SPINE TEAM TEXAS®

Patient Questionnaire

Today's Date:_____

Please clearly mark the check boxes and fill in the blanks where indicated. Your accurate responses will give us a better understanding of you and your symptoms so that we can provide you with the best care possible. Thank you for helping us understand you better!

Name: _____

DOB: _____ Age: _____

Height: _____ Weight: _____ Hand preference: ❍ Right ❍ Left ❍ Both

Primary Care Physician: _____ Referring Physician: _____

HISTORY

Chief complaint: ❑ Neck ❑ Low back ❑ Other: _____

How long have you had this pain? _____

Does the pain radiate into extremities? (please circle which side)

❑ Arms (Left/Right/Both) ❑ Buttocks (Left/Right/Both) ❑ Legs (Left/Right/Both) ❑ Other: _____

Do you feel any of the following? If so, please list where on your body.

❑ Weakness: _____ ❑ Tingling: _____

❑ Numbness: _____ ❑ Stiffness: _____

Any other symptoms with the pain?

❑ Loss of bladder control ❑ Loss of bowel control ❑ Headaches ❑ Other: _____

Are you having difficulty with sleep because of your pain? ❑ Yes ❑ No

What makes the pain better?

❑ Sitting ❑ Heat/cold ❑ Standing ❑ Massage

❑ Walking ❑ Nothing ❑ Lying down ❑ Exercise ❑ Other: _____

What makes the pain worse?

❑ Sitting ❑ Heat/cold ❑ Standing ❑ Massage

❑ Walking ❑ Nothing ❑ Lying down ❑ Exercise ❑ Other: _____

How severe is your pain (mark below)?

0	1-2	3-4	5-6	7-8	9-10
Absent (No pain)	**Tolerable** (tolerate without medications)	**Bearable** (some activities restricted/ prevented, requires medication)	**Nearly intolerable** (sedentary, only able to watch TV, read, etc.)	**Intolerable** (Can't read, watch TV, use the phone, need to visit ER for pain killers)	**Devastating** (need hospitalization for pain control)

SPINE TEAM TEXAS®

Patient Questionnaire

Patient Name: _____ DOB: _____

Did anything specific happen to cause the pain? ❍ YES ❍ NO

If yes, please describe: _____

PLEASE NOTE: SPINE TEAM TEXAS DOES NOT ACCEPT WORKER'S COMP.

Is the injury or pain motor vehicle related? ❍ YES ❍ NO Date of injury?

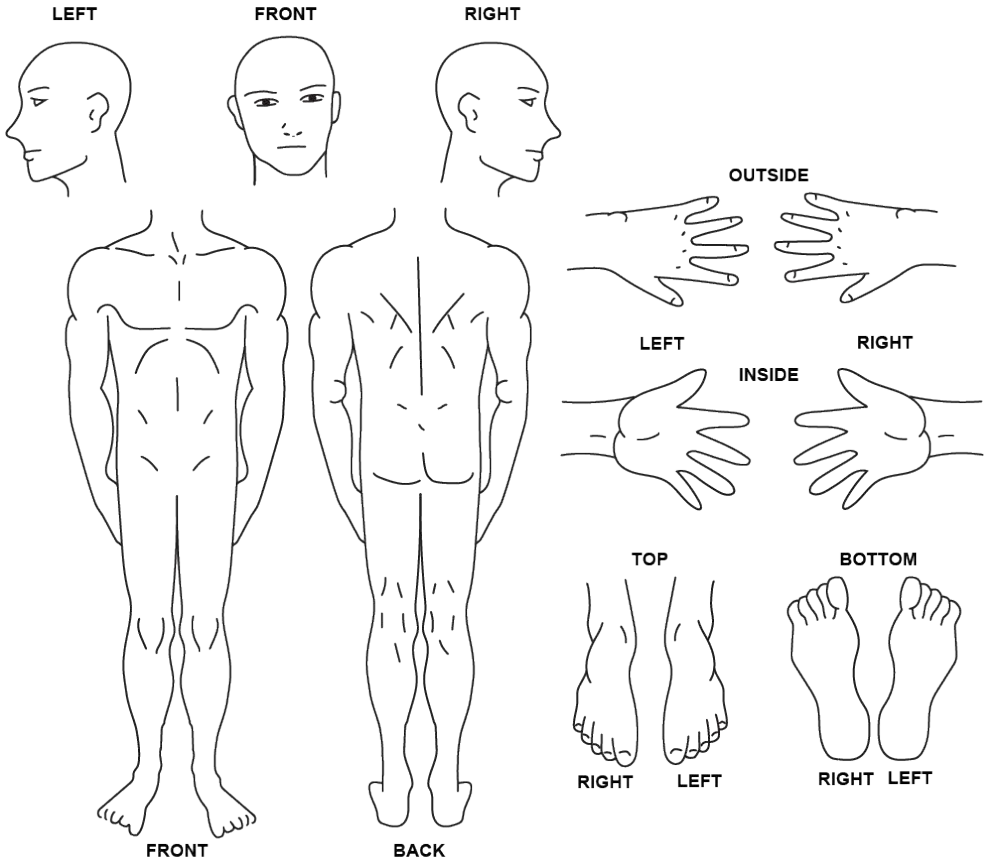
_____ Is there a lawsuit (pending or considered)? ❍ YES ❍ NO

