Institute of
PRECISION PAIN MEDICINE

Patient Registration Form

Patient Name (Last/First): ____

Date of Birth (MM/DD/YYYY): _______________________

Social Security #: __________________________________

Driver's License (State/Number): _____________________

Sex (Male/Female): ____

Marital Status (Single/Married/Divorced/Widowed): _____________________________

Race (African American/American Indian/Asian American/Caucasian/Hispanics/Others):
____

Preferred language (English/Spanish/Others): _________________________________

Street Address: ____

City: _________________________________ State: __________ Zip Code: __________

Cell #: _________________ Home #: _________________ Work #: _________________

Email Address: ____

Preferred Contacting Method (Cell #/Home #/Work #/Email): ____________________

Employer: ___________________________________ Full Time: _____ Part Time: _____

Occupation: ____

Spouse Name: ______________________ Spouse Contact #: ____________________

Authorized and Responsible Party Information

Name (Last/First): ____

Date of Birth (MM/DD/YYYY): _______________________

Social Security #: __________________________________

Relationship to Patient: _____________________________

Cell #: _________________ Home #: _________________ Work #: _________________

Email Address: ____

Preferred Contacting Method (Cell #/Home #/Work #/Email): _____________________

Insurance Information

Primary Insurance Company Name: ____

Insurance Address: ____

City: _________________________________ State: __________ Zip Code: __________

Name of Insured: _____________________ DOB: __________ Relationship: __________

Insurance ID #: ____

Group #: ____

Secondary Insurance Company Name: ____

Insurance Address: ____

City: _________________________________ State: __________ Zip Code: __________

Name of Insured: _____________________ DOB: __________ Relationship: __________

Insurance ID #: ____

Group #: ____

Referral Information

Who referred you to IPPM? ____

Emergency Contact

Name: ____

Age: __________________

Relationship to Patient: ____

Cell #: __________________ Home #: __________________ Work #: _______________

Email Address: _____________________________________

Authorized Persons for RX Pick Up

Name: ______________________________________ Relationship: _________________

Name: ______________________________________ Relationship: _________________

Office Policy

Our office policy will accept assignment on your insurance; however, it must be fully understood that your insurance policy is a contract between you and your insurance company. Our office will NOT enter into a dispute with your insurance company over policy limitations or issues. This is your responsibility and obligation. All charges incurred are your responsibility. Our office will file your claims for you and assist you in every way possible to insure benefit recovery.

Please Read the Following:

- We will file with your insurance company as a courtesy to you. You will be responsible for your deductible, copays, and percentage not paid by your insurance company.
- **Insurance:** Our physicians are providers for most major insurers including HMO's and PPO's. HOM insurers may require authorization from your primary care doctor, prior to seeing a specialist. **You must get that insurance authorization prior to your appointment with us to receive maximum benefits.** We also accept assignment from Medicare. Texas Workers Compensation is gladly accepted when properly verified in advance of the appointment.
- **Copays:** Your copays and deductibles are due at time of service.
- **Office Visits:** Your coinsurance portion of the fee is due at time of service.
- **Office Procedures:** Many of the patients referred to Institute of Precision Pain Medicine require interventional pain procedure therapy. If procedure is indicated, we will pre-certify your procedure with your insurance carrier. We will also verify your insurance benefits, and get deductible and out-of-pocket status. From this information, we can estimate the patient portion of the physician fees. The patient portion of the procedure fee is collected at time of service.
- **Hospital Procedures:** We will pre-certify your procedure with your insurance carrier. We will also verify your insurance benefits, and get deductible and out-of-pocket status. From this information, we can estimate the patient portion of the physician fees. The patient portion of the procedure fee is due at time admission is scheduled unless prior arrangements are made with our office manager and/or physician.
- **Usual and Customary Charges:** Our practice is committed to providing the best treatment and therapy possible to our patients. We charge what we believe to be the usual and customary fees for our area. You are responsible for paying the bill in full, regardless of your insurance company's interpretation of usual and customary rate.
- **Self-Pay Patients:** Payment in full is due for all office services and procedures at time of service. Hospital procedures are subject to a 50% pre-payment at time of admission is scheduled. Remaining 50% is collected prior to the treatment date.
- Our office hours are Monday through Friday 8:00AM to 5:00PM. All messages are checked daily. All non-urgent calls will be returned within 72 hours.

