Consultants in Pain Medicine, P.A.
Phone (210) 546-1480
Fax (210) 546-1489

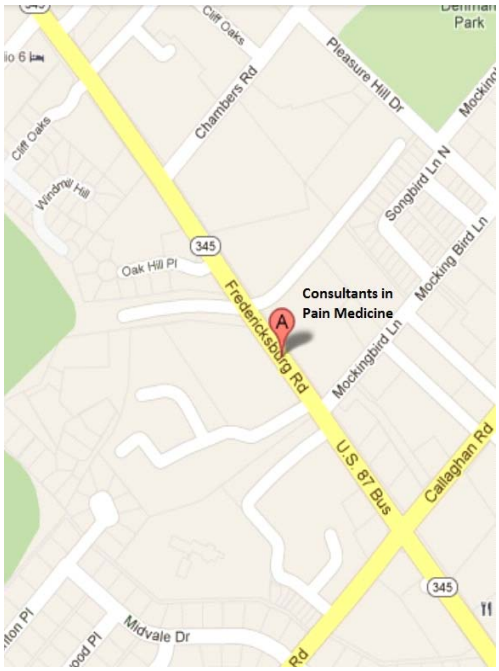
Scott P. Worrich, M.D.
Donald Stevenson, PA-C

Medical Center—Legacy Oaks
5368 Fredericksburg Rd
Building C, Suite 210
San Antonio, TX. 78229

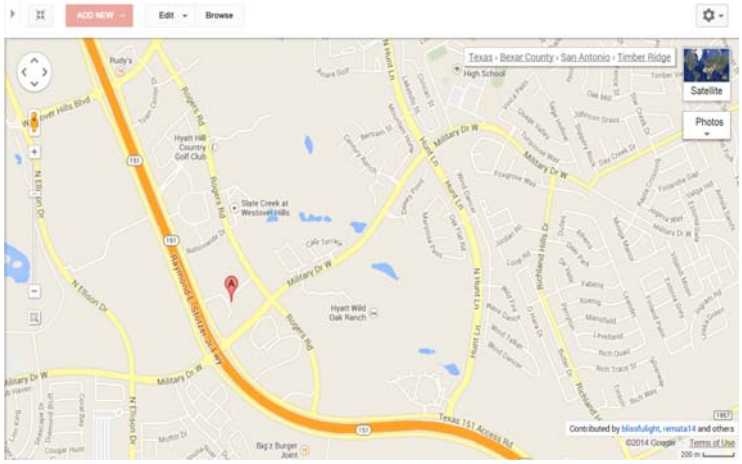
Westover Hills
10423 State Hwy. 151
Suite 103
San Antonio, TX. 78251

Stone Oak
116 Gallery Circle
Suite 202,
San Antonio, TX 78258

MEDICAL CENTER OFFICE
5368 FREDERICKSBURG RD, BLG C,
STE 210
SAN ANTONIO, TX 78229



WESTOVER HILLS OFFICE
10423 HWY 151, STE 103
SAN ANTONIO, TX 78251



STONE OAK OFFICE
116 GALLERY CIRCLE, STE 202
SAN ANTONIO, TX 78258

Consultants in Pain Medicine, P.A.

5368 Fredericksburg Rd. Ste. 210
San Antonio, Texas 78229
Phone (210) 546-1480 Fax (210) 546-1489

DATE: _____

Dear Mr./Mrs./Ms._____,

You have been referred to **Scott P. Worrich M.D.**, with Consultants in Pain Medicine by your physician. Please complete the enclosed information regarding your pain on the patient intake form provided for you. You must bring the questionnaire completed to the office on

_____, _____ at _____ a.m./p.m. at our _____
(*arrival time*) location (*see map attached*)

**NOTE IF REFERRED BY MILITARY BASE DOCTORS MAKE SURE YOU HAVE THE IMAGING REPORTS AT THE TIME OF YOUR APPOINTMENT, ** IF THE FORMS ARE NOT COMPLETELY FILLED OUT YOUR APPOINMENT MAY BE RESCHEDULED OR DELAYED.

