12606 Greenville Ave, Suite 195
Dallas, TX 75243
214.826.8000 f. 214.826.8001

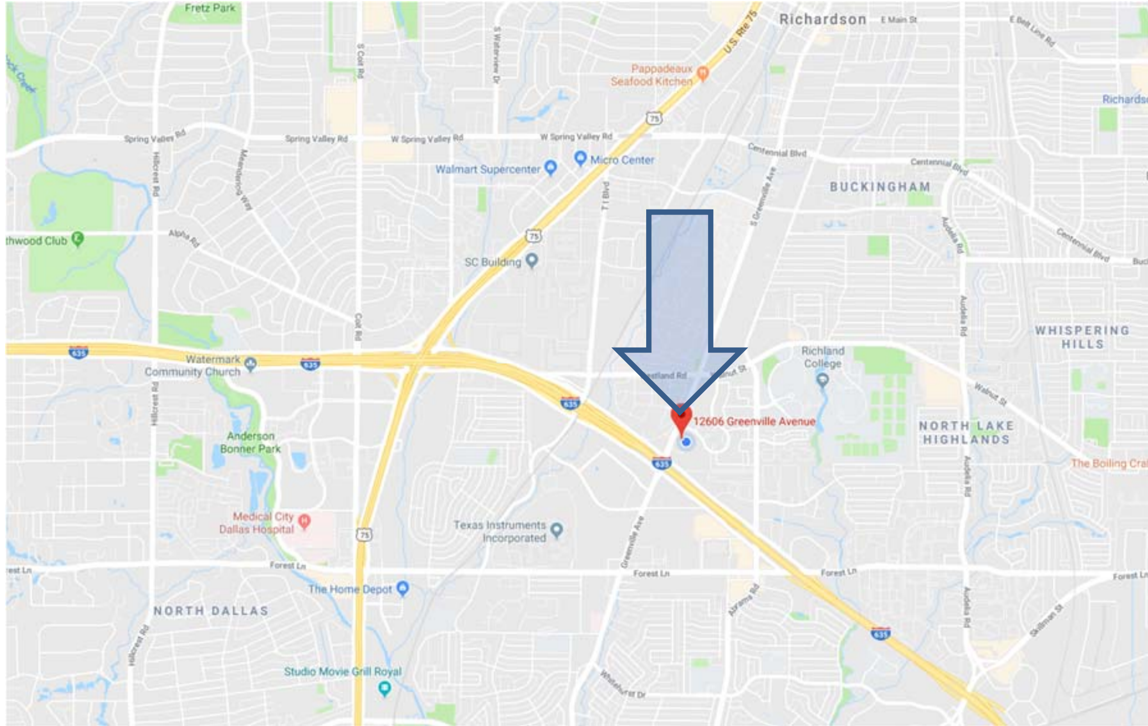
IMPORTANT - PLEASE READ

We want to make sure your visit is a success!☺
Please read the following instructions. If you have any questions, call us immediately at 214.826.8000.

Your appointment is: Date:____________________ Time:____________________

- You must complete this entire packet **before** your appointment and bring it with you or you **will not** be seen. Dr. Cohen makes no exceptions to this rule.
- Be prepared to pay your co-pay, co-insurance or deductible for the doctor's visit on the date of service. If you arrive and are unable to pay, you will be re-scheduled. Credit Card and Cash are accepted methods of payment.
- Bring your license/ID and insurance card(s).
- If you need to cancel, you must do **so 24 hours BEFORE** your appointment. Failure to do so will be considered a 'No Show' and you will be subject to a $400 rescheduling fee.
- You will receive a reminder call from our office 48 hours before your appointment.

Any questions, please call (214) 826-8000



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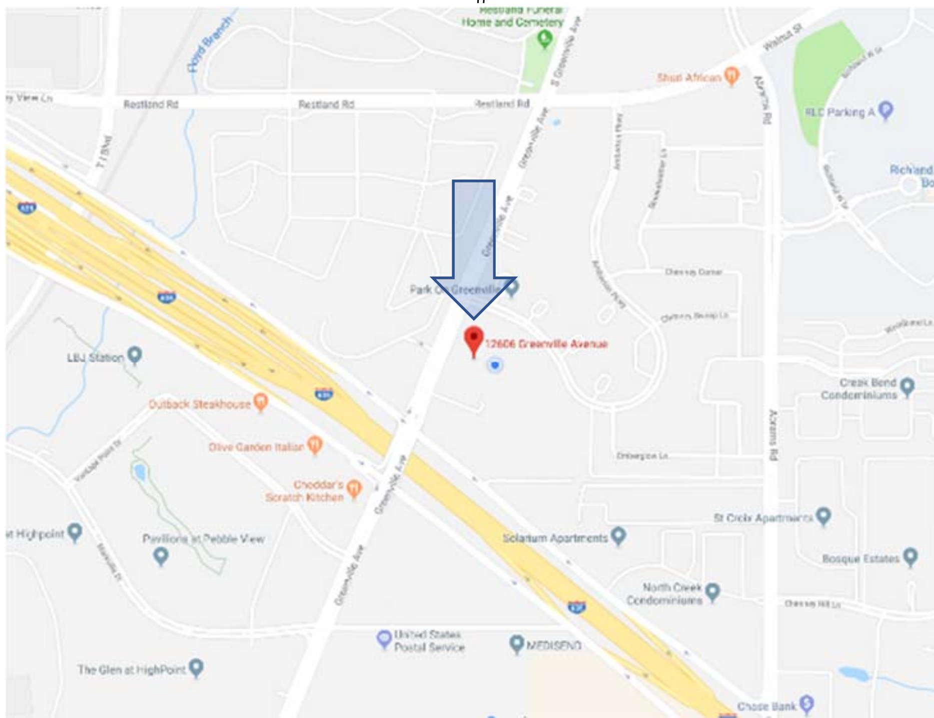

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12606 Greenville Ave, Suite 195

Dallas, TX 72543

PROGRESSIVE PAIN + INTERVENTIONAL PSYCHIATRY
2019

Howard Cohen MD

Privacy Statement
In order to be able to treat you effectively, we will need to ask you in depth questions about your medical and personal history. This information is confidential and cannot be released without your consent.

