RACZ
Pain Management

Dear New Patient,

Thank you for the trust you have placed in our practice to assist you with your pain management healthcare needs. We appreciate the opportunity to be your practice of choice and want to make the pre-visit experience as convenient as possible. Dr. Racz has a philosophy of treating patients like he would want his family members to be treated. We know you will find him to be sincere in this goal as well as benefit from his years of experience and knowledge in the field of Pain Management.

In order to understand your specific pain needs, we have an attached packet of paperwork for you to complete prior to your visit. These forms and information are very important to us and to our physician, Dr. Tibor Racz as he proceeds in a your course of care. Please print these forms and complete fully and provide to the front desk when you sign in for your first visit.

We do our very best to see our patients as close their scheduled time as possible. We ask that you arrive for your appointment 30 minutes early on your first visit as there will be a few remaining in-office preparations to be completed prior your time with Dr. Racz.

We appreciate your understanding and look forward to working together to create the best treatment options and provide you with best-in-class service. If you have any questions, please feel free to call our office 972-776-3250. Or you can reach out to our scheduler, Candi Wakefield at 972-934-5255. Thank you again for joining our practice as a patient.

Warm Regards,
Racz Pain Management Team

17051 North Dallas Parkway, Suite 440, Addison, TX 75001 | (p) 972.776.3250 (f) 469.568.9531
info@RaczPainManagement.com | www.RaczPainManagement

A Division of Pinnacle Partners in Medicine, in partnership with U.S. Anesthesia Partners

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PAIN MEDICINE PATIENT QUESTIONNAIRE

Patient Name: _____ Referring Physician: _____
Age: _____ Date of Birth: _____ Family Doctor: _____
Greatest Area of Pain: _____ Other Areas of Pain: _____
When did it start (mo/yr)? _____
Was this due to an injury? ☐Yes ☐No
Please describe: _____
_____

Are there any legal actions related to your pain? ☐Yes ☐No

Rate your pain on a scale of 0 (best) to 10 (worst) at its most **SEVERE:**

Best 0 1 2 3 4 5 6 7 8 9 10 Worst

Rate your pain on a scale of 0 (best) to 10 (worst) at its most **TODAY:**

Best 0 1 2 3 4 5 6 7 8 9 10 Worst

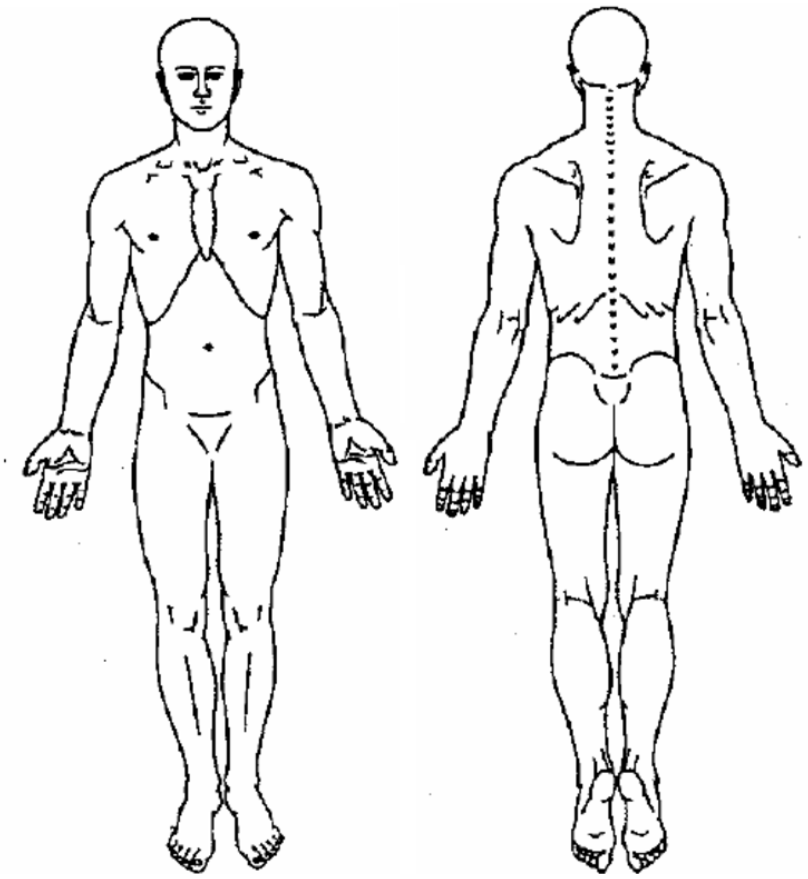
Rate your pain on a scale of 0 (best) to 10 (worst) at its **BEST:**

Best 0 1 2 3 4 5 6 7 8 9 10 Worst

Pain is? ☐Constant ☐Intermittent

When is your pain the worst?
☐Mornings ☐Midday ☐Evening ☐Night

Please shade in the areas of pain in the picture below:



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How do you describe your pain?