Please be aware that you are liable for any applicable co-pays at office and facility visits. Please follow up with your insurance company to be prepared for the cost that may possibly be incurred. Please bring your insurance card to your appointment. If you do not understand the questions and require assistance arrive 30/45 minutes prior to your office appointment and please call our office.

***** If you are scheduled for an **injection** at the surgery center please arrive at least 30 minutes prior to your procedure. **You must bring a driver**. You should not eat or drink for 8 hours prior to your procedure except for essential medications, which can be taken with a **sip** of water only.

***Please notify our office if you are taking any Blood Thinners so we can arrange your lab work to be done prior to your procedure. Also, if you are on a blood thinner for cardiac reasons, especially an artificial heart valve, you must discuss stopping it with your primary care physician or cardiologist first. If you are placed on Lovenox, it must be stopped 12 hours prior to your procedure.**

We appreciate your cooperation and if you have any questions or require further assistance, please feel free to contact our office.

Consultants in
Pain Medicine, P.A.

ASSIGNMENT OF BENEFITS

Private insurance authorization for assignment of benefits and information release:

I, the undersigned, authorize payment of medical benefits to Consultants in Pain Medicine for any services furnished to me by the physician. I understand I am financially responsible for any amount not covered by my insurance policy. I also authorize Consultants in Pain Medicine to release to my insurance company, referring physician and other consultants on my case information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Date_____ Signed_____

MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made on my behalf to Consultants in Pain Medicine for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Date_____ Signed_____

CERTIFICATION

Consultants in Pain Medicine, P.A. is pleased to offer you treatment for your injury or suffering. However, you are advised that according to most commercial insurance policies and generally accepted practice, treatment for work related chronic injuries must first be filed under Texas Workman's Compensation. We will be happy to assist you in this process. Also, if this is a litigation case, our office needs to be informed before services are rendered.

*I _____ hereby certify that I **am /am not** seeking treatment for an illness or injury that resulted from an incident/accident at my place of work or from a motor vehicle accident.*

MVA / Date of Incident_____

If applicable, Attorney's Name_____ Phone #_____

_____ _____

Print Patient Name Date

_____

Patient Signatur

Health Insurance Portability and Accountability Act

By signing this document, I acknowledge that I have been given the opportunity to read the Notice of Privacy Practices of Consultants in Pain Medicine, P.A.

_____ _____

Print Patient Name Date

_____

Patient Signature

Consultants in Pain Medicine, P.A.
5368 Fredericksburg Rd. Ste. 210
San Antonio, Texas 78229
Phone (210) 546-1480 Fax (210) 546-1489

I hereby authorize Consultants in Pain Medicine, Inc., to take my photograph for inclusion in my medical chart retained by the clinic. I understand this photograph is solely for the purpose of identification and familiarization by the office staff and the clinic physician(s).

_____

Patient Signature

Please fill out and sign the following release form so we can obtain copies of any medical records that may be needed in order to assess your condition more thoroughly.

Date: _____

I, _____ hereby authorize the release of my medical records to Consultants in Pain Medicine

_____ _____

Patient Signature Date

_____ _____

Witness:

Informed Consent to Obtain Medication History

Consultants in Pain Medicine, PA has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your "medication history." A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer. An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions.

By signing this consent form you give us permission to collect, and give your pharmacy and your health plan permission to disclose, information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your medical record.

This medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, and the drug history from your health plan might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to point out to us any errors in your medication history.

Patient Acknowledgement

By signing below, I give permission for Consultants in Pain Medicine, PA to obtain my medication history from my pharmacy, my health plans and other healthcare providers.

Patient Signature _____Date_____

For internal office use:

Medication History Consent updated by: _____Date_____
(Patient demographics- misc tab.)

