12201 MERIT DR. SUITE 300 DALLAS, TX 75251

PATIENT REGISTRATION FORM

PATIENT INFORMATION

_____ _____ _____
Legal First Name Middle Name Last Name
Date of Birth: _____/_____/_____ Age: ____ Sex: M / F
Marital Status: Married / Single / Divorced / Widowed
Address:_____
Home #: _____ Work #: _____ Cell#_____
Email:_____
Referring or Primary Care Physician:_____

INSURANCE POLICY

_____ _____ _____
Insurance Network Group Number Subscriber ID Number
Claims Mailing Address: _____
Subscriber Name_____
Date of Birth: _____/_____/_____

Employer Name & Address: _____
Relationship to patient: Spouse / Parent / Other: _____

EMERGENCY CONTACT

Name: _____ Relationship to patient_____
Address: _____
Home/Work/Cell #: _____ Home/Work/Cell #: _____

LETTER OF PROTECTION COVERAGE

LOP: Attorney's Name: _____ Phone #: _____
Attorney Address: _____ Fax #: _____

AUTHORIZATION TO RELEASE INFORMATION I hereby authorize the above-named agency to release any treatment information requested by attorneys, physicians, insurance companies, employees, health care providers, or any other entity which may be concerned with the payment of charges incurred for the treatment services of Sumit Katyal MD.
ASSIGNMENT OF INSURANCE BENEFITS I hereby do authorize payment directly to PREMIER PAIN SOLUTIONS. I am responsible for payment of all services rendered not covered by insurance.

_____ _____
PATIENT SIGNATURE DATE

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INITIAL PATIENT VISIT

PATIENT NAME: _____ DATE: _____

REFERRED BY: _____ AGE: _____ SEX: M / F

PRIMARY CARE DOCTOR: _____ REASON FOR VISIT: _____

Please describe how your problems began:
how the pain started, and events until now

_____

_____

_____

_____

_____

_____

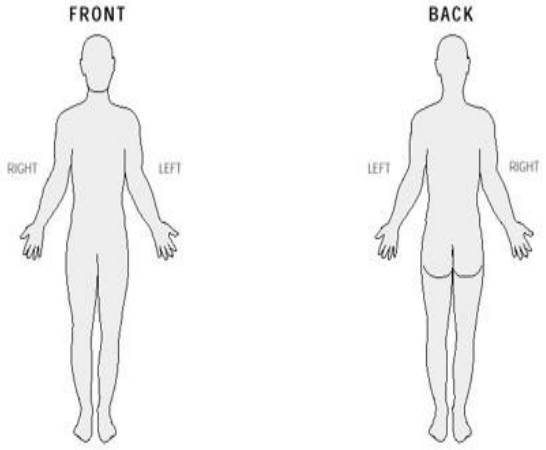
_____

_____

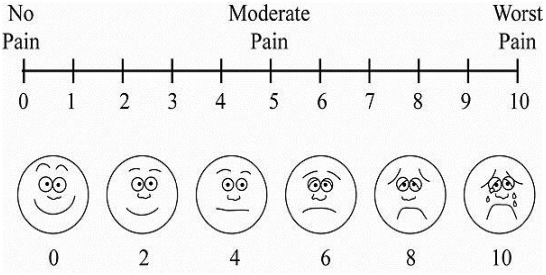
_____

_____

Indicate your pain location(s) by drawing on the figure below:



What is your current pain level?



When the pain first start? □ 1 week □ 2 weeks □ 1 month □ 3 months □ 6 months □ 1 year □ > 1 year

Describe the pain: □ Aching □ Burning □ Tingling □ Sharp □ Dull □ Throbbing □ Band like

What is the frequency of the pain? □ Comes and goes □ Always present □ Only when I _____

When is the pain the worst? □ Morning □ Evening □ After significant activity □ All the time

What makes the pain better? □ Rest □ Ice □ Heat □ Motrin/Aspirin, etc. □ Lortab/narcotics, etc. □ Massage
□ Lying flat □ Bending forward

12201 MERIT DR. SUITE 300 DALLAS, TX 75251

PLEASE COMPLETE ALL QUESTIONS, CIRCLING ITEMS BELOW THAT APPLY TO YOU

MEDICAL PROBLEMS

Diabetes Heart Disease Cancer/Tumor Stroke Osteoarthritis Osteoporosis Depression Fibromyalgia Migraines Obesity Chronic Pain Psychiatric Previous Car Accident Work Injury
Other: _____

PRIOR SURGERIES

Disc Surgery Laminectomy Low Back Fusion Neck Fusion Shoulder Arthroscopy Shoulder Replacement Knee Arthroscopy Knee Replacement Hip Replacement Carpal Tunnel Release
Other: _____

FAMILY HISTORY

Rheumatoid Arthritis Lupus/Connective Tissue Disease Heart Trouble Diabetes Cancer Stroke Depression/Suicide Other: _____