Name: ____ Date: ______________
Age:_________

1. What brings you to the office? ____
____
____
____
____

2. Please check and circle past or current medical problems:

- ❑ Glasses/contacts
- ❑ Hearing problems/tinnitus
- ❑ Sinus infections
- ❑ Glaucoma/ Cataracts/Mac. Degen.
- ❑ Asthma /COPD / Lung Disease/TB
- ❑ Mitral valve prolapse/ murmur
- ❑ Hypertension / MI/ Cardiovascular
- ❑ Ulcers/gastritis/esophagitis
- ❑ Crohn's disease/ Irritable bowel
- ❑ Liver disease/ Hepatitis A,B,C
- ❑ Pancreatitis
- ❑ Kidney stones/disease/cystitis
- ❑ Prostate disease
- ❑ Gynecological problems/pelvic pain
- ❑ Sexual problems or difficulties
- ❑ Fibromyalgia/ Muscle Pain/spasm
- ❑ Knee /Foot disorder
- ❑ Back /Thoracic disorder
- ❑ Neck /Shoulder disorder
- ❑ TMJ /Facial Pain
- ❑ AIDS/HIV/immune disorder
- ❑ Rheumatic Disorders/Lupus
- ❑ Skin disorders
- ❑ Chronic infections
- ❑ Chronic Regional Pain Syndrome
- ❑ Osteoarthritis/degenerative joints
- ❑ Serious childhood disease
- ❑ PMS
- ❑ Anemia or blood disorders
- ❑ Cancers/ Benign tumors
- ❑ Genetic/Metabolic disorders
- ❑ Diabetes/Endocrine/Hormonal
- ❑ Attention deficit disorder (ADD)
- ❑ Nerve/Phantom Pain
- ❑ Sciatica/neuropathy
- ❑ Severe Allergies
- ❑ Headaches/Migraines
- ❑ Stroke/TIA/Aneurysm
- ❑ Multiple sclerosis
- ❑ Parkinson's Disease
- ❑ Neurologic Disorders
- ❑ Head Injury (mild /severe)
- ❑ Dementia/ Alzheimer's
- ❑ Seizures/Pseudoseizures
- ❑ Depression/Bipolar disorder
- ❑ Panic/OCD/Anxiety
- ❑ Developmental/Autism
- ❑ Sleep Apnea/ Disorders
- ❑ Schizophrenia
- ❑ Alcohol/Drug Problems
- ❑ Personality Disorder

Other: ____
____
____
____

Please list your current medications (& herbs, and supplements), including **dose** and **frequency:**

____
____
____
____

3. Please check / circle if you are having any of the following symptoms:

- ❑ Visual Changes
- ❑ Ringing in ears
- ❑ Change in ability to smell/taste
- ❑ Hearing changes
- ❑ Trouble swallowing
- ❑ Shortness of breath/cough
- ❑ Coughing up blood
- ❑ Constipation/diarrhea
- ❑ Bloody or black stools
- ❑ Rashes
- ❑ Muscle Aches/spasms
- ❑ Frequent Colds or infections
- ❑ Tremors
- ❑ Excessive thirst / urination
- ❑ Difficulty with urination
- ❑ Palpitations
- ❑ Weakness/dizziness
- ❑ Swelling of extremities
- ❑ Chest Pain
- ❑ Abdominal Pain/cramps
- ❑ Bloating, gas
- ❑ Forgetfulness
- ❑ Balance problems
- ❑ Personality Change
- ❑ Blackouts/Fainting spells
- ❑ Fever/Chills/Night sweats
- ❑ Weight Loss/Gain

4. Food Allergies: ____
Medication Allergies: ____
Medication side effects: ____
____

5. If female, are you pregnant? ________ Previous number of times pregnant? ________
Abortions/stillbirths? ________ Live Births ________ Post partum depression? __________

6. List any surgeries you have had and list years of operations:
Surgery:____ Date: _______________
Surgery:____ Date: _______________
Surgery:____ Date: _______________
Surgery:____ Date: _______________
Surgery:____ Date: _______________
Surgery:____ Date: _______________

7. List any hospitalizations, reason and years:
Reason:____ Date: _______________
Reason:____ Date: _______________
Reason:____ Date: _______________
Reason:____ Date: _______________
Reason:____ Date: _______________
Reason:____ Date: _______________

8. List your current medical doctors (full name) and their specialties:
   Name:____ Specialty: ________________
   Name:____ Specialty: ________________
   Name:____ Specialty: ________________
   Name:____ Specialty: ________________
   Name:____ Specialty: ________________
   Name:____ Specialty: ________________

9. Where were you born? ________________________ Raised By Whom? _______________

10. Please list your family members, their ages, and what kind of significant medical, psychological, or alcohol/drug problems, they may have had.

	Name (Optional)	Age	Medical Problems	Psychological Problems	Alcohol/Drug Problems	If deceased, cause of death
Biological Father						
Biological Mother						
Brothers						
Sisters						
Children						

11. Do you have any other close relatives with significant medical, psychological or genetic illnesses?

____

____

12. What is your highest level of education? Degree? School? Any other training or schooling? Military service?

____

____

13. Please indicate your marital history - single, married, separated, divorced, widowed, significant other? How long? Any children? If single, are you currently in a relationship?

____
____
____
____
____

14. Are you currently employed? How long? What are your previous jobs/careers? Are you disabled?

____
____
____
____
____
____

15. Do you currently have any legal problems such as lawsuits, charges pending, probation? Past felony convictions or time served?

____
____
____
____

16. What type of exercise do you get?

____
____

17. How many times a day do you eat? Please describe your diet.

____
____
____
____

18. What do you like to do in your free time? Please list hobbies/interests.

____
____
____
____

19. How would you describe your personality?

____
____
____
____

20. Briefly describe your childhood. Were you ever the victim of abuse, neglect or trauma?

____
____
____
____

21. Please check treatments you have received

- ❑ Acupuncture
- ❑ Biofeedback/hypnosis
- ❑ Research Trial
- ❑ Massage therapy
- ❑ Muscle stimulator
- ❑ TENS Unit
- ❑ Physical Therapy
- ❑ Stress Management
- ❑ Aqua therapy
- ❑ Pain pump or trial
- ❑ Chiropractic/ ice
- ❑ Trigger point injections
- ❑ Epidural/nerve blocks
- ❑ Dorsal column stimulator
- ❑ Chinese herbs
- ❑ Psychotherapy

22.Current Stressors - check all that apply.

- ❑ Pain
- ❑ Medical/health problems
- ❑ Conflicts with spouse/significant other
- ❑ Financial Problems
- ❑ Problems with job/employer/career
- ❑ Legal problems
- ❑ Problems with children
- ❑ Illness of family members
- ❑ Problems with parents

23. Please check/circle if you currently use or have used any of the following:

	Currently Use Amount/Frequency	Past Use/ Experimentation
Alcohol	______________	______________
Tobacco	______________	______________
Caffeine (coffee, soda, tea)	______________	______________
Marijuana/Salvia	______________	______________
Methamphetamine /Khat	______________	______________
Prescription Opiate abuse	______________	______________
Heroin/Cocaine	______________	______________
Ecstasy/GHB	______________	______________
PCP/Ketamine	______________	______________
LSD/Mushrooms	______________	______________