Information Form DATE: _____

Name: _____ Date of Birth: _____ Age: _____

Employer: _____ Occupation: _____

Do you work now? Yes No Part Time What does your work involve? _____

_____

_____

Name of Doctor who referred you?_____

List of other Doctors you have seen for this pain

problem_____

_____

Names of other Doctors you see for other medical reasons:

_____

_____

When did your pain begin? _____

Where were you injured? WORK, HOME, CHURCH, VACTION, DRIVING, OTHER (circle one)

Details:_____

How were you injured? LIFTING, MVA, FALL, BENDING, TWISTING, OTHER (circle one)

Post-injury Symptoms? _____

When did you feel symptoms? IMMEDIATELY, INTERMEDIATE, LATER (circle)

Were you injured on the job? Yes No Is there an attorney involved? Yes No

How and when were you treated for this

problem?_____

_____

Have you had surgery for this problem? Yes No

If yes, give:

Date	Hospital	Name of surgeon
_____	_____	_____
_____	_____	_____

Tests performed: X-Rays MRI CT Scan EMG Bone Scan Discogram Other

Where & When: What other treatments have you received? (i.e., bed rest, physical, therapy, hypnosis, chiropractic manipulation, acupuncture, injections) Please list details:

_____

MEDICATIONS

Please list medications to which you are ALLERGIC, and the type of reaction to each (i.e. rash, upset stomach, etc…..):

_____

_____

Please list medications you have previously taken **for pain**:

MEDICATION	HELPFUL?	REASON STOPPED
_____	YES/NO	_____
_____	YES/NO	_____
_____	YES/NO	_____
_____	YES/NO	_____
_____	YES/NO	_____
_____	YES/NO	_____

Please list medications you are CURRENTLY TAKING FOR PAIN:

MEDICATION	DOSAGE	TIMES/DAY	HELPFUL?
_____	_____	_____	YES/NO
_____	_____	_____	YES/NO
_____	_____	_____	YES/NO
_____	_____	_____	YES/NO
_____	_____	_____	YES/NO
_____	_____	_____	YES/NO
_____	_____	_____	YES/NO

Please list other medications you are CURRENTLY TAKING (include vitamins, etc.):

MEDICATION	HELPFUL
_____	YES/NO
_____	YES/NO
_____	YES/NO

For the following descriptions, place a SINGLE number for each word that describes you pain:

NONE = 0 MILD = 1 MODERATE = 2 SEVERE = 3

STANDING _____ STOOPING _____ WALKING _____ CLIMBING ____

SITTING _____ LAYING _____ DRIVING _____ STRESS ____

LIFTING _____ ANGER _____ TWISTING _____INTERCOURSE _____

BENDING _____ PUSHING _____

Married? **Yes** **No** Widowed? **Yes** **No** Separated? **Yes** **No**

How many children do you have?_____

Have you lost or gained weight in the last six months? Yes No

Pounds lost/gained _____lbs.

Do you: Drink alcoholic beverages? Yes (Amt) _____ No Smoke? Yes (Amt) ____ No

Have you ever been treated for addiction to alcohol or any other substance? Yes No

Do you currently take any illegal drugs or have you taken any narcotics in a non-prescribed manner? Y/N

FAMILY HISTORY (Circle all that apply TO YOUR BLOOD RELATIVES and their relationship to you)

Asthma_____ Genetic Disorders_____ Kidney Problems_____

Arthritis _____ Headaches _____ Lung Problems_____

Cancer _____ Heart Problems_____ ___ Seizure_____ Diabetes _____

High Blood Pressure_____ Tuberculosis _____

PERSONAL HEALTH HISTORY (Circle all that **APPLY TO YOU)**

Anxiety	Depression	Hepatitis	Kidney Problems (specify)
Arthritis	Diabetes	Headaches	Lung Problems (specify)
Asthma	Genetic Disorder	Heart Problems	Stomach Ulcer
Cancer(specify)	GI Bleed	HIV	Seizures
Constipation	Glaucoma	High Blood Pressure	Tuberculosis

Please list previous surgeries:

DATE	PROCEDURE	SURGEON	HOSPITAL
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Welcome to Consultants in Pain Medicine. The following information is provided for your benefit so we may serve you better.