- After hour calls will be answered by our answering service for **EMERGENCY CALLS ONLY**. When you call our office a (361) 387-0046 , the answering service will answer the call. They will contact the doctor on call to answer **ONLY EMERGENCY CALLS**. Medication refill requests do not constitute an emergency. For cancellations or changes of appointments, please call us during regular business hours.
- For prescription refills, please call us within 5 days of needing the refills, this will give us time to get the doctor's approval for this refill and call your pharmacy. Refills will not be made at nights, on holidays, or weekends.
- In order to provide better service for all our patients, we ask that you give us a 24 hour notice for all cancelled appointments. **ALL NO CALL AND NO SHOW APPOINTMENTS** will be subject to a $25.00 non-cancellation fee which will be patient's responsibility. Three missed appointments with **NO CALL AND NO SHOW** may result in discharge from the Institute of Precision Pain Medicine.

I have read and fully understand the office polices.

Patient Signature: ____

Patient Print Name: ____

Date: ____________

Institute of
PRECISION PAIN MEDICINE

HIPAA Patient Consent Form

Our Notice of Practice provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how your protected health information is used or disclosed for treatment, payment, or health care operations.

By signing this form, you consent to our use and disclosure of information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The Practice has a Notice of Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The Patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment, upon the execution of this Consent.

Consent Signed by Patient/Authorized Party: ____

Print Name: ____

Witness: ____

Date: _____________________

IPPM Electronic Communication Agreement

E-mail offers an easy and convenient way for patients and doctors to communicate. In many circumstances, it has advantages over office visits or telephone calls. But remember: there are important differences. E-mail is not the same as calling our office; there is no person at the other end of the call – just a computer. You can't tell for certain when your message will be read, or even if your doctor is in the office or on vacation. Nonetheless, we believe that the ease of communication e-mail affords is a benefit to patient care.

Below are our rules for contacting us using e-mail.

- E-mail is never, ever, appropriate for urgent or emergency problems. Please call 911 or go to the Emergency Department for emergencies.
- If you send us an email question or request, our practice will assume that you agree to (consent to) a reply e-mail.
- E-mail is only for asking little questions that don't require a lot of discussion. E-mail is not a substitute for seeing us. If you think that you might need to be seen, please call and book an appointment.
- **Appropriate uses of e-mail include prescription refill requests, referrals, appointment scheduling requests and billing/insurance questions.**
- E-mail should not be used to communicate sensitive medical information, such as information regarding mental health or substance abuse.
- **E-mail is not confidential. It is like sending a postcard through the mail. Our e-mail system is encrypted. However, most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email. When we send you an email, or you send us an email, the information that is sent is not encrypted outside of our system. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.**
- You should know that if you send e-mails from work, your employer has a legal right to read your e-mail if he or she chooses.
- E-mail may become a part of the medical record when we use it.
- E-mail is not a substitute for seeing us. If you think that you might need to be seen, please call and book an appointment!

- E-mail may be answered or addressed by our staff, if appropriate.
- Our practice uses both email and texting to notify patients of upcoming appointments. Like e-mail, texting may not be secure or confidential.

I DO want to communicate with my doctor electronically. I have read the above information and understand the limitations of security on information transmitted.

Patient Name: ____

Patient Signature: _____________________________________

E-mail Address: ______________________________________

Date: ____

Institute of
PRECISION PAIN MEDICINE

Assignment of Benefit Financial Agreement

I hereby give authorization for payment of insurance benefits to be made directly to Li-Herng (Eric) Liu, M.D., Mitchell P. Engle, M.D., Ph.D. any assisting physicians, and any Mid Level Practitioners for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.

Patient Signature: ____

Patient Print Name: ____

Payment Method: ____

Date: ____

Institute of
PRECISION PAIN MEDICINE

CREDIT CARD ON FILE POLICY

At The Institute of Precision Pain Medicine, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Without this authorization, a billing fee of $10 will be added to your account for any balances that we must attempt to collect through mailing monthly statement.