24. Please check/circle all that apply:

- ❑ Do you feel sad, blue, or irritable?
- ❑ Have you had a change in appetite or weight loss? Weight gain?
- ❑ Do you have problems going to sleep, staying asleep, or sleeping too much?
- ❑ Do you find you're not as interested in activities you used to enjoy?
- ❑ Do you have problems concentrating?
- ❑ Have you noticed problems with your memory?
- ❑ Do you have feelings of being worthless/useless?
- ❑ Do you have problems with excessive worry?
- ❑ Have you had thoughts that life is not worth living?
- ❑ Have you experienced panic attacks or feelings of losing control?
- ❑ Have you been increasing your alcohol or recreational drug use?
- ❑ Have you been experiencing problems with low energy?
- ❑ Have you experienced a loss of zest for life or an inability to experience pleasure?
- ❑ Have you noticed a change in your sex drive?
- ❑ Have you had thoughts about killing yourself?
- ❑ Have you been experiencing frequent nightmares or sleepwalking?
- ❑ Do you startle easily or feel jumpy?
- ❑ Have you felt so full of energy that you do not need to sleep? Spending too much money?
- ❑ Are you bothered by repetitive thoughts about the same things?
- ❑ Have you noticed excessive hand washing or checking on things?
- ❑ Have you experienced periods of increased energy with racing thoughts or rapid speech?
- ❑ Have you had episodes of hearing voices that you are not sure others can't hear?
- ❑ Have you felt as if you are being followed or that someone is watching you?

Progressive Pain & Interventional Psychiatry

PAIN MEDICATION HISTORY 4/2019

(Please circle any medications you have ever taken)

Patient Name: ______________________ Date: ______________

ANTIDEPRESSANTS/PAIN
Emsam/selegiline
Viibryd
Pristiq/Effexor (venlafaxine)
Savella/Fetzima
Cymbalta (duloxetine)
Anafranil (clomipramine)
Asendin (amoxapine)
Celexa (citalopram)
Trazodone
Trintellix/Brintellix
Elavil (amitriptyline)/notriptyline
Lexapro (escitalopram)
Nardil (phenelzine)/Parnate
desipramine/imipramine
protriptyline
Zoloft (sertraline)
Paxil (Paroxetine)
Prozac (fluoxetine)
Parnate (tranylcypromine)/Nardil
Remeron (mirtazapine)
Serzone (nefazodone)
Doxepin, Silenor

ANTI-ANXIETY
Ativan (lorazepam)
Klonopin (clonazepam)
Librium (chlordiazepoxide)/Librax
Serax (oxazepam)
Valium (diazepam)
Xanax (alprazolam)
Tranxene (chlorazepate)
Buspar (buspirone)
Valerian
Kava
Phenobarbital
Lavender/Kava

MUSCLE RELAXERS
Lorzone (chlorzoxazone)
Flexeril (cyclobenzaprine)
Lioresal (baclofen)
Norflex (orphenadrine)
Parafon Forte / Lorzone (chlorzoxazone)
Robaxin (methocarbamol)
Skelaxin (metaxalone)
Soma (carisoprodol)/Meprobamate
Zanaflex (tizanidine)
Botox

NON-OPIOID PAINKILLERS
Tylenol (acetaminophen)
Advil, Motrin, Nuprin (ibuprofen)
Aleve, Naprelan, Naprosyn (naproxen)
Ansaid (flubiprofen)
Arthrotec (diclotenac/misoprostol)
Aspirin (acetylsalicylic acid)
Voltaren (diclofenac)/Zipsor
Celebrex (celecoxib)
Clinoril (sulindac)
Daypro (oxaprozine)
Doloboid (diflunisal)
Feldene (piroxicam)
Indocin (indomethacin)
Lodine (etodolac)
Mobic (meloxicam)
Nalfon (fenoprofen)
Orudis, Oruvail (ketoprofen)
Relafen (nabumetone)
Toradol (ketorolac)
Plaquenil/methotrexate
Enbrel/Remicade/Humira/Biologics
Prialt (ziconotide)
Intravenous Lidocaine/Ketamine
Nuedexta
Oxytocin spray
Ketamine oral/spray

TOPICALS
Lidoderm (lidocaine patch)
Zonalon Cream (doxepin)
Ketamine gel/cream
Biofreeze
Voltaren gel/Flector patch
Lidocaine cream

ANTI-NAUSEANTS
Vistaril, Atarax (hydroxyzine)
Zofran (ondansetron)/Kytril
Tigan (trimethobenzamide)
Phenergan (promethazine)
Marinol (dronabinol)
Compazine
Reglan (metoclopramide)
Chlorpromazine
Emend

HYPNOTICS
Ambien (zolpidem)
Dalmane (flurazepam)
Halcion (triazolam)
Somnote (chloral hydrate)
Restoril (tempazepam)
Sonata (zaleplon)
Melatonin
Xyrem (GHB)
Lunesta (eszopiclone)
Rozerem (ramelteon)
Belsomra
Benadryl
Trazodone
Seroquel (quetiapine)
mirtazapine

OPIOIDS

Nucynta (tapendatol)
Tylenol with codeine, #2, #3, #4
Duragesic Patch (fentanyl)
Actiq Lozenge/Fentora (fentanyl)/Subsys/Abstral
Lortab, Norco, Vicodin, (hydrocodone), Trezix
Opana (oxymorphone)
Dilaudid (hydromorphone), Exalgo
Levorphanol
Demeral/Mepergan (meperidine)
Methadone
Darvon/Darvocet (propoxyphene)
Morphabond, MS-Contin, Embeda, Kadian (morphine)
Oxycontin/Roxicodone/Xtampza/Percocet (oxycodone)
Suboxone/Subutex/Butrans/Belbuca/Bunavail/
Zubsys (buprenorphine)
Nubain (nalbuphine)
Stadol (butorphanol)
Talwin NX (pentazocine/naltrexone)
Ultram (Tramadol)
LDN (low dose naltrexone)

HEADACHE MEDICATIONS
Relpax (eletriptan)/Amerge/Axert/Maxalt/Zomig/Frova
Imitrex tablet/injection/spray (sumatriptan)/Onzetra/
Zembrace
Bellergal (ergotamine tartrate, belladonna alkaloids,
Phenobarbital)
Cafergot (ergotamine tartrate, caffeine)
D. H. E. 45 (dihydroergotamine mesylate)
Migranal nasal spray (dihydroergotamine)
Midrin (isometheptene)
Petadolex (butterbur)
Periactin (cyproheptadine)
Sansert (methysergide) /methergine
Esgic, Fioricet/Fioricet (butalbital)
Calan (verapamil)
Inderal (propranolol)/ Tenormin (atenolol)
Botox
Aimovig/Ajovy/Emgality
Magnesium/Coenzyme Q10/Riboflavin
Lidocane drops/spray
Cambia

CENTRAL NERVOUS SYSTEM
Amantadine
Cogentin (benztropine)
Selefeline
Symmetrel (amantadine)
Parlodel (bromocryptine)
Permax (pergolide)
Sinemet (levodopa/carbidopa)
Mirapex (pramipexole)
Requip (ropinirole)
Mysoline
Inderal (propranolol)
Tenormin (atenolol)
Prazosin/terazosin/Dibenzyline
Clonidine
Nuedexta/Namenda
Bentyl/hyoscyamine/Librax