Have you had any of the following treatments for your current condition?

Other Clinicians	❍ YES	❍ NO	Name, date, and treatment: _____
Physical Therapy	❍ YES	❍ NO	Number of sessions: _____ ❑ Better ❑ Worse ❑ No change
Epidural or Facet Injections	❍ YES	❍ NO	Number of injections: _____ ❑ Better ❑ Worse ❑ No change
Back or Neck Surgery	❍ YES	❍ NO	Date and type: _____
Diagnostic Tests	❍ YES	❍ NO	❑ CT ❑ MRI ❑ EMG ❑ Other: _____

Select all those that describe your pain:

❒ achy	❒ burning	❒ cramping	❒ deep	❒ dull	❒ electric	❒ gnawing
❒ heavy	❒ knife-like	❒ pressure	❒ prickling	❒ sharp	❒ shooting	❒ spasm
❒ stabbing	❒ stinging	❒ throbbing	❒ twisting	❑ other: _____		



Please mark the location of your symptoms on the figure to the left:

Key

Pain=XX

Numbness/Tingling=OO

Stabbing=//

Burning=++

What do you hope we can accomplish today?

_____

_____

_____

_____

_____

_____

_____

SPINE TEAM TEXAS®

Patient Medical Questionnaire

Patient Name: _____ DOB: _____

Illness/Condition	Is your PCP the treating physician?		If no, list treating physician's name	Is problem stable/ well controlled?		If no, please explain
Please check all that apply:	YES	NO		YES	NO	
❑ Alcoholism	☐	☐		☐	☐	
❑ Anemia	☐	☐		☐	☐	
❑ Anxiety	☐	☐		☐	☐	
❑ Arthritis	☐	☐		☐	☐	
❑ Asthma	☐	☐		☐	☐	
❑ Bleeding Disorder	☐	☐		☐	☐	
❑ Deep Vein Thrombosis	☐	☐		☐	☐	
❑ Depression	☐	☐		☐	☐	
❑ Diabetes	☐	☐		☐	☐	
❑ GERD	☐	☐		☐	☐	
❑ Gout	☐	☐		☐	☐	
❑ Heart Attack	☐	☐		☐	☐	
❑ Heart Disease	☐	☐		☐	☐	
❑ Heart Murmur	☐	☐		☐	☐	
❑ High Blood Pressure	☐	☐		☐	☐	
❑ High Cholesterol	☐	☐		☐	☐	
❑ History of Addiction	☐	☐		☐	☐	
❑ History of Substance Abuse	☐	☐		☐	☐	
❑ HIV/AIDS	☐	☐		☐	☐	
❑ Hyperthyroidism	☐	☐		☐	☐	
❑ Hypothyroidism	☐	☐		☐	☐	
❑ Kidney Disease	☐	☐		☐	☐	
❑ Liver Disease/Hepatitis	☐	☐		☐	☐	
❑ Lung Disease	☐	☐		☐	☐	
❑ Migraines	☐	☐		☐	☐	
❑ MRSA	☐	☐		☐	☐	
❑ Muscle Disease	☐	☐		☐	☐	
❑ Osteoporosis	☐	☐		☐	☐	
❑ Pneumonia	☐	☐		☐	☐	
❑ Psoriasis	☐	☐		☐	☐	
❑ Psychiatric Problem	☐	☐		☐	☐	
❑ Pulmonary Embolism	☐	☐		☐	☐	
❑ Rheumatic Fever	☐	☐		☐	☐	
❑ Rheumatoid Arthritis	☐	☐		☐	☐	
❑ Seizure Disorder	☐	☐		☐	☐	
❑ Sleep Apnea	☐	☐		☐	☐	
❑ Stroke	☐	☐		☐	☐	
❑ Thyroid Disorder	☐	☐		☐	☐	
❑ Tuberculosis	☐	☐		☐	☐	
❑ Ulcers	☐	☐		☐	☐	
❑ Other (Please explain)						

