Drinks per day: _____
History of Drug Abuse: ☐YES ☐NO If yes, please elaborate: _____

Anything else we can help you with today? _____

SOAPP® Version 1.0 – SF
Name: _____ Date:_____

The following questionnaire will allow us to determine the plan of care for chronic pain. This questionnaire is given to all patients at The Pain Relief Center who are on or being considered for opioid treatment.

Please answer each question honestly and to the best of your ability. This information will remain confidential. These answers alone will not determine your complete plan of care.

Please answer the questions below using the following scale:
0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

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

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

_____
_____
_____
_____
_____

New Patient Pain Form

The PAIN RELIEF Center
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How would you describe your pain? (Check all that apply)

☐Aching ☐Penetrating ☐Stabbing ☐Tender ☐Miserable ☐Twisting ☐Tiring

☐Shooting ☐Numb ☐Sharp ☐Burning ☐Pressure ☐Throbbing ☐Nagging ☐Gnawing ☐Unbearable ☐Dull

☐Tingling ☐Shocking ☐Other:_____

Pharmacy Name:_____ Phone:_____

CURRENT MEDICATIONS: **List below or please attach a list**

Medications	Dose	Frequency

ALLERGY: _____

Reaction: _____

Other Pain Treatments: (Check all that apply)

☐Physical Therapy ☐Nerve Blocks ☐Back Brace

☐Other: _____

How much pain relief have pain treatments and medicines (in total) provided for you in this past week?

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Are you currently taking any blood thinners or anti-coagulants? ☐YES ☐NO

Does your pain interfere with (Check all that apply)

☐General Activity ☐Normal Work ☐Relationships ☐Mood ☐Sleep, How many hrs a night are you sleeping?_____

☐Life Enjoyment

What other symptoms do you have? (Check all that apply)

☐Fatigue ☐Nausea ☐Depression ☐Anxiety ☐Drowsiness ☐Difficulty Thinking ☐Shortness of Breath

Bowel Patterns: Usual Frequency: _____ Last BM:_____ Bowel Regimen: ☐YES ☐NO

Last Menstrual Cycle: _____ Are you on Birth Control? ☐YES ☐NO

Sexual Dysfunction: ☐YES ☐NO

Past Medical History: (Check all that apply) ☐Diabetes ☐High Blood Pressure ☐Seizure ☐Stroke ☐Heart Attacks

☐Kidney Problems ☐Liver Problems ☐Bleeding Problems ☐Cancer ☐Infections

☐Other:_____

Past Surgery History: (Past surgeries with date) _____

_____

Family History of Cancer or Painful Conditions:_____

_____

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New Patient Pain Form

PATIENT NAME:_____ DATE:_____

Which doctor are you here to see? _____

Patient Race: ☐White ☐Black ☐Asian or Pacific Islander ☐American Indian or Alaskan Native ☐Multiracial ☐Hispanic

Patient Ethnicity: ☐ Hispanic ☐Non-Hispanic

Chief Pain Complaint:_____

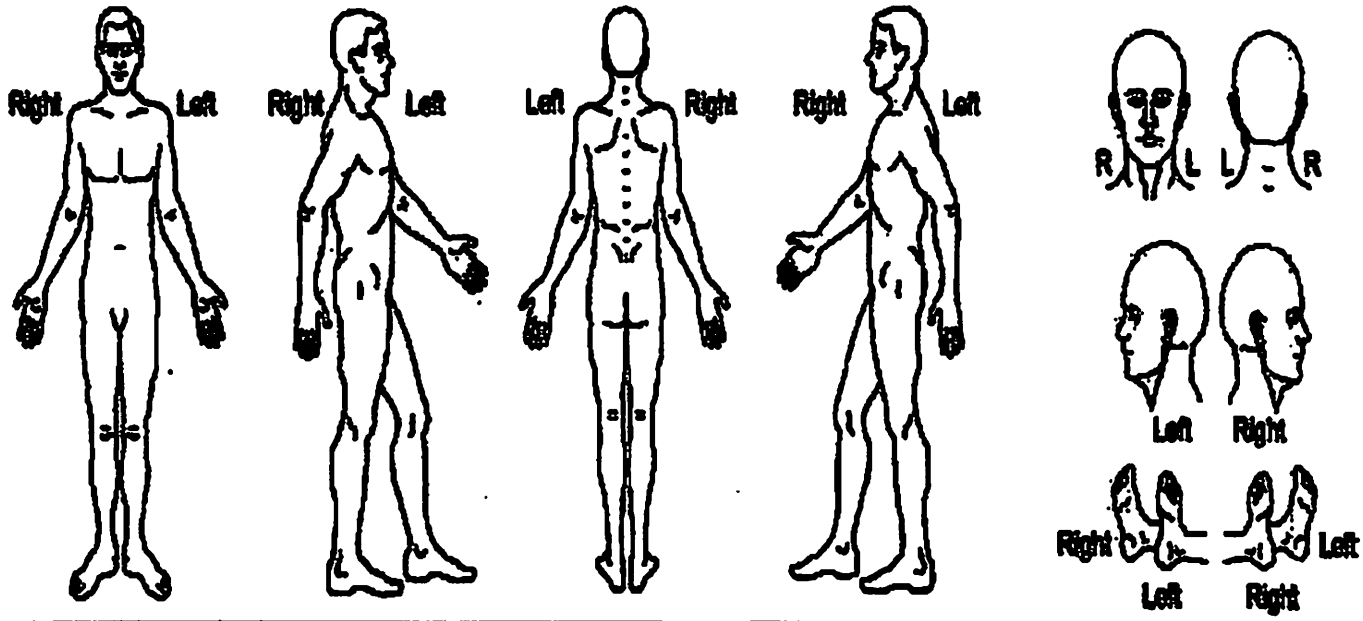
Physicians and Specialty seen for this pain including pain management_____