- ☐ aching
- ☐ burning
- ☐ dull
- ☐ electrical
- ☐ knifelike
- ☐ sharp
- ☐ shooting
- ☐ stabbing
- ☐ stinging
- ☐ throbbing
- ☐ tingling
- ☐ toothache
- ☐ Other: _____

What makes your pain worse?

- ☐ arching your back
- ☐ bending over
- ☐ bowel movement
- ☐ cooking
- ☐ coughing
- ☐ getting out of a chair
- ☐ lying down
- ☐ sex
- ☐ sitting
- ☐ sneezing
- ☐ standing
- ☐ twisting
- ☐ vacuuming
- ☐ walking
- ☐ climbing stairs
- ☐ walking down a hill
- ☐ driving
- ☐ lifting

What makes your pain better?

- ☐ activity
- ☐ sitting
- ☐ standing
- ☐ lying down
- ☐ walking
- ☐ stretching
- ☐ hot bath or shower
- ☐ application of heat
- ☐ ice
- ☐ relaxation
- ☐ massage
- ☐ TENS unit
- ☐ acupuncture
- ☐ chiropractor
- ☐ previous injections
- ☐ pain management
- ☐ physical therapy
- ☐ rest

Do you have? / **Where?**

- ☐ numbness _____
- ☐ tingling _____
- ☐ weakness _____
- ☐ new bladder or bowel changes _____

Have you had surgery before?

Surgery Type	Year?
☐ Back Surgery	
☐ Neck Surgery/fusion	
☐ Lumbar Spine Surgery	
☐ Lumbar Fusion	
☐ Cardiac Surgery	
☐ Bypass	
☐ Angioplasty	
☐ Pacemaker/AICD	

☐ Other: _____

Have you tried any of the following for your current pain? Did it work?

- ☐ Bracing ☐ Yes ☐ No
- ☐ Chiropractor ☐ Yes ☐ No
- ☐ Injections ☐ Yes ☐ No
- ☐ Medication ☐ Yes ☐ No
- ☐ Oral Steroids ☐ Yes ☐ No
- ☐ Physical Therapy ☐ Yes ☐ No
- ☐ Surgery ☐ Yes ☐ No
- ☐ TENS Unit ☐ Yes ☐ No

Do you have any of the following symptoms?

- ☐ abnormal bruising
- ☐ chest pain
- ☐ constipation
- ☐ diplopia - double
- ☐ headaches
- ☐ indigestion/heartburn
- ☐ memory loss
- ☐ rash
- ☐ shortness of breath
- ☐ tinnitus – ringing in ears
- ☐ abnormal bruising
- ☐ urinary frequency
- ☐ allergic rash
- ☐ confusion
- ☐ depression
- ☐ edema
- ☐ hearing loss
- ☐ insomnia - sleep
- ☐ nausea
- ☐ recurrent infections
- ☐ sore throat
- ☐ sweats
- ☐ allergic rash
- ☐ urinary hesitancy
- ☐ anxiety
- ☐ cold intolerance
- ☐ cramps
- ☐ fatigue
- ☐ heat intolerance
- ☐ itching
- ☐ pain at night
- ☐ restless leg
- ☐ sore throat
- ☐ unusual weight gain
- ☐ anxiety
- ☐ vision loss
- ☐ bleeding
- ☐ cough
- ☐ diarrhea
- ☐ fever
- ☐ incontinence
- ☐ joint pain
- ☐ palpitations
- ☐ sexual dysfunction
- ☐ syncope-dizziness
- ☐ unusual weight loss
- ☐ weakness
- ☐ wheezing

Do you have or have you had any of the following?