Furthermore, an "outstanding balance" charge of 5% of the total bill will charge for each month that the bill remains unpaid. Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

I authorize The Institute of Precision Pain Medicine to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐Amex ☐Visa ☐Mastercard ☐Discover

Credit Card Number ____

Expiration Date _____ / _____ / _____

Cardholder Name ____

Signature ____

Billing Address ____

City ______________________________ State_______ Zip ____________

I (we), the undersigned, authorize and request The Institute of Precision Pain Medicine to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by The Institute of Precision Pain Medicine. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to The Institute of Precision Pain Medicine in writing and the account must be in good standing.

Patient Name (Print): ____

Patient Signature: ____

Date: _____ / _____ / _____

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT

AS REQUIRED BY THE TEXAS MEDICAL BOARD

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

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/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 for drugs and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to

termination of treatment. The presence of unauthorized substances may result in my being discharged from your care.

For female patients only:

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

If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment.

I accept that it is **MY responsibility** to inform my physician immediately if I become pregnant.

If I am pregnant or am uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY.

All of the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo/fetus/baby.

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension (low blood pressure), arrhythmias (irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.

The risk of addiction is increased in patients who have prior history of addiction. Therefore, I will tell my doctor if I have such a history including addiction to cigarettes, smokeless tobacco, alcohol, gambling, etc. If I develop an addiction problem, my doctor will help me with this. My doctor may decide that I should not continue on the particular drug, or may decide that I may continue on the medication but only with very careful treatment guidelines.

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

PAIN MANAGEMENT AGREEMENT:

I UNDERSTAND AND AGREE TO THE FOLLOWING:
That this pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called 'narcotics, painkillers', and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). **Therefore, medication(s) will only be provided so long as I follow the rules specified in this Agreement.**

My physician may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior:

- My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the **medication(s) may be discontinued**.
- I will **disclose** to my physician **all medication(s)** that I take at any time, prescribed by any physician.
- I will use the medication(s) **exactly as directed by my physician**.
- I agree **not to** share, sell or otherwise permit others, including my family and friends, to have access to these medications.
- I will **not allow or assist in the misuse/diversion of my medication**; **nor will I give or sell them** to anyone else.
- All medication(s) must be obtained at **one pharmacy, where possible**. Should the need arise to change pharmacies, my physician must be informed. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my physician to release my medical records to my pharmacist as needed.
- I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money**. If either are lost or stolen, they may NOT BE REPLACED.**
- Refill(s) **will not be ordered before the scheduled refill date**. However, early refill(s) are allowed when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.
- I will receive medication(s) **only from ONE physician** unless it is for an emergency **or** the medication(s) that is being prescribed by another physician is approved by my physician. Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.
- If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then **my physician may try alternative medication(s) or may taper me off all medication(s**). I will not hold my physician liable for problems caused by the discontinuance of medication(s).
- I **agree to submit to urine, blood, hair, or other 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, 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 specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.
- I understand that my physician will intermittently check the **Texas Prescription Monitoring Program**. This database will provide my physician with all controlled substance prescriptions that I have received. If my physician identifies problematic prescriptions or potential drug interactions, then this may be a reason to discontinue opioid therapy.

- I agree to intermittent paper or computerized psychological screenings as part of my medication monitoring.
- I agree to return to the clinic with all my controlled substance pills should my physician think it is important to perform a pill count.
- I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize **that my active participation** in the management of my pain is extremely important. I agree to **actively participate in all aspects of the pain management program** recommended by my physician to achieve increased function and improved quality of life.
- I agree that I **shall inform any doctor** who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.
- I hereby give my physician **permission to** discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).
- I must take the medication(s) as instructed by my physician. **Any unauthorized increase** in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.
- I must **keep all follow-up appointments** as recommended by my physician or my treatment may be discontinued.

I certify and agree to the following:

1) I am **not currently using illegal drugs or abusing prescription medication**(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

2) I have **never been involved** in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.)

3) **No guarantee or assurance has been made** as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life.