Patient Medical Questionnaire

Patient Name: _____ DOB: _____

Cancer History	Is your PCP the treating physician?		If no, list treating physician's name	Is problem stable/ well controlled?		If no, please explain
Please check all that apply:	YES	NO		YES	NO	
❑ Leukemia	☐	☐		☐	☐	
❑ Breast Cancer	☐	☐		☐	☐	
❑ Cervical Cancer	☐	☐		☐	☐	
❑ Prostate Cancer	☐	☐		☐	☐	
❑ Ovarian Cancer	☐	☐		☐	☐	
❑ Throat Cancer	☐	☐		☐	☐	
❑ Bone Cancer	☐	☐		☐	☐	
❑ Skin Cancer	☐	☐		☐	☐	
❑ Lung Cancer	☐	☐		☐	☐	
❑ Cancer: other (please explain)						

PAST SURGICAL HISTORY

Please list any previous surgeries: ❑ No surgeries ❑ See attached

_____ Approximate Date: _____

_____ Approximate Date: _____

_____ Approximate Date: _____

_____ Approximate Date: _____

MEDICATIONS

Please list all medications you are currently taking. *(Include any over the counter medications. Be sure to list if you are taking any form of aspirin.)* ❑ No medications ❑ See attached

_____ Dose: _____ Frequency: _____

_____ Dose: _____ Frequency: _____

_____ Dose: _____ Frequency: _____

_____ Dose: _____ Frequency: _____

_____ Dose: _____ Frequency: _____

_____ Dose: _____ Frequency: _____

List medications that you have taken in the past and if they did or did not help:

_____ Did the medication help? ❍ YES ❍ NO

_____ Did the medication help? ❍ YES ❍ NO

_____ Did the medication help? ❍ YES ❍ NO

SPINE TEAM TEXAS®

Patient Medical Questionnaire

Patient Name: _____ DOB: _____

Medication allergies? ❍ YES ❍ NO

Please list: _____

Allergy reaction: _____

Do you have any other known allergies? ❍ YES ❍ NO

Please list: _____

Allergy reaction: _____

Preferred Pharmacy Name: _____

Preferred Pharmacy Address: _____

Preferred Pharmacy Phone: _____

FAMILY HISTORY

Please list any medical illnesses that the following blood relatives have a history of:

Grandparents: _____ ❍ Living ❍ Deceased

Father: _____ ❍ Living ❍ Deceased

Mother: _____ ❍ Living ❍ Deceased

Brother(s): _____ ❍ Living ❍ Deceased

Sister(s): _____ ❍ Living ❍ Deceased

SOCIAL HISTORY

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widow

Number of children: _____ Ages: _____

Do you smoke? ❍ YES ❍ NO How much? _____ For how long? _____

Previous smoker? ❍ YES ❍ NO When did you quit? _____

Do you use smokeless tobacco? ❍ YES ❍ NO How much? _____ For how long? _____

Do you vape or use e-cigarettes? ❍ YES ❍ NO How much? _____ For how long? _____

Do you use non-tobacco inhalants? ❍ YES ❍ NO How much? _____ For how long? _____

Do you drink alcohol? ❍ YES ❍ NO How many drinks per day? _____

Do you use recreational drugs? ❍ YES ❍ NO If yes, what type: _____

Do you have a history or alcohol or drug abuse? ❍ YES ❍ NO

Occupation: _____

SPINE TEAM TEXAS®

Review of Systems

Patient Name: _____ DOB: _____

Please mark an "X" for Yes or mark "I have none of the symptoms listed above" if you have these symptoms <u>TODAY</u>.