- ☐ Heart attack
- ☐ Atrial fibrillation
- ☐ Kidney failure/disease
- ☐ Diabetes insulin: Yes/No
- ☐ Seizures
- ☐ HIV or immune disease
- ☐ Heart attack
- ☐ Hypertension
- ☐ Asthma
- ☐ Cirrhosis
- ☐ Thyroid problem
- ☐ Multiple sclerosis
- ☐ Alcoholism
- ☐ Hypertension
- ☐ Chest pain (angina)
- ☐ COPD (emphysema)
- ☐ Liver disease
- ☐ Peptic ulcers
- ☐ Bleeding disorders
- ☐ Drug addiction
- ☐ Chest pain (angina)
- ☐ Congestive heart failure
- ☐ Lung disease
- ☐ Hepatitis A? B? C?
- ☐ Stroke or TIA's
- ☐ Sickle cell disease
- ☐ Psychiatric disorders
- ☐ Congestive heart failure
- ☐ Other:

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Please list ALL Medications you are now taking or provide an updated medication list:

Medications	Dose	How many per day?

Please list any medications which you have tried which did not help your pain:

Allergies to Medication

Have you had side effects from pain medications?

Medication	Side Effects

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Family History

Living	Deceased	Family Member	Please list their major health problems
☐	☐	Mother	
☐	☐	Father	
☐	☐	Brothers	
☐	☐	Sisters	
☐	☐	Children	

Personal History

Occupation: _____

Currently Working? ☐Yes ☐No

Are you receiving disability? ☐Yes ☐No Disability diagnosis: _____

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed

Do you live: ☐independently ☐do you require home health assistance ☐in an assisted facility?

Do you smoke? ☐Yes ☐No Amount: _____

Do you drink alcohol? ☐Yes ☐No Amount: _____

Do you use illegal drugs? ☐Yes ☐No Describe: _____

Did you, within the past year, want or need to cut down on controlled substance use? ☐Yes ☐No

Have you been *annoyed* or *angered* by someone else complaining of your drug or alcohol use? ☐Yes ☐No

Have you felt *guilty* about the consequences of prescription drug or alcohol use? ☐Yes ☐No

Do you use a drug or alcohol in the morning as an “Eye opener" for "withdrawal" or a hangover? ☐Yes ☐No

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SOAPP® Version 1.0-14Q

Name: _____ Date: _____

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

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 any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	0 1 2 3 4
4. How often have any of your close friends had a problem with alcohol or drugs?	0 1 2 3 4
5. How often have others suggested that you have a drug or alcohol problem?	0 1 2 3 4
6. How often have you attended an AA or NA meeting?	0 1 2 3 4
7. How often have you taken medication other than the way that it was prescribed?	0 1 2 3 4
8. How often have you been treated for an alcohol or drug problem?	0 1 2 3 4
9. How often have your medications been lost or stolen?	0 1 2 3 4
10. How often have others expressed concern over your use of medication?	0 1 2 3 4
11. How often have you felt a craving for medication?	0 1 2 3 4
12. How often have you been asked to give a urine screen for substance abuse?	0 1 2 3 4
13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0 1 2 3 4
14. 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.

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REGISTRATION FORM

(Please Print)

Today's date: ____/____/_____ Primary Care Physician: _____

PATIENT INFORMATION

Patient's last name: First: Middle:			❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital status (circle one) Single / Mar / Divorce / Sep / Widow		
Is this your legal name? ☐ YES ☐ NO	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ☐M ☐F	Race:
Street address:		Social Security no.:		Cell Phone No.: Other Phone No:		
P.O. box: City: State: ZIP Code:						
Email:						
Patient Occupation:	Patient Employer:			Employer phone no.: ( )		
Employer's Address: City: State: Zip Code:						
Referring Physician: Physician's Address: City: State: Zip Code: Referring Physician Phone:						

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Is this patient covered by insurance? ☐ YES ☐ NO	Name of Primary Insurance (if applicable):				
Subscriber's Name:	Subscriber's S.S. #	Birth date: / /	Policy#	Group #	Co-Payment $
Patient's Relationship to Subscriber	☐ Self ☐ Spouse ☐ Child ☐ Other:_____				
Occupation:	Employer:	Employer Address:		Employer Phone No: ( )	
Name of Secondary Insurance:	Subscriber's Name:	Policy#	Group#		
Patient's Relationship to Subscriber	☐ Self ☐ Spouse ☐ Child ☐ Other:_____				
Is this a workers' compensation injury? ☐ YES ☐ NO	Adjuster Name:	Adjuster Phone: ( )			
IF W/C, claim #:	Date of injury:				
Party Responsible for Bill	Birth date: / /	Address (if different)	Home Phone No: ( )		
Is this person a patient here? ☐ YES ☐ NO					
Occupation:	Employer:	Employer Address:	Employer Phone No:		

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

☐	The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Pinnacle Pain Medicine or insurance company to release any information required to process my claims.
☐	Pinnacle provides the opportunity for patients to communicate by email. By providing an electronic mail address to Pinnacle, the patient acknowledges that medical information may be contained in these communications. Email should never be used for emergency problems. Pinnacle cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Pinnacle's intentional misconduct.