How long have you had this pain? _____

Has the pain recently changed in intensity and/or character? YES or NO If Yes, please describe:_____

_____

Where is your pain located? (Please mark location of pain with an X)



PAIN SCALE

Over the last week, rate: (Circle Answer)

	None										Worst
Worst Pain:	0	1	2	3	4	5	6	7	8	9	10
Least Pain:	0	1	2	3	4	5	6	7	8	9	10
Usually:	0	1	2	3	4	5	6	7	8	9	10
Right Now:	0	1	2	3	4	5	6	7	8	9	10
Acceptable Level:	0	1	2	3	4	5	6	7	8	9	10

Office use only:

Vital Signs

Temp:_____ BP:_____ SP:_____

Weight:_____ Height:_____

Pulse:_____ Resp:_____

Taken by:_____

What makes the pain better? (Check all that apply)

☐Heat ☐Cold ☐Walking ☐Sitting ☐Standing ☐Massage ☐Resting in bed ☐Medications ☐Other:_____

What makes the pain worse? (Check all that apply)

☐Heat ☐Cold ☐Walking ☐Sitting ☐Standing ☐Activity ☐Bending down ☐Stretching ☐Running

☐Coughing ☐Being still ☐Lying down ☐Other:_____

Authorization to Release Information & Financial Policy

The PAIN RELIEF Center
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I hereby authorize The Pain Relief Center/Ajay Aggarwal, M.D. to release any information acquired in the course of my examination or treatment for the purpose of determining eligibility for benefits and claims processing. Furthermore, I hereby authorize the payment directly to The Pain Relief Center/Ajay Aggarwal, M.D. benefits, otherwise payable to me for the services rendered. I understand that I am financially responsible for any and all charges not covered by this authorization and all outstanding balances maybe referred to collections. It is office policy that patients will be subject to Urine Drug Screens at any/all office visits and these charges will be submitted to your insurance. Be aware that due to your insurance policy, you may be billed at a later date. I agree a photographic copy is as valid as the original. This assignment will remain in effect until revoked by me in writing.

Initials:_____

ASSIGNMENT OF BENEFITS TO THE PAIN RELIEF CENTER/AJAY AGGARWAL, M.D.

Medicare/Medicaid and all other insurance: I request that payment of authorized insurance Medicare & Medicaid benefits be made either to me or on my behalf to The Pain Relief Center/Ajay Aggarwal, M.D. for any services furnished to me by the provider/clinic. I authorize any holder of medical information about me to release to the insurance company or to CMS (Centers for Medicare and Medicaid services) and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. *In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier* as *the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services.* Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Initials:_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE AND PATIENT BILL OF RIGHTS

By signing this form, you are agreeing that you have received a copy of our Notice of Privacy Practice, which describes how we use and disclose your health information and our Patient Bill of Rights notice, which outlines standards and use of your protected health information. You have the right to refuse to sign this Acknowledgment, in which case we must document our good faith effort to obtain your acknowledgement and the reason why it was not obtained.

Initials:_____

CONSENT FOR TREATMENT

I voluntarily give my permission to the health care providers of The Pain Relief Center and other health care providers deemed necessary to provide medical services to me. I understand by signing this form I am authorizing them to treat me in the duration of my care with The Pain Relief Center or until I withdraw my consent in writing.

Initials:_____

RECEIPT AND ACKNOWLEDGEMENT OF THE ABOVE POLICIES/AUTHORIZATIONS/CONSENTS BY:

Patient, spouse, legal representative, or beneficiary (patient's spouse may authorize disclosure of patient's health information only when the health information is for the sole purpose of processing an application for health insurance, for enrollment in a health care service plan or an employee benefit plan, and where patient is to be an enrolled spouse or dependent under the policy or plan.)

Name of person completing form: _____ Date:_____

Signature of patient/authorized representative: _____ Relationship:_____

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Patient Intake Sheet

NAME (last, first):_____, _____ DOB:_____

Address:_____ City:_____ State:_____ Zip_____

SS#:_____-____-_____ Marital Status:_____ Gender: □ Female □ Male

Phone – Home:_____ Work: _____ Cell: _____

E-mail Address:_____@_____

Employer:_____ Occupation:_____ Yrs. Employed:_____

Referring Physician:_____ Phone:_____

Address:_____

Primary Care Physician: _____ Phone:_____

Address:_____

Therapist/Counselor:_____ Phone:_____

Address:_____

Emergency Contact

Name of person not living with you:_____ Relationship:_____

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

Home / Cell Phone:_____ Work Phone:_____

Insurance Information (all blanks must be filled in) Please provide insurance cards on day of visit.

□ SELF-PAY □ INSURANCE

Primary INS Name: _____ Policy Holder:_____

ID#:_____ Group#:_____

SS# of Policy Holder: _____-____-_____ DOB of Policy Holder:_____

Employer of Policy Holder:_____ Relationship to Patient:_____

Secondary INS Name: _____ Policy Holder:_____

ID#:_____ Group#:_____

SS# of Policy Holder: _____-____-_____ DOB of Policy Holder:_____

Employer of Policy Holder:_____ Relationship to Patient:_____

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient, and authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment of services rendered.

_____ _____

SIGNATURE OF PATIENT/RESPONSIBLE PARTY DATE