CONSTITUTIONAL
- ❑ Chills
- ❑ Night Sweats
- ❑ Unexplained weight Gain/Loss
- ❑ I have none of the symptoms listed above

EYES/EARS/NOSE/THROAT
- ❑ Vision changes
- ❑ Hearing Loss
- ❑ Hoarseness
- ❑ Ringing in the ear
- ❑ Dizziness/ Vertigo
- ❑ Difficulty Swallowing
- ❑ Discharge/ Drainage
- ❑ I have none of the symptoms listed above

CARDIOVASCULAR
- ❑ Chest Pain
- ❑ Palpitations
- ❑ Leg Swelling
- ❑ I have none of the symptoms listed above

GASTROINTESTINAL
- ❑ Abdominal pain
- ❑ Nausea
- ❑ Constipation
- ❑ Blood in stool
- ❑ Diarrhea
- ❑ Vomiting w/wo blood
- ❑ I have none of the symptoms listed above

GENITOURINARY
- ❑ Painful urination
- ❑ Blood in urine
- ❑ Venereal Disease
- ❑ Difficult urination
- ❑ Sexual problems
- ❑ Menstrual Problems
- ❑ Pregnant
- ❑ Menopausal
- ❑ I have none of the symptoms listed above

SKIN
- ❑ Rashes
- ❑ Nail changes
- ❑ Easy Bruising
- ❑ Color changes
- ❑ Jaundice
- ❑ Infections
- ❑ I have none of the symptoms listed above

RESPIRATORY
- ❑ Cough
- ❑ Wheezing
- ❑ Coughing up blood
- ❑ Shortness of Breath
- ❑ Sputum Production
- ❑ Recent Infection
- ❑ I have none of the symptoms listed above

MUSCULOSKELETAL
- ❑ Joint swelling
- ❑ Stiffness
- ❑ Cramping
- ❑ Infection
- ❑ I have none of the symptoms listed above

ENDOCRINE
- ❑ Changes in urination
- ❑ Changes in heat/cold intolerance
- ❑ Changes in appetite/thirst/ sweating
- ❑ I have none of the symptoms listed above

PSYCHIATRIC
- ❑ Depression
- ❑ Anxiety
- ❑ Suicidal Thoughts
- ❑ Mood Changes
- ❑ I have none of the symptoms listed above

Consent for Treatment

Patient Name: _____ DOB: _____

DISCLOSURE OF INFORMATION:

The undersigned agrees that all records concerning this patient's visit shall remain the property of Spine Team Texas. The undersigned understands that medical records and billing information generated or maintained by Spine Team Texas are accessible to facility personnel and medical staff. Facility personnel and medical staff may use and disclose medical information for treatment, payment and healthcare operations and to any other physician, healthcare personnel or provider that is or may be involved in the continuum of care. The facility is authorized to disclose all or part of the patient's medical record to any insurance company, third party payor, worker's compensation carrier, self-insured employer group or other entity (or their authorized representatives) which are necessary for payment of patient's account. Law requires that the facility advise the undersigned that **THE INFORMATION RELEASED MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT NOT BE LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWS AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). THE INFORMATION MAY ALSO CONTAIN PSYCHIATRIC RECORDS.** The facility is authorized to disclose all or any portion of the patient's medical record as set forth in its Notice of Privacy Practices, unless the patient objects in writing. By signing this form, you are authorizing such disclosures.

SPECIAL CONSENT FOR HIV TESTING:

The undersigned specifically consents to the testing of the patient's blood for human immunodeficiency virus (also known as AIDS) and/or Hepatitis if determined by the patient's attending physician to be necessary for the protection of the attending physician and/or any employee or agent of the facility or the attending physician exposed to the bodily fluids of the patient in a manner which could transmit such disease.

❑ Do ❑ Do Not	I (we) authorize Spine Team Texas, PA to obtain my photograph for identification verification.
_____ (Initial)	**ACKNOWLEDGEMENT OF RECEIPT OF PAYMENT POLICY:** I acknowledge the receipt of the payment policy by initialing and signing below. Spine Team Texas, PA is committed to serving you. As part of this commitment, we want you to understand your payment obligations. **Payment is expected at the time services are rendered. If you are unable to pay in full on date of service, payment arrangements must be made.**
_____ (Initial)	**ACKNOWLEDGEMENT OF RECEIPT OF PATIENT RIGHTS:** I acknowledge receipt of information explaining my rights as a patient and, on request, I received a copy of the State notice and this facility policy statement regarding Patient's Rights.
_____ (Initial)	**I GIVE PERMISSION** for Spine Team Texas to release any and all of my medical information to my Primary Care/Referring Physician by written or oral communication. I understand these records may contain psychiatric and/or infectious disease information.
_____ (Initial)	**I GIVE PERMISSION** for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others. **❑ Yes ❑ No** **If yes, please list names below.** Name: _____ Name: _____ Name: _____
_____ (Initial)	**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:** A description of how your medical information will be used and disclosed is summarized on the Patient Privacy Notice. A complete copy of the Facility's Notice of Privacy Practice is included in your admissions packet and posted in the Facility. By signing below, you acknowledge that you have received a copy of the Facility's Notice of Privacy Practice.