Patient/Guardian signature *Date*

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NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW HEAL TH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW IT CAREFULLY

Racz Pain Management is issuing this Notice of Privacy Practices about the information we share in common and your legal rights and our common duties with respect to your health information.

OUR PLEDGE TO YOU

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care, bill for your care, and comply with legal requirements. This notice applies to all of the records of your care that we maintain, whether made by our staff and authorized trainees, or by your personal doctor. This notice tells you about the ways in which Pinnacle may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe our obligations regarding the use and disclosure of your health information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

Pinnacle doctors, nurses, pharmacists, laboratory technicians, and other health care professionals may use health information about you to provide you with health care **treatment** or services. We may also disclose health information about you to others who are involved in taking care of you. For example, we may send health information about you to a specialist as part of a referral.

Pinnacle may use and disclose health information about you to obtain **payment** for the treatment and services you receive from us. For example, we may send billing information to your insurance company or Medicare. We may also tell your insurance company about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. Pinnacle may send you a statement of your account if payment is due from you. We may send the guarantor (responsible party for payment) monthly statements for charges for all patients under that guarantor.

Pinnacle may use and disclose health information about you to support our health care **operations**.
For example, we may use health information to review the treatment and services and to evaluate the performance of our staff in caring for you. We may combine health information about many patients to decide what additional services we should offer. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning who our specific patients are.

We may disclose information to notify **a family member or other person responsible for your care** about your condition, status, and location.

If you are admitted and unless you tell us otherwise, we may provide your name, location in the hospital, and your general condition (good, fair, etc.) for information to be included in a **patient directory** and make this information available to anyone who asks for you by name.

We may use and disclose health information to contact you for an **appointment reminder**, to tell you about **health-related services** or recommend **possible treatment options or alternatives** that may be of interest to you, or to contact you about supporting **our fundraising** efforts.

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Subject to certain requirements, we may use or disclose health information about you **without your prior authorization** for other reasons:

We may give out health information about you for **public health** purposes; to **report abuse or neglect;** for **health oversight reviews**; in **research** studies; for **funeral arrangements** and **organ donation**; in response to special **law enforcement** requests, valid judicial or administrative orders, or for authorized national security and intelligence activities; for **workers' compensation** purposes; to **avert a serious threat** to your health or safety or those of the public or another person; and when **required by law**. If you are or were a member of the armed forces, we may release information about you as required by military command authorities or the Department of Veterans Affairs. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official.

In any other situation not covered by this notice, we will ask for your written **authorization** before using or disclosing your health information. You may **revoke** this authorization for any subsequent disclosures by notifying us in writing.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the right to request in writing that you **inspect and obtain a copy** of the health information that we use to make decisions about your care. We may charge a fee for the costs of copying, mailing or other supplies and services associated with your request. If we deny your request to inspect or obtain a copy in certain limited circumstances, you may request that the denial be reviewed. Another licensed health care professional chosen by Pinnacle will review your request and the denial and we will comply with the outcome of that review.

If you believe that health information we have about you is incorrect or incomplete, you may make a written request to ask us to **amend information**. The request should state the reason for the amendment and specific information to be amended. The amendment must be limited to one page. Any amendment we make to your health information will be disclosed to those with who we disclose information as previously stated.

We may deny your request for an amendment if the information to be amended was not created by us, is no longer maintained by us, is not part of the information which you would be permitted to inspect and copy; or is accurate and complete. We will notify you if we deny your request for amendment and you may appeal, in writing, our decision. Any statements of disagreement or rebuttal will be linked to your health information and made a part of any subsequent disclosure we make of such information.

You have the right to make a written request for a **list of disclosures** we have made of your health information, except for uses and disclosures for treatment, payment, and health care operations, as previously described, and those for which you have authorized disclosure. Your request must state a time period which may not be longer than six years and may not include date April 14, 2003. We will not charge you for the first list you request within a 12-month period, additional requests will be charged according to our cost for producing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

You have the right to **request a restriction** on the health information we use or disclose about you for treatment, payment, or health care operations. There may be risks associated with such restrictions and we may ask you to acknowledge these risks in writing for certain requests you may make. **We are not required to agree to your request for restrictions** if it is not feasible for us to ensure our compliance or believe it will negatively impact the care we may provide you. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

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You have the right to request, in writing without requiring you to state a reason, that **confidential communications** with you be made in an alternative manner or location. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

WRITTEN REQUESTS

If you have any questions about this notice, please contact: Pinnacle Partners In Medicine, to the attention of the Privacy Officer at 13601 Preston Road, Suite 1000 W, Dallas, Texas, 75240 or call (972) 715-5000.