STIMULANTS
Ritalin, Concerta (methylphenidate)
Cylert (pemoline)
Dexedrine, Adderall (dextroamphetamine),
Desoxyn
Provigil (modafinil)/ Nuvigil (armodafinil)
Fastin/Adipex (phentermine)

ADDICTION MEDICATIONS
Revia/Trexan/Vivitrol (naltrexone)
Catapres (clonidine)
Antabuse (disulfuram)
Methadone
Suboxone/Subutex/Bunavail/Zubsys (buprenorphine)
Campral (acamprosate)
Chantix

ANTICONVULSANTS/NERVE PAIN
Mexitil (mexiletine)
Carbatrol, Tegretol (carbamazepine)
Dilantin (phenytoin)
Gabitril (tigabine)/Keppra
Klonopin (clonazepam)
Lamictal (lamotrigine), Keppra/Depakote (valproate)
Neurontin (gabapentin)/Lyrica
Topamax (topiramate)/Quedexy/Trokendi
Trileptal (oxcarbazepine)/Oxtellar
Zonegran (zonisamide)
Ketamine/Nuedexta/Namenda
Vimpat

MOOD STABILIZERS

Abilify (aripiprazole)
Geodon (ziprasidone)
Risperdal (risperidone)
Seroquel (quetiapine)
Zyprexa (olanzapine)
Clozaril, Haldol (haloperidol)
Oxtellar Trileptal (oxycarbazepine)
Loxitane (loxapine)
Depakote (valproate)
Stelazine (trifluoperazine)
Thorazine (chlorpromazine)
Trilafon (perphenazine)
Invega (palloperidone)
Saphris
Latuda Fanapt
Rexulti
Vraylar
Lithium
Vimpat
Lamictal (lamotrigine)

COGNITIVE ENHANCERS

Hydergine (ergoloid mesylates)
Aricept (donepezil)
Exelon (rivastigmine)
Piracetam/Aniracetam
Centrophenoxine
Vinpocetine
Razadyne (galantamine)
Ginko Biloba
Elderpryl/Deprenyl (selegiline)
DMAE/Choline/Phosphatadiylcholine
Namenda (memantine)
Bacopa

Insomnia Severity Guide

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the 'Guidelines for Scoring/Interpretation' below to see where your sleep difficulty fits.

For each question, please CIRCLE the number that best describes your answer.

Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
Difficulty falling asleep	0	1	2	3	4
Difficulty staying asleep	0	1	2	3	4
Problems waking up too early	0	1	2	3	4

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
0	1	2	3	4

5. How NOTICABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all Noticeable	A little	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

6. How WORRIED/DISTRESSED are you about your current problem?

Not at all Noticeable	A little	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not at all Noticeable	A little	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

Guidelines for Scoring/Interpretation:

Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 + 6 + 7) = _____________ your total score

Total score categories:
0-7 = No clinically significant insomnia
8-14 = Subthreshold insomnia
15-21 = Clinical insomnia (moderate severity)
22-28 = Clinical insomnia (severe)

PROGRESSIVE PAIN &
INTERVENTIONAL PSYCHIATRY

BECK INVENTORY

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling the PAST WEEK. INCLUDING TODAY: Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

1. 0 I do not feel sad.
1 I feel sad.
2 I am sad all the time and I can't snap out of it.
3 I am so sad or unhappy that I can't stand it

2. 0 I am not particularly discouraged about the future.
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel that the future is hopeless and that things cannot improve.

3. 0 I do not feel like failure.
1 I feel I have failed more than the average person.
2 As I look back on my life, all I can see is a lot of failures.
3 I feel I am a complete failure as a person.

4. 0 I get as much satisfaction out of things as I used to.
1 I don't enjoy things the way I used to.
2 I don't get real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.

5. 0 I don't feel particularly guilty.
1 I don't feel guilty a good part of the time.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6. 0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7. 0 I don't feel disappointed in myself.
1 I am disappointed in myself.
2 I am disgusted with myself.
3 I hate myself.

8. 0 I don't feel I am any worse than anybody else.
1 I am critical of myself for my weakness or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.

9. 0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. 0 I don't cry any more than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.

11. 0 I am no more irritated now than I ever am.
1 I get annoyed or irritated more easily than I used to.
2 I feel irritated all the time now.
3 I get irritated at all by the things that used to irritate me.

12. 0 I have not lost interest in other people.
1 I am less interested in other people that I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13. 0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions than before.
3 I can't make decisions at all anymore.

14. 0 I don't look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel that there are permanent changes in my appearance that makes me look unattractive.
3 I believe that I look ugly.

15. 0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16. 0 I sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18. 0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19. 0 I haven't lost much weight, if any, lately.
1 I have lost more than 5 pounds.
2 I have lost more than 10 pounds.
3 I have lost more than 15 pounds.
I am purposely trying to lose weight by eating less
Yes________ No_________

20. 0 I am no more worried about my health than usual.
1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think about anything else.

21. 0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

HIT-6™ Headache Impact Test

HIT is a tool used to measure the impact headaches have on your ability to function on the job, at school, at home and in social situations. Your score shows you the effect that headaches have on normal daily life and your ability to function. HIT was developed by an international team of headache experts from neurology and primary care medicine in collaboration with the psychometricians who developed the SF-36® health assessment tool. This questionnaire was designed to help you describe and communicate the way you feel and what you cannot do because of headaches.

To complete, please circle one answer for each question.

When you have headaches, how often is the pain severe?

never	rarely	sometimes	very often	always

How often do headaches limit your ability to do usual daily activities including household work, work, school, or social activities?

never	rarely	sometimes	very often	always

When you have a headache, how often do you wish you could lie down?

never	rarely	sometimes	very often	always

In the past 4 weeks, how often have you felt too tired to do work or daily activities because of your headaches?

never	rarely	sometimes	very often	always

In the past 4 weeks, how often have you felt fed up or irritated because of your headaches?

never	rarely	sometimes	very often	always

In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?

never	rarely	sometimes	very often	always

☐	+ ☐	+ ☐	+ ☐	+ ☐
COLUMN 1 6 points each	COLUMN 2 8 points each	COLUMN 3 10 points each	COLUMN 4 11 points each	COLUMN 5 13 points each

To score, add points for answers in each column.

If your HIT-6 is 50 or higher:

You should share your results with your doctor. Headaches that stop you from enjoying the important things in life, like family, work, school or social activities could be migraine.