Consent for Treatment

Patient Name: _____ DOB: _____

_____ (Initial)	**I AUTHORIZE** Representatives of Spine Team Texas PA to leave messages for me regarding appointments, prescriptions, or any other information pertinent to my medical care, on any phone number that I have provided. I also understand that I may revoke this agreement by sending a written, certified letter to Spine Team Texas PA, 1545 E. Southlake Blvd. #100 Southlake, Texas 76092, ATTN: Compliance Officer
_____ (Initial)	**I ACKNOWLEDGE AND UNDERSTAND** that Spine Team Texas PA and/or Spine Team Texas ASC LP may not participate with my insurance plan and that any payment due as a result will be discussed with me in detail before services are rendered. I also understand that as a courtesy, Spine Team Texas will review my payment options and evaluate them in detail before any services are rendered.
_____ (Initial)	I acknowledge and understand that Spine Team Texas has a late arrival policy. I understand and acknowledge that if I arrive 15 minutes or more past my scheduled appointment, then I may have to be rescheduled.
_____ (Initial)	**APPOINTMENT POLICY:** I acknowledge and understand that Spine Team Texas has a No Show policy. I understand that if I no show for 3 or more appointments, or cancel with less than 24 hours' notice, I may be dismissed from the practice. I further acknowledge and understand that there is a $50.00 no show fee for EMGs that are no showed or cancelled with less than 24 hours' notice and Spine Team Texas also reserves the right to charge a $35.00 no show fee for office appointments that patients no show or cancel with less than 24 hours' notice. I understand the fees charged for no shows are not covered by my insurance and I will be liable for payment in full.
_____ (Initial)	**MEDICATION HISTORY:** By initialing this paragraph and signing this form, I acknowledge and agree that in the event that I am given a prescription, I am granting permission for Spine Team Texas to obtain my medication history. This may be acquired through direct pharmacy contact.

I (WE) THE UNDERSIGNED CERTIFY THAT I (WE) HAVE READ AND FULLY UNDERSTAND THIS "CONDITIONS OF ADMISSION AND TREATMENT" FORM.

PATIENT SIGNATURE: **X**_____ DATE:_____

PATIENT NAME PRINTED:_____

WITNESS SIGNATURE: **X**_____ DATE:_____

PATIENT IS UNABLE TO CONSENT BECAUSE: _____

RELATIVE / AUTHORIZED AGENT _____

RELATIONSHIP TO PATIENT: _____ DATE: _____

Consent for Treatment

Patient Name: _____ DOB: _____

_____ (Initial)

CONSENT FOR DESTRUCTION OF FILMS

I understand that Spine Team Texas will **not** be responsible for the storage of my x-rays or any other radiological images. By signing this form, I understand and agree that I am responsible for my films and other radiological images that have been performed at a facility other than Spine Team Texas.

I further understand and agree that Spine Team Texas scans my images into their imaging system and retains those images on their scanning system. Spine Team Texas has the right to destroy my actual films if the films have been left at Spine Team Texas for 12 months or longer from today's date.

_____ (Initial)

FINANCIAL GUIDELINES FOR PATIENTS

STT is committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. We will assist you when we can, so that you receive all of the insurance benefits to which you are entitled.

To meet the needs of our patients, we participate in many insurance programs. Each insurance company has its own specific rule regarding the level of care and the amount of reimbursement. Insurance plans and benefits vary considerably, and we cannot guarantee what part of our service will or will not be covered by your particular insurance coverage.