COPIES OF NOTICE AND CHANGES

You have the right to obtain a paper copy of this notice at any time.

We reserve the right to change this notice, and to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future.

COMPLAINTS

If you are concerned that your privacy rights may have been violated or you disagree with a decision we make about your health information, you may contact Pinnacle's Privacy Officer at 13601 Preston Road, Suite 1000 W, Dallas, Texas, 75240, or call (972) 715-5000. You may also send a written complaint to the U.S. Department of Health and Human Services. We can provide you with the address.

Under no circumstances will we ever ask you to waive your rights under this notice or retaliate against you in any manner for filing a complaint.

Please sign the attached acknowledgement that you have received our Notice of Privacy Practices, effective April 14, 2003.

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Acknowledgement of Receipt of Notice of Privacy Practices
Pinnacle Anesthesia Consultants, P.A.
Pinnacle Consultants, LP.
Pinnacle Pain Medicine

I received a copy of the Notice of Privacy Practices from the above noted entities.

Signature: _____ Date: _____

Print Name: _____

Personal Representative: _____

If personal representative, please note relationship to patient: _____

Prescription Pick-up Authorization

If you would like to give consent for another individual to pick up your prescriptions or documentations, please provide that name below:

_____

I give consent for my provider to discuss my medical care with the persons listed below:

Name: _____ Relationship: _____

Signature: _____
(Authorized Representative must present valid photo ID upon pick up)

Name: _____ Relationship: _____

Signature: _____
(Authorized Representative must present valid photo ID upon pick up)

FOR OFFICE USE ONLY:

By: _____ Date: _____

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PATIENT RESPONSIBILITIES

1. Please arrive at least 15 minutes (30 minutes on your first visit) prior to your appointment time for clinic appointments in order to take care of any insurance issues or required paperwork. If you are 15 minutes or more late for your appointment time and/or your initial paperwork is not complete by your appointment time, your appointment will be rescheduled.
2. We require at least 24 hours' notice for cancellations/rescheduling of appointments. A missed clinic appointment or appointment for a scheduled procedure without calling to reschedule will be charged $25.00 for missed clinic appointments or $100 for a missed scheduled procedure.
3. Prescriptions will only be filled during office hours by appointment only. No prescriptions will be filled after hours, on weekends, or holidays.
4. State law requires compliance and close monitoring for narcotic medications. If these are prescribed for you, you will be asked to sign a Patient Responsibility Agreement for Controlled Substance Prescriptions.
5. Payment is due at the time services are rendered to the patient. Failure to settle past due balances, pay at the time of service, etc., can result in the patient's termination from the treatment program.

Your signature below constitutes acknowledgement and acceptance of the terms of these guidelines.

_____

Patient Name Date

_____

Signature of Patient/Legally Responsible Person Signature of Witness

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Advanced Practice Nurse/Nurse Practitioner and Physician Assistant Consent

Racz Pain Management would like you to know that we employ Advanced Practice Nurses, also known as Nurse Practitioners, and Physician Assistants to assist us in a team approach to deliver our high quality of medical care.

An Advanced Practice Nurse (APN)/Nurse Practitioner (NP) and Physician Assistants (PA) are mid-level practitioners who have received advanced education and training in the provision of health care. Advanced Practice Nurses/Nurse Practitioners or Physician Assistants are not doctors. They can however, diagnose, treat, and monitor routine and complex pain disorders. If you are seen by an APN/NP or PA, your doctor will review your care with the APN/NP or PA as part of the care plan.

I have read the above and understand that in this practice a team approach is used, with my unique needs presented and discussed with one or more physicians in the development of my care plan. I also understand that typically one physician will direct my overall care, but that from time to time I may be seen by any or all the practitioners in this practice, including a APN/NP or PA.

I hereby consent to the services of an Advanced Practice Nurse/Nurse Practitioner or Physician Assistant for my healthcare needs.

I understand that I can refuse to see the APN/NP or PA and request to see a Physician.
I understand that this may require my appointment to be rescheduled.

☐ Please check this box to acknowledge that you have read and accept the above.

_____

Signature Date

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WARNING REGARDING PHYSICAL DEPENDENCE
OF CONTROLLED SUBSTANCES

Physical dependence and/or tolerance can occur with the use of controlled substances.