SOCIAL HISTORY

Whom do you live with? _____
Do you smoke? □ yes □ no How many packs per day? _____ For how long? _____
Do you use alcohol regularly? □ yes □ no Any Illicit drug use? □ yes □ no
Are you: □ married □ single □ divorced □ widowed

Describe your work: □ office □ heavy labor □ homemaker □ driver □ retired □ student
□ Other: _____
Do you drive yourself? □ yes □ no because_____

FUNCTIONAL

Circle all the actions you are unable to perform:
Dress Bathe Groom Toilet Walk Run Climb Stairs Perform Sport: _____

REVIEW OF SYMPTOMS

Circle all the items you currently suffer from:

Anxiety/Depression Headaches Irritability Lack of Energy Trouble Sleeping Weight Gain Stiffness Falls Poor Balance Bowel/Bladder Changes Numbness/Tingling Weakness Cramps Memory Problems Fevers/Chills Night Sweats Shortness of Breath Other: _____

DRUG ALLERGIES

_____

PRIOR MEDICINES

Lortab/Vicodin Norco Percocet Percodan Codeine Celebrex Ibuprofen/Advil Mobic Aleve/Naproxen Oxycontin MS Contin Methadone Duragesic Patch Morphine Actiq Neurontin Elavil Topamax/Zonegran Ambien Xanax Restoril Trazodone Robaxin Skelaxin Flexeril Zanaflex Baclofen Soma Prozac Celexa Lexapro Paxil Remeron Zoloft
Other_____

IMAGING STUDIES

MRI_____ CT SCAN_____ XRAYS_____ BONE SCAN_____
OTHER_____

THERAPY

Have you ever had physical therapy? □ yes □ no If yes, when was the last time? _____
Have you had occupational therapy? □ yes □ no If yes, when was the last time? _____
Have you had chiropractic treatment? □ yes □ no If yes, when was the last time? _____
For what condition(s)? _____

PRIOR PROCEDURES

Trigger Point Injections Epidural Injection Nerve Blocks Joint Injection Rhizotomy/RFA

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PATIENT MEDICATION FORM

Premier Pain Solutions is dedicated to providing the highest quality medical care to our patients. Please assist us in our efforts to ensure your complete, accurate electronic medical record by providing us with a list of your known allergies, as well as all medications you are currently taking.

ALLERGIC TO:	DESCRIBE REACTION:

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING, PRESCRIPTION AND OVER- THE-COUNTER. PLEASE INCLUDE MEDICATIONS THAT YOU TAKE ON AN AS-NEEDED BASIS.

DATE STARTED	NAME OF MEDICATION	DOSE	HOW OFTEN DO YOU TAKE IT?

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OPIOID AGREEMENT

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long term benefit and improvement in a patient function and quality of life. There is also the risk of an addictive disorder developing or relapse occurring in a person with a prior addiction. The extent of this risk is not certain. Chronic opioid therapy is only ONE part of your overall pain management plan (which may also include therapeutic injections, exercise, physical therapy, or other therapies/treatments) - if at any point you discontinue adherence to your overall treatment plan, your provider will no longer prescribe pain medication.

Because these drugs all have potential for abuse or diversion, rather strict accountability is necessary when these medications are prescribed. Please read this contract carefully. If you do not understand any of the information contained below, or require additional clarification on the policies of this office regarding the prescribing of opioid medications, please ask. You will be required to complete and sign this contract before receiving any opioid medications.

1. All controlled substances must come from your primary pain physician or by the covering physician, unless specific authorization is obtained for an exception. Renewals are contingent on keeping scheduled appointments. Consistently missing appointments or refusing to schedule medication refill appointments may lead to discontinuation of treatment.
2. Requests for pain medications after normal business hours and on nights, weekends, holidays, or through the emergency room will not be honored.
3. All controlled substances must be obtained at the same pharmacy. Should the need arise to change pharmacies, our office must be informed.
4. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.
5. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.
6. **You may not use illegal or street drugs, or other medications that were obtained illegally or that were intended for use by another person. You may not share, sell, or otherwise permit others to have access to these medications.**
7. These drugs should not be stopped abruptly, as medication withdrawal symptoms will likely develop.
8. Unannounced urine or serum toxicology screens and random pill counts may be requested, and your cooperation is required to monitor compliance. Presence of unauthorized substances may prompt referral for assessment for addiction and discontinuation of further opioid prescriptions.