We will gladly process your claim for you and when time permits we will also estimate your deductible, co-payment, co-insurance and charges for services rendered. Co-payment, co-insurance and deductibles are a contract responsibility between the patient and their employer and/or insurance carrier. These amounts are non-negotiable. That amount is due at the time of treatment and may be paid by cash, check or credit card. **Our estimates are subject to final approval by your insurance company and what actually takes place in the clinic visit and/or operative/procedure session; therefore, the amount due to our office could change.**

If you are scheduled for procedures or surgery, additional information will be available to you at the time of the scheduling. Please ask if you have any questions about our fees, financial policy or your responsibility.

Please indicate your receipt of this Notice by your signature below.

PATIENT SIGNATURE: **X**_____ DATE:_____

WITNESS SIGNATURE: **X**_____ DATE:_____

SPINE TEAM TEXAS®

NOTICE TO PATIENT OF FINANCIAL INTEREST

As a patient of Spine Team Texas, (the "Practice"), some of your treatment or related procedures may be scheduled at our Texas Health Spine Surgery Centers (the ASC). You are informed by this notice the physicians listed below hold financial interest in the ASC as indicated:

Texas Health Spine Surgery Center Allen, LLC	David Rothbart, MD; Anthony Berg, MD; David Cooper, MD; Amit Darnule, MD; Michael Garcia, MD; David Garrigues, MD; Cortland Miller, MD; Ryan Reeves, MD; Jennifer Donnelly MD; Andrew Carver Wilkins, MD; Anton Zaryanov, DO; Daniel Sanders, MD
Texas Health Spine Surgery Center Alliance, LLC	David Rothbart, MD; Ryan Reeves, MD: Michael Garcia, MD; Amit Darnule, MD; Anthony Berg, MD; David Cooper, MD; Harish Badhey, MD; Jennifer Donnelly, MD; Cortland Miller, MD; Neil Patel, MD; Joseph Platon, MD; Carver Wilkins, MD; David Garrigues, MD; Christina Nguyen, DO
THR/STT Rockwall ASC, LLC (d/b/a Texas Health Spine Surgery Center Rockwall, LLC)	David Rothbart, MD; Ryan Reeves, MD; Michael Garcia, MD; Amit Darnule, MD; Anthony Berg, MD; David Cooper, MD, Anton Zaryanov, DO; Richard S. McPherson, DO
THR/STT Southlake ASC, LLC (d/b/a Texas Health Spine Surgery Center Southlake, LLC)	David Rothbart, MD; Ryan Reeves, MD: Michael Garcia, MD; Amit Darnule, MD; Jennifer Donnelly, MD; Neil Patel, MD, Mark Bauernfeind, MD

In addition, you may receive services at Texas Health Harris Methodist Hospital Southlake or Texas Health Presbyterian Hospital Rockwall. You are informed by this Notice that your physician may hold a financial interest in this entity. You have the option, at your discretion, to use an alternative health care facility.

Please indicate your receipt of this Notice by your signature below.

Date: _____ _____

Patient Signature

_____

Patient Printed Name

IMPORTANT INFORMATION FOR PATIENTS

Each facility listed above has entered into a name use agreement with Texas Health Resources (THR).

THR does not supervise any health care professionals at any Texas Health Spine Surgery Center, nor does it provide any patient care services at any Texas Health Spine Surgery Center.

It is important that you also understand that all ASC physicians who provide their services using ASC facilities are employed by Texas Health Back Care and are members of the Texas Health Spine Surgery Center Medical Staff.

Date: _____ _____

Patient Signature

_____

Patient Printed Name

Rev: 7/3/2023

Controlled Substances

Understanding the Use of Controlled Substance Prescriptions

Controlled substance medications (which include narcotics, tranquilizers, and barbiturates) are very useful in the treatment of pain and can be used in combination with or assist with other treatments such as nerve blocks, exercise, physical therapy, surgery psychological techniques and other non-controlled medications. Your doctor may decide to do a trial of these medications to assess their efficiency in treating your pain. Some patients have an excellent response with these medications with minimal interference from side effects. However, not all patients have a favorable response or may experience significant side effects that prevent further use of these types of medications. These drugs do not decrease all pain syndromes. Your doctor has no way of predicting your response to these medications and will discuss with you the proper way to use them. These medications may cause unintended psychological effects such as a false sense of well being and improved ability to cope with problems. Although they are intended for relief of pain and improvement of function, they have a greater potential for abuse and misuse if used incorrectly. Sometimes patients who experience these psychological effects may use these medications in ways other than prescribed.