☐ TOTAL SCORE

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Name: ____ Date:____________________________

PAIN DRAWING DIAGRAM ASSESSMENT

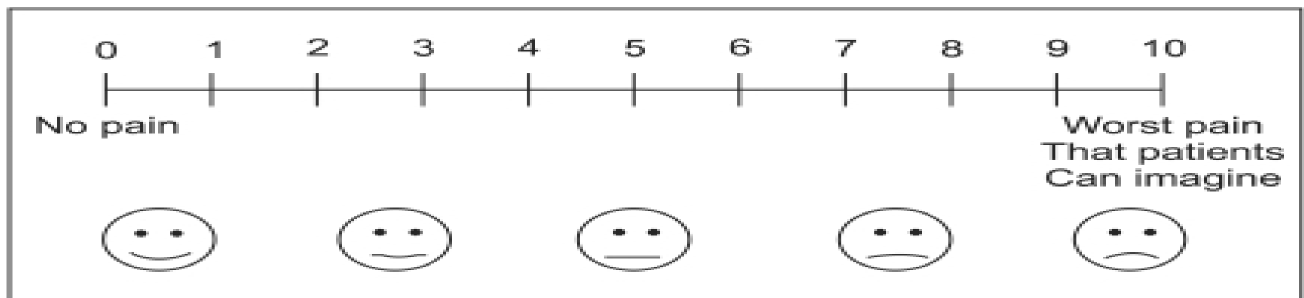
THINKING ABOUT ALL YOUR PAIN IN THE LAST 7 DAYS:

Mark the location of your pain on the body outlines.

RIGHT LEFT LEFT RIGHT

FRONT BACK

Indicate how bad your pain is.



Progressive Pain & Interventional Psychiatry

Patient Comfort Assessment Guide

Name: ____

Date:_____________________

1. Where is your pain? ____
2. Circle the words that describe your pain.

Aching	sharp	penetrating
throbbing	tender	nagging
shooting	burning	numb
stabbing	exhausting	miserable
gnawing	tiring	unbearable

Circle One occasional continuous

What time of day is your pain the worst?

morning afternoon evening nighttime

3. Rate your pain by circling the number that best describes your pain at its <u>worst</u> in the last month.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

4. Rate your pain by circling the number that best describes your pain at its <u>least</u> in the last month.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

5. Rate your pain by circling the number that best describes your pain at its <u>average</u> in the last month.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

6. Rate your pain by circling the number that best describes your pain <u>right now.</u>

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

7. What makes your pain better? ____

8. What makes your pain worse? ____

9. What treatments or medicines are you receiving for your pain? Circle the number to describe the amount of relief the treatment or medicine provide(s) you.

a) _______________________________ No 0 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) Relief Relief

b) _______________________________ No 0 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) Relief Relief

c)_______________________________ No 0 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) Relief Relief

d)_______________________________ No 0 1 2 3 4 5 6 7 8 9 10 Complete
Treatment or Medicine (include dose) Relief Relief

PROGRESSIVE PAIN & INTERVENTIONAL PSYCHIATRY

Central Sensitization Inventory: Part A

Please circle the best response to the right of each statement.

1	I feel un-refreshed when I wake up in the morning.	Never	Rarely	Sometimes	Often	Always
2	My muscles feel stiff and achy.	Never	Rarely	Sometimes	Often	Always
3	I have anxiety attacks.	Never	Rarely	Sometimes	Often	Always
4	I grind or clench my teeth.	Never	Rarely	Sometimes	Often	Always
5	I have problems with diarrhea and/or constipation.	Never	Rarely	Sometimes	Often	Always
6	I need help in performing my daily activities.	Never	Rarely	Sometimes	Often	Always
7	I am sensitive to bright lights.	Never	Rarely	Sometimes	Often	Always
8	I get tired very easily when I am physically active.	Never	Rarely	Sometimes	Often	Always
9	I feel pain all over my body.	Never	Rarely	Sometimes	Often	Always
10	I have headaches.	Never	Rarely	Sometimes	Often	Always
11	I feel discomfort in my bladder and/or burning when I urinate.	Never	Rarely	Sometimes	Often	Always
12	I do not sleep well.	Never	Rarely	Sometimes	Often	Always
13	I have difficulty concentrating.	Never	Rarely	Sometimes	Often	Always
14	I have skin problems such as dryness, itchiness or rashes.	Never	Rarely	Sometimes	Often	Always
15	Stress makes my physical symptoms get worse.	Never	Rarely	Sometimes	Often	Always
16	I feel sad or depressed.	Never	Rarely	Sometimes	Often	Always
17	I have low energy.	Never	Rarely	Sometimes	Often	Always
18	I have muscle tension in my neck and shoulders.	Never	Rarely	Sometimes	Often	Always
19	I have pain in my jaw.	Never	Rarely	Sometimes	Often	Always
20	Certain smells, such as perfumes, make me feel dizzy and nauseated.	Never	Rarely	Sometimes	Often	Always
21	I have to urinate frequently.	Never	Rarely	Sometimes	Often	Always
22	My legs feel uncomfortable and restless when I am trying to go to sleep at night.	Never	Rarely	Sometimes	Often	Always
23	I have difficulty remembering things.	Never	Rarely	Sometimes	Often	Always
24	I suffered trauma as a child.	Never	Rarely	Sometimes	Often	Always
25	I have pain in my pelvic area.	Never	Rarely	Sometimes	Often	Always
					Total =	

Central Sensitization Inventory: Part B

Have you been diagnosed by a doctor with any of the following disorders?
Please check the box to the right for each diagnosis and write the year of the diagnosis.

		NO	YES	Year Diagnosed
1	Restless Leg Syndrome			
2	Chronic Fatigue Syndrome			
3	Fibromyalgia			
4	Temporomandibular Joint Disorder (TMJ)			
5	Migraine or tension headaches			
6	Irritable Bowel Syndrome			
7	Multiple Chemical Sensitivities			
8	Neck Injury (including whiplash)			
9	Anxiety or Panic Attacks			
10	Depression			

SOAPP® Version 1.0 – SF

Name: ____ Date: _____________________

The following are some questions given to all patients 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 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, etc.) in the past five 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.

Any Drug Allergies

Patient Name: ___________________________________

DOB: ____

If No, Allergies *Please Circle* NKA = No Known Allergies

Allergic To:

1. ____
2. ____
3. ____
4. ____
5. ____

PROGRESSIVE PAIN &
INTERVENTIONAL PSYCHIATRY

Pharmacy Information Form

Patient Name: ________________________________

Patient Date of Birth: ________________________________

Today's Date: ________________________________

Pharmacy Name: ____

Pharmacy Address: ____

____

Phone: ______________________________

Fax: ______________________________

Progressive Pain + Interventional Psychiatry

12606 Greenville Ave, Suite 195; Dallas, TX, 75230

Consent Forms

Patient Name:____

Date Signed:____________________________________

Year:____

[***Consent forms to be up-dated each new year***]

Patient Signature:____

BASIC INFORMATION FORM

Patient Name: ____ Today's Date: __________________

Address_____________________________City___________________State_________Zip___________

Email address: ____

Home Phone (_______) ________________________Cell Phone(________)________________________

DOB______/________/________ Gender: __M__F Marital Status: Single/Married/Divorced/Widowed

Dr. License #______________________________ SS Number: ________-________-________

Pharmacy: ____ Phone (________) __________________

Employer Name: ______________________________________ Phone (________) __________________

Address___________________________City_____________________State________Zip____________

Emergency Contact Name: _______________________________Phone (________) __________________

Do you have insurance? ☐ Yes ☐No If no, how will you be paying today? ☐ Cash ☐ Check ☐ Credit Card

Whom should we thank for referring you? ____

PRIMARY INSURANCE (Insurance companies require the below information for billing purposes.)