Physical dependence means that if the controlled substance is abruptly stopped or not taken as directed, a withdrawal symptom can occur. This is a normal physiological response. The withdrawal syndrome could include, but not exclusively, sweating, nervousness, abdominal cramps, diarrhea, goose bumps, and alterations in one's mood.

It should be noted that physical dependence does not equal addiction. One can be dependent on insulin to treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to the insulin or prednisone.

Addiction is a primary, chronic neurobiological disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases one's quality of life.

Tolerance means a state of adaptation in which exposure to the drug induces changes that result in diminution of one or more of the drug's effects over time. The dose of the controlled substance may have to be titrated up or down to a dose that produces maximum function and a realistic decrease of the patient's pain.

It may be deemed necessary by your doctor that you see an addiction medicine specialist at any time while receiving controlled substance medications. Understand that if you do not attend such an appointment, your medication may be discontinued or may not be refilled beyond a tapering dose to completion. If the specialist feels that you are at risk for addiction or psychological dependence, medications will no longer be refilled.

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GUIDELINES FOR OPIATE THERAPY

Side effects for Opiate/Narcotic Medications may include...

- Drowsiness, sedation, disorientation, resulting in falls and resultant significant injury
- Constipation and bowel obstruction, possibly requiring surgical intervention and potentially resulting in ischemic (dead) bowel, sepsis and death
- Allergic and/or anaphylactic reactions to the medications resulting in hypotension (low blood pressure), tachycardia (fast heart rate), arrhythmia (irregular heart rhythm), respiratory or cardiac arrest and death
- Respiratory depression resulting in respiratory arrest and/or death, as well as resultant cardiac arrest and/or death
- Tolerance to the medication may develop after long-term use, which means that ultimately this medication may become less effective
- Physical dependency, psychological dependency and addiction are possible with all narcotic medications. These situations may result in discontinuation of the pain medication by your doctor.
- Withdrawal phenomenon may occur with abrupt discontinuation of the pain medication. This may cause significant side effects such as heart palpitations, diaphoresis (sweating), anxiety, nausea, vomiting, elevated pulse and blood pressure. Do not abruptly discontinue this medication. Your health care provider will guide you on how to stop narcotics using a slow weaning process.

Precautions while taking Opiate Medications:

- Patients taking anticoagulants (blood thinners) are at particularly high risk of any kind of trauma (falls, etc.) as a resultant life-threatening hemorrhage, intracranial bleeding, or death may occur.
- The elderly may exhibit marketed or dramatic side effects from narcotic medications, even in low doses.
- Patients with other significant medical problems (including heart or lung disease) are at high risk for complications related to the use of narcotic medications.
- Patients taking sedative medications or central nervous system depressants should use narcotics sparingly and in reduced doses due to additive and/or synergistic interactions and greater than expected or enhanced side effects.
- Narcotic analgesics should not be used during pregnancy.

Take precautions with the following activities while taking Opiate Medications:

- Any kind of activity where judgment is required (i.e. driving, signing important documents, caring for the sick, the elderly, or the very young).
- Narcotic medications may affect the ability to drive or operate machinery.
- Avoid working on high-risk area (i.e. construction sites, elevated work sites, working with power tools, etc.).
- Drinking alcohol is prohibited while on narcotics due to potent and unpredictable enhancement of central nervous system depression if these two substances were taken together.
- If you experience the side effects such as sedation with opiate use, do not participate in the above activities.

If you have questions regarding these items, please ask your physician or nurse practitioner during your visit.

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PATIENT RESPONSIBILITY AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

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 (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 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 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 physician will explain his treatment plan(s) for me.

REGARDING SIDE-EFFECTS: I understand that the most common side-effects that could occur in the use of controlled substances 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 automobiles or other machinery while using these medications and I may be impaired during all activities, including work. I also understand that operating a motorized vehicle while taking these medications may lead to a conviction of driving while under the influence if it is determined that I am impaired.

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 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

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regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition, and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

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

1. My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the medications(s) may be discontinued.
2. I will disclose to my physician ***all medication(s)*** that I take at any time, prescribed by any physician. This disclosure will include any herbal remedies, since controlled substances can interact with over-the-counter medications and other prescribed medications, especially cough syrup that contains alcohol, codeine or hydrocodone.
3. I will receive controlled substance pain 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.
4. I will use **ONE pharmacy, where possible**, to obtain all controlled substances prescribed by my physician. Should the need arise to change pharmacies; Pinnacle Pain Medicine will be notified. In addition, I will provide my pharmacist a copy of this agreement. I authorize my physician to release my medical records to my pharmacist as needed.