The specific medications that my physician plans to prescribe will be described and documented separate from this agreement. This includes the use of medication for possible purposes different than what have been approved by the drug company and the government (this is referred to as off-label prescribing, often used in treatment of pain). My doctor will explain his treatment plans for me and documented in my medical chart.

There exists a significant misunderstanding regarding the use of Soma, Tramadol and opioid analgesics. The following definitions are important for you to understand.

1. Physical Dependence: A pharmacologic property of certain drugs such as caffeine and opioids which cause biochemical changes in the body such that abruptly stopping these drugs will result in a “withdrawal” response.

2. Addiction: A psychological and behavioral syndrome in which there is a drug craving and drug seeking behavior for purposes other than those intended by your physician. Addictive behavior would include increasing your usual dose of opioid (without prior discussion with your doctor) for psychological benefit to self-medicate during a stressful situation.

3. Tolerance: A pharmacologic property of certain drugs defined by the need for increasing dosage to maintain effect.

The risk of addiction in patients who do not have prior addiction history (to any substance) is low. The risk of addictive behavior is much higher in patients who have prior history of addiction. Therefore, you must tell your doctor if you have such a history including addiction to cigarettes, smokeless tobacco, alcohol, gambling, etc. If you develop an addiction problem, your doctor will help you with this. Your doctor may decide that you should not continue on the particular drug or may decide that you may continue on the medication but only with very careful treatment guidelines.

I understand that the most common side effects that occur in the use of pain medications in my treatment include, but are not limited to the following: Constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention, low blood pressure, irregular heartbeat, insomnia, depression, impairment of reasoning or judgment, respiratory depression, impotency, decreased libido, decreased testosterone levels, and even death.

Initials:_____

SPINE TEAM TEXAS®

Controlled Substances

Patient Name: _____ DOB: _____

Patient Responsibility Agreement for Controlled Substance Prescriptions

I understand that the use of controlled substances can be part of a safe and effective treatment for my pain condition. I also understand that there exists a risk of developing an addiction disorder. I am aware that the government has warned that improper use of these medications can cause addiction and be lethal with inappropriate usage. I also understand that the government tracks the prescription writing of some of these drugs. Thus, I agree to the following:

1. I alone am responsible for the controlled substance medications prescribed to me and am responsible for their safe keeping. If my prescriptions are **LOST, MISPLACED, OR STOLEN**, or if I use more than prescribed and "run out early" the medication will **NOT** be replaced or refilled early. If my medication is lost or stolen, I will report this to the police and obtain a stolen/missing item report to be sent to my doctor.
2. I will **NOT** increase my dosage or use more pills than prescribed without the prior consent of my doctor, so that this will be documented as "proper acceptable use" of the medication.
3. Refills of my controlled medication will only be made during regular office hours, (Monday – Friday), excluding holidays. Refills will **NOT** be made at night, on weekends, during holidays or for improper usage other than prescribed. Refills may take up to 72 hours to process and will require an office visit.
4. I understand my prescription will take a few hours to process at the pharmacy and will not be immediately available for pick-up once sent in.
5. For female patients only: To the best of my knowledge I am not pregnant. If I am not pregnant, I will use appropriate birth-control contraception including but not limited to prophylactics, IUDs and abstinence during the course of my treatment. I accept it is my responsibility to inform my physician immediately, if I should become pregnant, If I am pregnant, or uncertain, I will notify my physician immediately.

Initials: _____

6. I am responsible for keeping track of how many pills I have left and notifying my doctor or making an appointment to be seen in the clinic to avoid running out of medication before a weekend or holiday.
7. I understand that it is ILLEGAL to give, lend, share, sell or transfer my medications. Likewise, I will NOT receive, borrow or purchase additional controlled substances from anyone who is not a health care provider.
8. I will NOT crush, cut, break, or chew the medication unless I have discussed this with my physician.
9. During my treatment, I may be asked to meet with Medication Use Specialist at any time to help assess for and treat risk factors for addiction, and/or to learn other coping mechanisms to help deal with pain that are not addressed by the pain medication. This evaluation is critical to safely and properly treat my condition, and medication refills may be withheld if I refuse to be evaluated.
10. I agree to comply with random urine, blood, or computerized psychological assessment to document proper use of my medication and to confirm compliance with this agreement and Spine Team Texas policies. I also understand that I will be billed for these drug tests first by Spine Team Texas, then also by Quest Laboratory. Drug tests are run in 2 parts, 1st is the initial test, and then the test is sent out for quantitative testing. There will be an additional cost for the psychological testing.
11. I understand that driving a motor vehicle may be restricted while taking controlled substance medications and that is my responsibility to comply with the laws of the state while taking the prescribed medications. In the event I feel impaired or sedated I must not drive and should discuss with my physician.
12. I understand that the combination of these medications and alcohol or other prescription medications can impair my thinking, reaction time, and vital functions and may be life threatening.