Name of Insured: _______________________________ Relationship to Pt: ________________________

Insured's Social Security#________-________-________ Insured's DOB: ________/________/________
Insurance Co. Name: ___________________________________Phone (________) __________________
Address___________________________City_____________________State________Zip____________
Policy # _______________________________________Group ID: ________________________________

SECONDARY INSURANCE

Name of Insured: ____________________________ Relationship to Pt._____________
DOB ________/ ________/ ________ SS#________-________-________
Insurance Co. Name: ___________________________________Phone (________) __________________

I authorize Howard Cohen, MD and/or staff involved with my care to discuss medical and/or billing with the following individual:

Name:____Relationship to Pt:____________________________

I authorize the release of any information concerning my healthcare, to expedite insurance payment. I also hereby authorize payment of insurance and understand that I am responsible for all charges, regardless of insurance coverage.

____ ____________________________________
Signature of patient, parent, or legal guardian Date

Progressive Pain & Interventional Psychiatry

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT
AS REQUIRED BY THE TEXAS MEDICAL BOARD
REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9, CHAPTER 170
4TH Edition: Developed by the Texas Pain Society, August 2017 (www.texaspain.org)

NAME OF PATIENT: ________________________________ DATE: __________________

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug(s) after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to use the drug(s) recommended to you by me, as your physician. For the 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 (HOWARD M COHEN, MD) to treat my condition which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent for my physician to administer or write prescription(s) for dangerous and/or controlled drugs (medications) as an element in the treatment of my chronic pain.

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

THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT HAVE BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT (THIS IS SOMETIMES REFERRED TO AS "OFF-LABEL" PRESCRIBING). MY DOCTOR WILL EXPLAIN HIS TREATMENT PLAN(S) FOR ME AND DOCUMENT IT IN MY MEDICAL CHART.

I HAVE BEEN INFORMED AND understand that I will undergo medical tests and examinations before and during my treatment. Those tests include random unannounced checks (urine, blood, saliva or any other testing indicated and deemed necessary by my physician at any time) 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 or absence of authorized substances may result in my being discharged from your care.

For female patients only:

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

_____________If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment. I accept that it is **MY responsibility** to inform my physician immediately if I become pregnant.

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

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

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension(low blood pressure), arrhythmias(irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction times might still be slowed. Such activities include but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medication(s) for the treatment of my chronic pain.

The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and functional life. I realize that I may have a chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored specifically for me. I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time and that I will notify my physician of any discontinued use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

I understand that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of 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:

____ I am aware that all controlled substance prescriptions are now being monitored by the Texas State Board of Pharmacy and that information will be accessed by my physician each time a prescription is written.

____ My progress will be periodically reviewed and, if the medication(s) are not improving my 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.

____ My pain management physician will manage the chronic pain symptoms. All other health related issues must be managed by my primary care physician.

____ I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money**. If either are lost or stolen, they may NOT BE REPLACED.**

____ Refill(s) **will not be ordered before the scheduled refill date**. However, early refill(s) are allowed when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.

____ I will receive medication(s) **only from ONE physician** unless it is for an emergency **or** the medication(s) that is being prescribed by another physician is approved by my physician. Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.

____ If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then **my physician may try alternative medication(s) or may taper me off all medication(s**). I will not hold my physician liable for problems caused by the discontinuance of medication(s).

____ I **agree to submit to urine and/or blood screens** to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), 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 recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize **that my active participation** in the management of my pain is extremely important. I agree to **actively participate in all aspects of the pain management program** recommended by my physician to achieve increased function and improved quality of life.

____ I agree that I **shall inform any doctor** who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.

____ I hereby give my physician **permission to** discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s). I give my

pain physician permission to obtain any and all medical records necessary to diagnose and treat my painful conditions.

____ I must take the medication(s) as instructed by my physician. **Any unauthorized increase** in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.

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

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

I certify and agree to the following:

1. I am **not currently using illegal drugs or abusing prescription medication**(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.
2. I have **never been involved** in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.)
3. **No guarantee or assurance has been made** as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life.
4. I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain. **I fully understand the explanations regarding the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.**

____

Patient Signature

____

Physician Signature (or Appropriately Authorized Assistant)

CONTROLLED SUBSTANCES

- Controlled substances will not be replaced if they are lost or stolen or taken more frequently than prescribed and used up early. If medication is legitimately stolen you must bring the police report that you have filed to the appointment to discuss replacement medication. Each request will be taken on a case basis and will require drug screening.
- All patients may be subject to pill counts and random drug screens at their expensein order to continue receiving pain medication.
- Medications are not to be shared.
- Controlled substances and other medications may impair your ability to safely drive a vehicle and/or perform daily activities and may be habit-forming. It is your responsibility to monitor yourself and enlist your family's assistance if necessary.
- Patients are not allowed to receive controlled substances from other physicians without our prior consent outside of emergency situations.
- Controlled substances will be prescribed only during business hours. There will be no controlled substances called in outside of business hours, no exceptions.
- Opiate withdrawal is very uncomfortable, but not a life threatening medical emergency. Unfortunately, if you take your medication more frequently than prescribed without prior authorization, you will be responsible for the consequences.
- At our discretion, there will be a $50.00 charge to pick up prescriptions without appointment.
- It is both unacceptable and inappropriate to "drop in" to obtain prescriptions.

PRESCRIPTION REFILLS

It is your responsibility to assure that your prescription refill authorizations are up-to-date during your office visits. **We do not accept requests from your pharmacy to extend your refills.** Mail order prescriptions will be handled during office visits only. Pharmacy and prescription issues that arise are non-emergency and we suggest you make sure the prescription given will carry you to your next appointment. An appointment must be made in order to receive a controlled substance medication refill. Any changes to medication (i.e., they don't work or if a new medication is required) must be handled by an appointment and not over the phone.