   Pharmacy: _____
   Phone Number: _____

5. I will use the medication(s) **exactly** as directed by my physician.
6. I will **not use** MARIJUANA for medicinal or recreational purposes while receiving controlled substance prescriptions, unless there is a change in Texas legislation to legalize it for medicinal use.
7. 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.
8. 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. I am responsible for keeping my pain medication in a safe

and secure place, such as a locked cabinet or safe. Stolen medications should be reported to the police and to my physician immediately. ***If either are lost or stolen, they WILL NOT be replaced.***

9. 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. Only my prescribing physician or his/her surrogate can decide to increase my medication(s) dosage. I understand that self-medicating **will result** in running out of my medication(s) early and that I will not be granted an early refill.
10. I understand that **I am responsible** for providing **48 to 72 hours**' notice on any refill(s). I understand that if I make a refill request after 12:00 pm it **will not** be processed until the following day, and that refill request(s) **will not** be taken on Fridays, weekends, or holidays since the on-call physician cannot prescribe these safely for me.
11. I understand that there are side effects with controlled substances which may include, but not exclusively, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, or the possibility of impaired cognitive and/or motor ability. Overuse of controlled substances can cause decreased respiration.
12. If I have a history of alcohol or drug misuse/addiction, I **will notify** the physician of such history since the treatment with controlled substances for pain may increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one for treatment of pain with controlled substances but starting or continuing a program for recovery is a must.
13. If the responsible legal authorities have questions concerning my treatment, as might occur, for example if I obtained medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to Pinnacle Pain Medicine records of controlled substances administration. In the event that I am arrested or incarcerated related to legal or illegal drugs, refills on controlled substances will not be given to you.
14. 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) and **agree to allow** my physician to contact any healthcare professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about my care or actions, if the physician feels it is necessary.
15. 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), such as marijuana, amphetamines, cocaine, etc., this may be grounds for termination of the doctor/patient relationship at the sole discretion of my physician. If I decide not to provide a urine sample, I understand that my physician may change my treatment plan, including safe discontinuation of any controlled substances when applicable or complete termination of the doctor/patient relationship. Urine drug testing is not forensic testing, but is done for my benefit as a diagnostic tool and in accordance with certain legal and regulatory materials on the use of controlled substances to treat pain. I accept responsibility for the cost of the urine drug test in the event that my healthcare coverage will not cover the cost of this test. I am also aware that my physician may refer me to the on-staff professional counselor, or that a consult with, or referral to a qualified professional, such as an addictionalogist, or a professional who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy may also be provided if my physician feels it is necessary.
16. I understand that any evidence of drug hoarding, acquisition of any controlled substances from other physicians (which includes emergency rooms), uncontrolled dose escalation or reduction, loss of prescriptions, or failure to follow the agreement may result in termination of the doctor/patient relationship.

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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.**

I understand that if I violate any of the above conditions, my prescription for controlled substances may be terminated immediately. If the violation involves obtaining controlled substance medications from another individual, or the use of non-prescribed illicit drugs, I may also be reported to all my physicians, medical facilities and appropriate authorities.

I have read this agreement and the same has been explained to me by Pinnacle Pain Medicine staff. In addition, I fully understand the consequences of violating this agreement may include cessation of therapy with controlled substances and/or discharge from Pinnacle Pain Medicine.

Patient Signature: Date:

Physician Signature (or Appropriately Authorized Assistant) Date:

Name and contact for the Pharmacy

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Financial Policy

Thank you for choosing Racz Pain Management. Our goal is to provide you with the highest quality care possible. We find that communication with our patients regarding our financial policy assists us in providing the best service to you. Therefore, we take this opportunity to answer some of the most commonly asked questions. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Payment Methods
Payment is expected at the time services are rendered. We accept a variety of payment methods, including cash, check, money order, or credit card Visa, MasterCard, Discover and AMEX. Credit card payments are also accepted via telephone.

Insurance Information
We must emphasize that your health is our primary concern, regardless of your insurance. Because your insurance policy is a contract between you and your insurance company, please check with your insurance carrier to determine any pre-existing limitation or other benefit restrictions that you may have, prior to your appointment.

We will file your insurance as a courtesy and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

Most insurance companies do not cover 100% of the cost of services, and there is a portion that the patient is responsible for. There are several patient responsibility components that may apply to an insurance payment.