Initials: _____

Controlled Substances

Patient Name: _____ DOB: _____

13. I will not combine alcohol with any opioid substances, and I understand doing so is grounds for discontinuing therapy and may limit treatment options available to me.
14. I agree to fill my prescription with only one pharmacy. If, for some reason, I need to change my pharmacy or use more than one, I will notify my physician and both pharmacies about the change. I understand that tampering with a written prescription is unlawful and is grounds for discharge from the practice.
15. I will not get additional controlled medications to treat the same condition from other physicians. If "emergency" medication is given by another physician (i.e. Hospital, emergency department) I will notify my doctor as early as the next workday.
16. If it appears to my physician and treatment team that there are no demonstrable benefits to my daily function or quality of life in my physician may try alternate medications or may taper me off opioid medications all together.

Initials: _____

I understand that not abiding by the rules in this agreement may constitute grounds for withdrawal of controlled substances from my treatment plan. Blatant disregard, misuse, or illegal acts are also grounds for discharge from the practice entirely.

17. I will not use illegal substances (i.e. marijuana, cocaine, and heroin). Use of these substances are grounds for discharge from the practice.
18. I understand that abusive behavior of staff or providers will not be tolerated. If staff deems that a phone conversation is becoming abusive, they may choose to record it for later review by a provider or manager. Abusive behavior is grounds for discharge from the practice.
19. I understand that should I violate this agreement; Spine Team Texas reserves the right to discharge any family members that may be being treated in their facility.
20. I understand that the use of narcotic pain medicine in the elderly or severely debilitated can predispose them to impairment of balance resulting in falls. This will increase their risk of head trauma, broken bones, and internal organ injury. I agree that this increased risk is acceptable compared to the risks of untreated pain.
21. I understand that the absolute safety or relative risk of operating motorized vehicles (automobile, boat, etc.) while taking narcotic pain medications has not been determined. If I operate a motorized vehicle while taking narcotic pain medicine and become involved in any accident resulting in personal injury or property damage to myself or others, I agree to not hold liable Spine Team Texas or any member thereof.
22. The combined use of Benzodiazepine medication (I.e. Valium, Xanax) with Opioid medication can cause serious side effects. STT physicians may discuss you discontinuing the Benzodiazepine medication if Opioid therapy is being considered. Noncompliance can lead to discontinuation of opioid therapy, impact your candidacy for other treatment options or be grounds for dismissal from the practice.

I authorize the doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the Texas Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my doctor to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
I have read the above agreement and have had my questions answered in a manner that I understand. I accept the agreement to allow my doctor to prescribe such medications in a manner that they feel would be in the best interest of my care. I have received a copy of this document for my personal records.

Patient Signature _____ Date: _____

Patient Name (Printed) _____

FAMILY AND FRIENDS REFERRAL PROGRAM

Spine Team Texas would like to thank our patients for referring their family and friends to us. Please let us know who referred you so that we can send them a thank you gift.

Today's Date: _____

❒ **Fellow/Former Patient**

Full Name: _____

Mailing Address (if known): _____

❒ **Family/Friend/Neighbor**

Full Name: _____

Mailing Address (if known): _____

Please select the location you are visiting today:

❒ **Southlake** ❒ **Bedford** ❒ **Alliance** ❒ **Rockwall** ❒ **Richardson** ❒ **Allen**

DON'T FORGET!

In addition to the new patient paperwork, please make sure you bring the following with you to your appointment:

- ❑ A picture ID
- ❑ Insurance cards
- ❑ Your co-pay (if required by your insurance)
- ❑ Your referral (if required by your insurance)
- ❑ Any report, film, or disc of radiology relating to your pain and treatment
- ❑ Any medical records relating to your pain and treatment
- ❑ A list of medications you are currently taking or their medication bottles

THANK YOU FOR CHOOSING SPINE TEAM TEXAS!