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12201 MERIT DR. SUITE 300 DALLAS, TX 75251

9. You are instructed to take this medication only as prescribed and to not change the amount or dosing frequency without authorization from your physician. Unauthorized changes may result in running out of medications early, and early refills will not be allowed. You are not to increase or change medications without approval of the prescriber.
10. Prescription history will be monitored through the Texas DPS, and any patient with a record of "doctor-shopping" will be immediately discharged. In the event of emergency room treatment, this provider should be contacted and the problem will be discussed with the ER or other treating physician. No more than three (3) days of medications may be prescribed by the ER or other physician without the doctor's approval.
11. It is your responsibility to closely safeguard your prescriptions. These medications should not be left where others might have access to them and should be kept out of the reach of children. **Medications will not be replaced if they get wet, are lost, misplaced, stolen, or destroyed.**
12. Prescriptions may be issued early if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they are not to be filled prior to the appropriate date.
13. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality and consent is waived and these authorities may be given full access to our records of controlled substances administration.
14. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by the physician or referral for further specialty assessment.
15. The risks and potential benefits of these therapies were explained and include but are not limited to addiction, withdrawal symptoms, allergic reactions, breathing problems, drowsiness, dizziness, confusion, impaired judgment, inability to operate machinery or motor vehicles, nausea, vomiting, constipation, development of tolerance, overdose and potentially death. You agree to understand these potential risks and agree to opioid treatment.
16. **YOU UNDERSTAND AND AGREE THAT FAILURE TO ADHERE TO THESE POLICIES WILL RESULT IN PERMANENT CESSATION OF NARCOTIC PRESCRIPTIONS BY THE PRESCRIBING PHYSICIAN AND MAY RESULT IN TERMINATION OF OPIOID TREATMENT AND POSSIBLE DISMISSAL FROM THE PRACTICE.**

I, _____ (print name) have completely read, understood and accept each provision of this opioid agreement. I affirm that I have full right and power to sign and be bound by this agreement. I understand that adhering to the following is important in continuing to receive opioid medications prescribed by Premier Pain Solutions.

_____ _____

Patient Signature Date

_____

Patient Name (Printed)

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12201 MERIT DR. SUITE 300 DALLAS, TX 75251

AGREEMENT OF FINANCIAL RESPONSIBILITY

Thank you for choosing Premier Pain Solutions as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

Insurance

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company. The patient will be responsible for any deductible, coinsurance and co-payment amount. The patient is responsible for payment of any non-covered service.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In- Network rate.

Referrals

- If a referral is required for your insurance policy, it is your responsibility to obtain this referral from the primary insurance company prior to any appointments. Failure to obtain a referral may result in reduction of benefits.

12201 MERIT DR. SUITE 300 DALLAS, TX 75251

Self-Pay

- Patients are responsible for all visits, treatment and other related services covered by the treating provider at Premier Pain Solutions. While our office can try to estimate cost of services, the patient agrees in advance to pay for all services, tests and fees the providers feel are necessary for the patient's care.

Unpaid Balances

- Patients typically receive a statement from our office after the insurance company has processed the claims. This will include charges that the insurance company has not paid. Payment is due within 30 days of the statement date. An account is considered past due if not paid by due date listed on billing statement, unless prior arrangements have been made with our billing office.

Returned Checks

- The charge for a returned check is $35.00 payable by cash or money order. This will be applied to your account in addition to the insufficient fund amount.

No Show/Cancellation Policy

- No Show/Cancellation Policy: A charge of $50 will be applied to your account if notification of cancellation is not made within 24 hours of the appointment time.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full. I authorize payment of medical benefits to my treating provider at Premier Pain Solutions and authorize my provider to release any information requested by my insurance carrier. I understand and agree that the terms of this financial policy may be amended by the practice at any time without prior notification to the guarantor.

_____ _____

Signature of Patient /Responsible Party Date

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient

12201 MERIT DR. SUITE 300 DALLAS, TX 75251

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

PREMIER PAIN SOLUTIONS recognizes the patient's right to confidentiality of protected health information ("PHI"). This form obtains permission to discuss and/or release information regarding your care at our practice to a person whom you designate as an authorized representative. Authorization is optional- you may opt to not designate any authorized representatives.

Please bear in mind, if you intend for anyone else to schedule your appointments, manage your prescriptions, or receive billing/account/medical record information on your behalf, you must authorize them on this form.

PATIENT NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

I AUTHORIZE PREMIER PAIN SOLUTIONS TO DISCLOSE MY PHI TO THE LISTED PERSON(S):

NAME	PHONE NUMBER	RELATIONSHIP TO PATIENT

LIMITATIONS ON DISCLOSURE

I understand that by leaving this section blank, I am allowing all of my PHI to be disclosed to my authorized representative(s).

Limitations:

_____

I UNDERSTAND THAT INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT IF THEY ARE NOT A COVERED ENTITY UNDER THE FEDERAL PRIVACY RULE. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFYING PREMIER PAIN SOLUTIONS IN WRITING TO BE EFFECTIVE ON THE DATE NOTIFICATION IS RECEIVED. I AGREE THAT MY AUTHORIZATION IS VOLUNTARY.

_____ _____

PATIENT SIGNATURE DATE

12201 MERIT DR. SUITE 300 DALLAS, TX 75251

NOTICE OF PRIVACY PRACTICES AKNOWLEDGEMENT

Patient Name: _____

Date of Birth: _____

I acknowledge that PREMIER PAIN SOLUTIONS provided me with a written copy of the office's Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____

Patient Signature Date