> *Co-pay* - A set dollar amount per office visit that is the patient's responsibility.
> *Co-insurance* - A percentage of the charge that is the patient's responsibility.
> *Deductible* - A set annual amount that the patient is responsible for paying prior to his or her insurance making a payment.

Because of the contract you have with your insurance company, we are obligated to collect payment from you for your portion of the balance. All co-payments, co-insurance and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

To bill your insurance accurately and in a timely manner, we will need assistance from you.
We ask that you provide our office with accurate demographic information (address, phone number, etc.) and proof of insurance. All patients will be required to show proof of insurance and a Government issued Photo ID.

Insurance Changes
If there are any changes in your insurance, you are required to call our office and give the detailed changes of your insurance at least twenty-four (24) hours prior to your appointment.

If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance.

Managed Care: All managed care (i.e. HMO, PPO, and POS)
Co-payment, co-insurance & deductible amounts are due at the time of check-in. If your insurance plan requires a referral authorization from a primary care physician you are responsible for obtaining prior approval from your PCP prior to treatment & will need to present this at your visit. If you request an office visit or procedure without a

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referral authorization, your insurance plan may deem this as non-covered treatment and you will be responsible for the charges.

Medicare
We accept assignment with Medicare. Medicare pays 80% of their allowed amount after satisfaction of the yearly deductible. You are responsible for 20% of Medicare's allowed amount. All co-payments or deductibles are due and payable at the time of service.

Secondary & Tertiary Plans
We will bill your secondary insurance as a courtesy. We do not bill tertiary insurance. If you have supplemental insurance to cover the portion of the charges that Medicare or your primary insurance carrier does not pay, please provide us with a copy of this insurance card. Medicare and secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding.

Preauthorization
Please remember that it is up to you to understand the requirements of your individual insurance plan and know whether prior authorization from your insurance company is required

Non-covered Services
Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

Auto Injury Cases
This office does NOT bill auto insurance for auto accident cases. We do NOT accept liens or letters of protection (LOP's).

Worker's Compensation
If your injury is work-related, we will need the claim number, date of injury, employer, and worker's compensation carrier prior to your visit in order to bill the worker's compensation insurance company.

Cash Patients
Cash patients are accepted on a case by case basis. All uninsured patients will be required to pay in full at time of treatment.

Surgery & Injection Fees
All co-pays, co-insurance, deductibles, and payments for non-covered surgical procedures are due prior to surgery. We will make every attempt to determine your coinsurance amount prior to your surgery. This will be based on your insurance benefits and an estimate of the services to be provided. We will provide you with that estimate & we will expect to collect that amount prior to the time of surgery. If any changes are made to the scope of services provided and the coinsurance amount has changed, we will either refund or bill you upon final resolution of your account. Fees are ultimately the responsibility of the patient, whether your insurance company pays or not, and are due within thirty days of your receipt of Racz Pain Management statement.

Nonpayment
Please be aware that patient accounts over 180 days without satisfactory payment will be turned over to a collection agency and patients will face possible termination from the program.

Returned checks
A $25.00 fee will be charged for any returned checks and we will report bad checks to the District Attorney's Office. We will be unable to accept your check for any services thereafter.

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Missed appointments
A scheduled appointment is a commitment of time between you and our practice, a time we have reserved just for you. If you are unable to keep a scheduled appointment, please cancel or reschedule your appointment at least 24 hours in advance to avoid a service charge and help us meet the needs of other patients. Patients who habitually fail to keep scheduled appointments and do not give a 24 hour cancellation notice will face treatment termination.

Children of Divorced Parents
Responsibilities for payment of patients, who are minor children, whose parents are divorced, rest with the parent who seeks the treatment.

Medical Records
Please direct all medical record requests or questions to your physicians' business office.

Charges for Forms
A $30.00 fee will be charged for disability, life insurance, and other forms requested by a third party or patient.

Special Circumstances
We are aware that circumstances in our daily lives may vary. If you need to establish a payment plan or require additional assistance, please contact our Business Office prior to your scheduled appointment. Unless you have made prior arrangements for payment of your balance, our financial policy will stand.

Account Billing Questions & Refunds
Questions or concerns regarding your account or insurance claim should be directed to our business office staff. If your account has a credit balance, we will promptly release a refund check to you once your insurance carrier has processed all pending insurance claims remaining on your account. If you feel an error appears on the statement or if you have any questions or concerns please contact our billing office immediately at (972) 715-5000.

_____
Printed Name

_____
Signature Date