PHONE CALLS/MEDICAL EMERGENCIES

There will be an on-call clinician available 24 hours a day to handle medical emergencies. Medical emergency must be seen in an ER and may not be treated by telephone. Any visits to this office must be made by appointment, we accept no "drop-ins." Significant medical and administrative problems will be handled throughout the day; please call during business hours when your chart is readily available. Your call will be returned as soon as time allows. Non-emergency calls will be returned within 24 hours. Speak clearly, concisely, and leave your phone number at the beginning and at the end of your message. It is imperative that your emergency message be clearly understood as a significant number of messages received are indecipherable. There will be a $50.00 charge for each non-emergency, after-hours phone call; this is not billable to your insurance.

The following are examples of non-emergencies and will not be handled over the telephone:

1. Ran out of medications.
2. Pharmacy issues.
3. Lost or Stolen medications.
4. General medical advice.
5. Issues that could have been handled during normal business hours.

APPOINTMENT TIMES

The clinical staff tries to maintain a timely schedule. Emergencies are often not scheduled and can throw off appointment times. If a patient is more than 15 minutes late for an appointment the appointment time is rescheduled. If less than 15 minutes late the appointment will be limited to the assigned time allotted, shortening the appointment time.

MISSED APPOINTMENTS

You must give a 24-hour notice for appointment cancellations. There will be a $100.00 charge for forgotten/missed appointments if you are to continue care at the clinic (new patient missed appointments will be charged $400.00); this is not billable to your insurance. Patients with multiple cancellations without notice will be discharged from the clinic. **Even if you have a family or medical emergency and cannot make your appointment, you should call our office as soon as possible to allow other patients a chance to use your time slot.** Chronic pain is not an excuse to miss your appointment. Please keep your appointment card as this will be used for verification of scheduled appointments in the event of a discrepancy.

INSURANCE FORMS/PRE-AUTHORIZATIONS/APPEALS/DISABILITY LETTERS

You must make an appointment to complete paperwork. We will fill out a disability, medical excuse, jury duty, "letter of medical necessity," legal, handicapped parking, pre-authorization, or other insurance administrative form or letters during **a paperwork appointment only.** There will be a $100.00 charge to complete these forms/letters; this is not billable to your insurance. Disability issues may interfere with the doctor-patient relationship; we may require you to be evaluated by a physical medicine and rehabilitation specialist to have these determinations made.

There is an emerging trend for insurance carriers to require additional paperwork for routine prescriptions. Insurance carriers will arbitrarily limit doses and number of pills prescribed to save themselves money and pass costs on to patients. These rules are not generally part of your insurance policy, but an attempt to dissuade patients from using certain medications. It is not our responsibility to determine whether specific medications and/or dosages are covered by your carrier's prescription plan. Your formulary is available to you and we advise that you bring this to your appointment to avoid potential pre-authorization issues, however, we may handle the paperwork and phone calls for you for a $25.00 fee unless instructed otherwise. This service is not billable to your insurance. We highly recommend patients complain to their insurance carrier regarding these matters to help stop this trend.

If requested, we may testify on your behalf in a court hearing or deposition for a standard fee. **Please be aware that we are unable to do this on a short notice.**

____________________________________ ________________________________

Patient Signature **Provider Signature**

Financial Policy and Payment Agreement

Progressive Pain & Psychiatry is committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive the maximum allowable benefits. To achieve these goals however, we need your assistance and your understanding of our financial payment policy.

FINANCIAL POLICY

1. Self-pay patients are responsible for the cost of all services billable or non-billable to insurance. This may include random drug screening and any other tests or assessments ordered by the provider. Self-pay patients are expected to pay for services rendered in full at the time of service. Any financial arrangements must be made before you see the physician. We accept the following forms of payment: cash (exact change only) and all major credit cards.
2. As a courtesy to you, we will file your insurance claim form for reimbursement. In order to do this, we must have current insurance information for each visit. Patients who do not provide current insurance information will be treated as self-pay.
3. If your insurance plan requires a referral or authorization from your primary care physician, we will need to receive authorization before you see our physician. If you have not received an authorization prior to your arrival at our office, we have a telephone available for you to call your primary care physician or insurance company to get the required authorization.
4. In the event your insurance company determines a service to be "not covered", you will be responsible for payment. We try to inform patients when services may not be covered; however, it is the patient's responsibility to understand their health insurance limitations.
5. Appointment No-Show Fee: we understand that sometimes appointments must either be cancelled or rescheduled. Because we provide specialized services, we ask that you provide at least 24-hour prior notice for cancellations or rescheduled appointments. Your failure to provide us the requested 24-hour notice will result in a no-show fee. This fee will be due at the time of your next appointment.
   - $400.00 – New evaluation appointment no-show fee
   - $100.00 – Follow up appointment No-show fee
   - $100.00 – Evoke No-Show Fee
6. Additional Fees:
   - $50.00 – At our discretion, there will be a charge to pick up prescriptions without appointment.

*****Please be aware that any balance on your account over 90 days is subject to intensive collection procedures and may result in denial of future care until overdue balances are paid in full.**

PAYMENT AGREEMENT

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account. I accept full responsibility for any and all charges related to diagnosis and treatment, whether or not my insurance covers these services. I agree that my physician is not ultimately responsible for collection from my insurance company. I understand that my physician cannot file Medicaid or Workers Compensation. Office policy is to collect all co-pays, co-insurance and deductibles due at the time of service. I agree to pay IN FULL within 30 days of receipt of notice all balances due such as non-covered services, co-insurances, deductibles and co-payments not paid by my insurance company in addition to any fees charged against my account. Assignment of Benefits: I authorize my insurance carrier to pay benefits directly to my physician on any unpaid services on my behalf.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ, OR HAS BEEN READ, THE FOREGOING; UNDERSTANDS THE FOREGOING; HAS RECEIVED A COPY THEREOF; HAS BEEN GIVEN THE OPPORTUNITY TO ASK ANY QUESTIONS THEY MAY HAVE CONCERNING THE FOREGOING; AND THAT HE/SHE IS THE PATIENT OR DULY AUTHORIZED REPRESENTATIVE OF THE PATIENT. THE UNDERSIGNED, HAVING READ AND UNDERSTOOD THE AGREEMENT, ACCEPTS THIS FINANCIAL POLICY AND PAYMENT AGREEMENT.

Patient Name (Please Print) ____

Patient Signature____ Date____________________

Responsible/Authorized Representative (Guarantor)____

Guarantor Signature_____________________________________ Date_____________________

Relationship to Patient____________________________________

Medical Authorization to Treat and Obtain Confidential Information from Medical Records

Name:____________________________________DOB:_____________SS#:______________________

I, the undersigned, hereby authorize the physicians and their staff and/or Progressive Pain & Psychiatry, to evaluate and treat me pursuant to standards of medical and therapy practice. Such authorization assumes that I will receive full disclosure of potential risks and benefits of any invasive procedures to be performed upon me.

I, the undersigned, understand that I have the full opportunity to ask my physician any questions about any such treatment.