4) I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain. **I fully understand the explanations regarding the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.**

____ ________________
Patient Signature Date

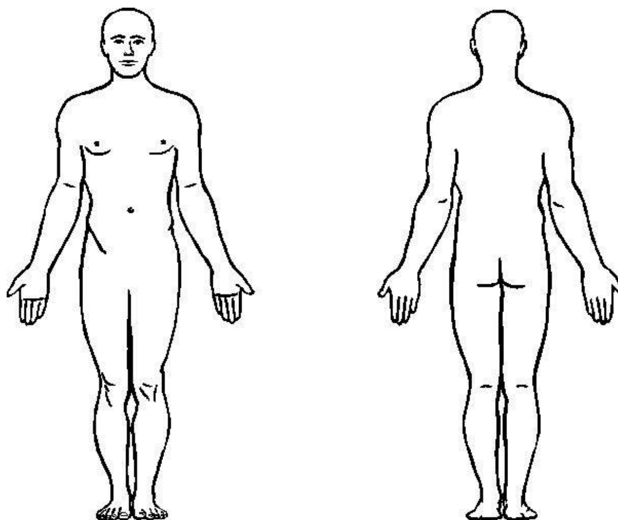
____
Physician Signature (or Appropriately Authorized Assistant)

Patient name: _____________________

Date __________

INITIAL HISTORY & PHYSICAL

MARK THE AREAS ON THIS BODY WHERE YOU FEEL PAIN



PREVIOUS PAIN TREATMENTS

Treatment Description	Answer	Was it helpful?
Pain Medicine Specialist Name:___________________________	Yes / No	Yes / No
Physical Therapy / Chiropractic	Yes / No	Yes / No
Psychologist / Psychiatrist	Yes / No	Yes / No
Pain medications	Yes / No	Yes / No
Spine injections / Nerve Blocks	Yes / No	Yes / No
Other:	Yes / No	Yes / No

Please circle any blood thinners that you take

Aspirin/ASA	Diclofenac/Voltaren	Ketorolac/Toradol	Etodolac/Lodine
Ibuprofen/Advil	Naproxen/Aleve	Meloxicam/Mobic	Celecoxib/Celebrex
Coumadin/Warfarin	Heparin	Enoxaparin/Lovenox	
Clopidogrel/Plavix	Prasugrel/Effiant	Ticagrelor/Brilinta	
Dabigatran/Pradaxa	Rivaroxaban/Xarelto	Apixiban/Eliquis	

PAST MEDICAL HISTORY

Please circle conditions you have been diagnosed with?

High blood pressure	Heart disease	Prior heart attack	Heart failure
COPD/emphysema	Asthma	Wheezing	Sleep apnea
Kidney disease	Dialysis	Kidney stones	
Heartburn	Stomach ulcer	Hepatitis	Cirrhosis
Diabetes	Hypothyroidism		
Depression	Anxiety	Bipolar	Psychosis
Seizures	History of stroke	TIA	Dementia
Easy Bruising	HIV	Cancer	

Other: ____

REVIEW OF SYSTEMS

Circle symptoms that you are experiencing

Chest pain	Wheezing	Shortness of breath	Cough
Constipation	Diarrhea	Nausea/Vomiting	Sore throat
Painful urination	Difficulty urinating	Rash	Joint swelling
Recent falls	Numbness/tingling	Weakness	Seizure
Difficulty sleeping	Snoring	Easy bruising	Sad/Depressed
Worried/Anxious	Fever	Weight loss	Night sweats

For women, date of last menstrual period: __________________________________

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Controlled Substances Patient Handout

To ensure all patients understand the current guidelines regarding controlled substances from the CDC and the FDA the following summary is provided. These guidelines are to ensure your safety and adherence to these federal regulations. The Institute of Precision Pain Medicine (IPPM) is committed to following these guidelines.

1. If IPPM is managing your pain medications they will be the ONLY group doing so. No pain prescriptions may be obtained from outside sources (ER, PCP, dentist, etc without prior approval).
2. Each prescription is written for 30 days unless otherwise specified. Early refills cannot be authorized. Medication cannot be changed without clinic visit.
3. Lost prescriptions or medication cannot be replaced.
4. Do not take more medication than prescribed.
5. Urinalysis will be performed. It is the patient's responsibility to accurately tell the technician all medications (including psychological meds) to have an accurate test. Failure to provide sample will result in holding of prescription.
6. I will bring all medications provided by IPPM to each visit.

Per federal guidelines, failure or refusal to comply with these guidelines will result in the inability of IPPM to manage your pain medications in the future.