I, the undersigned, hereby authorize the physicians, staff, and/or Progressive Pain & Psychiatry to contact and confer with any and all licensed physicians, chiropractors, therapists, hospitals, clinics and laboratories that may have examined or treated me, and to examine and copy any and all medical reports, x-rays and records pertaining to my medical condition or relating to such examination and treatment. This will also authorize any such licenses health providers, hospitals, clinics and laboratories, or other representatives, to deliver to the physicians and staff and/or Progressive Pain & Psychiatry, full and complete written reports, or copies thereof, of medical records, imaging and lab reports, hospital records, medical bills, and all other information relative to my physical or mental condition requested by said physician.

I further authorize the physician and their staff and/or Progressive Pain & Psychiatry to use my records to compile research data for the use of scientific publications/presentations, guideline development and the like, without using any of my identifying information (name, SS#, etc.…)

I further authorize the physician and his/her employees, in accordance with the laws of the State of Texas, to furnish authorized employers, insurance carriers, attorneys, or state administrators, or to any agent or representative who is identified by this party, with all necessary information which this party should request from the medical records compiled by the physicians, staff, and/or Progressive Pain & Psychiatry in his/her office during my course of treatment. The medical records from which this information may be obtained includes all records produced under the direction of the physician, staff, and/or Progressive Pain & Interventional Psychiatry, or any other health provider's office, clinic, hospital, or laboratory at which evaluations or procedures may be performed. I authorize the physicians and their staff and/or Progressive Pain & Interventional Psychiatry to release medical information that may be necessary to request reimbursement from insurance companies to whom I have submitted a claim.

I assume personal responsibility for any valuables I bring to this facility. Progressive Pain & Psychiatry or the physicians will not be responsible for lost valuables of any kind.

Patient's Signature: ______________________________________

Date:_____________________________

PROGRESSIVE PAIN &
INTERVENTIONAL PSYCHIATRY

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Progressive Pain and Interventional Psychiatry to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as ("HIV") and ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this information is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the release information may no longer be protected by federal and state privacy regulations.

Print Patient Name:____

Date of Birth:____/____/____ Last 4 of SS#:_______________ Phone #:(____)_______________

Patient Address:____

Date(s) of Service (If known):____

Description of information to be released: (Check ☑ all that apply)

___Emergency Room
___History & Physical
___Nurse's Notes
___Progress Notes
___Discharge Reports
___Radiology Reports
___Consultation Reports
___Physician's Orders
___Operative Records
___Radiology Films
___Admission/Registration Records
___Laboratory Reports
___Billing Records
___Other: ___________________________
____

Description of the purpose of the use and/or disclosure:____
The Health information described herein shall be released to: (Check the appropriate category)

___Hospital ___Physician ___Insurance Company ___Attorney
___Patient ___Other________________

Name:____
Address:____
Phone #:____
Fax #:____

(Check ☑ the appropriate delivery method)

___Mail
___Fax (Healthcare Organization only)
___Pick-up Records
___Other:___________________________

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify.
I desire this authorization to be in effect until _________________________ (Expiration date/Event).
I further understand that I may revoke this authorization at any time by notifying Progressive Pain and Interventional Psychiatry in writing at 12606 Greenville Ave suite 195 Dallas, Tx 75243.
I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization.
The revocation will not affect any actions taken before the receipt of the written revocation.
☐ When checked, I understand that the record is incomplete and additional documentation will continue to be added.
I understand that I may request a complete copy at approximately 30 days post discharge.

____ _____________________________
Signature of Patient or Patient's Representative Date

____
Printed Name of Patient's Representative

____
Relationship to Patient

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Progressive Pain & Psychiatry 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 Progressive Pain & Psychiatry 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:

Progressive Pain & Psychiatry 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.

Progressive Pain & Psychiatry 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. Progressive Pain & Psychiatry 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.

Progressive Pain & Psychiatry 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.

Subject to certain requirements, we may use or disclose health information about you **without 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 Progressive Pain & Psychiatry 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 whom we disclose information as previously noted.

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.

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: Progressive Pain & Interventional Psychiatry at 12606 Greenville Ave., Suite 195, Dallas, Texas 75243 or call (214) 826-8000.

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 Progressive Pain & Psychiatry at 12606 Greenville Ave Suite 195, Dallas, Texas 75243 or call (214) 826-8000. You may also send a written complaint to the U.S. Department of Health and Human Services. We can provide you 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 following form acknowledging that you have received our Notice of Privacy Practices, effective April 14, 2003.

Acknowledgement of Receipt of Notice of Privacy Practices
*You may refuse to sign this acknowledgement

I, ____, have received and reviewed a copy of this office's Notice of Privacy Practices which describes how they use and disclose my health information and their HIPAA notice, which outlines standards and use of my protected health information.

Patient Name ____

Signature ____

Date ________________________________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communication barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (please specify)

____
____
____
____

Advanced Practice Nurse/Nurse Practitioner Consent

The physicians of Progressive Pain & Psychiatry want you to know that they employ Advanced Practice Nurses (who are also called Nurse Practitioners) to assist them in a "team approach" to their high quality delivery of medical care.

An Advanced Practice Nurse (APN)/Nurse Practitioner (NP) is a Registered Nurse who has received advanced education and training in the provision of health care. Advanced Practice Nurses/Nurse Practitioners are not doctors. APN's/NP's of Progressive Pain & Psychiatry can diagnose, treat, and monitor routine and complex pain disorders. If you are seen by an APN/NP, your doctor will review your care with the ANP/NP 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 problems and/or needs presented and discussed with one or more physicians in the development of my care plan. I also understand that typically one MD will direct my overall care, but that from time to time I may be seen by any or all of the practitioners in this practice, including a Nurse Practitioner.

I hereby consent to the services of a Nurse Practitioner for my health care needs.

I understand that I can refuse to see the Nurse Practitioner, 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.**

______________________________	______________________________
Patient Signature	Provider Signature

Prescription Fill Agreement

I ____ agree to not fill prescription medications written by Progressive Pain and Interventional Psychiatry under any Medicare, Medicaid, or Medicare supplement plan. I understand that it is my responsibility that my pharmacy does not elect to file my prescriptions under any of the aforementioned plans. I understand that violation of this agreement will result in termination from this practice.

_______________________________________ ________________
Signature of Patient or Patient's Representative Date

_______________________________________ ________________
Printed Name of Patient or Patient's Representative Patient's Date of Birth

____
Relationship to Patient

PROGRESSIVE PAIN &
INTERVENTIONAL PSYCHIATRY

AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY MEMBERS

Patient Name: ____ Date of Birth: _____________________

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Progressive Pain & Psychiatry and/or my physician to release my medical and/or billing information to the following individual(s):

1. ______________________________________ Relation to Patient: ________________________

2. _____________________________________ Relation to Patient: ________________________

3. ______________________________________ Relation to Patient: ________________________

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.

You have the right to revoke this consent in writing.

Signature: ____ Date: ______________________________