Please read, initial each item, and sign to indicate your understanding and agreement.

_____1. **PAYMENTS**: All applicable fees, deductibles, coinsurance, or co-pays must be paid at the time of your appointment. **There is a $25.00 charge for all returned checks.**

_____2. **CANCELLATIONS:** To cancel your appointment, please contact us 48 hours **BEFORE** your scheduled appointment. You will be charged **$25 for an office visit and $100 for a procedure** for late cancellations or missed appointments. (**NO SHOWS**) No showing for more than three appointments may result in termination of your care with our office.

_____3. **MEDICATION REFILL REQUESTS:** Please contact your pharmacy for refill requests **5 days prior** to your refill date. We do not refill medications on Fridays.
******PLEASE BE ADIVISED, REQUESTING EARLY REFILLS FOR NARCOTIC MEDICATIONS, MAY RESULT IN YOUR INSURANCE DENYING FUTURE REFILL REQUESTS******

_____4. **PHYSICIAN ASSISTANT**: To expedite service of care, you may be treated by our Physician's Assistant, Don Stevenson, whom is under the direct supervision of Dr. Worrich.

_____5. **FACILITIES**: Your physician has an ownership interest in the following facilities that you may be referred to: Alamo MRI/CT, Huebner Sleep Center, Republic Rx, Hill Country Toxicology, Stone Oak Surgery Center, Surgcenter of Westover Hills, Advanced Genomics. As a patient, you have the right to choose where you are referred for services. Please make us aware of your preferences.

_____6. **INSURANCE**: It is your responsibility to notify us prior to your appointment if your insurance has changed to avoid possibly being charged private pay patient fees. It is your responsibility to ensure your visit is pre-approved, or you will be responsible for payment in full for office visits and procedures.

_____7. **FMLA & other forms**: There is a **$25.00-$50.00** fee for completion of FMLA or other forms. The form will take a MINIMUM of 7 working days to be returned to you. NOTE: We do not do Functional Capacity Tests.

_____ _____ _____/_____/_____

Patient Name **Signature** **Date**

_____

Witness

NARCOTICS CONTRACT

Consultants in Pain Medicine
Scott Worrich, M.D.
Phone: 210-546-1480
Fax: 210-546-1489

I, _____, understand that during the course of treatment I may
(PRINT NAME)
be prescribed opioids (narcotics) to treat the following chronic pain condition:_____.
The purpose of this agreement is to protect my access to controlled substances for the treatment of my pain.

I understand that there are risks associated with opioid treatment, such as physical dependence, ADDICTION, change in personality, sleep changes, respiratory depression, nausea, constipation and even bowel obstruction, changes in appetite, coordination, decreased testosterone, sexual desire and performance and death.
Stopping opioids suddenly can lead to rebound pain and to withdrawal symptoms. I have been informed not to stop my opioid medication suddenly.

Medication and other drug interactions can increase the risk of taking opioids. I agree to keep you up to date and informed regarding any medication changes that I may receive from any other doctor. I agree to inform you of my drinking practices so that we can discuss the risks of alcohol consumption. I also agree not to use any illegal drugs including Marijuana. If I smoke cigarettes, I agree to discuss with you the desirability of quitting smoking.

To minimize risk and assure adequate supervision, I agree to come in for regular visits every three (3) months. Failing to do so may result in a weaning dose of medications. I agree to have any labs you advise, including random drug blood levels and urine drug screens. I agree to come in on a short notice for random pill counts to help assure I am taking my medications in the prescribed manner. I agree to report any changes in my mental state or any adverse reactions. I agree to see any specialists you deem necessary.

I agree not to obtain any opioids from any other physician unless you are notified, even if I am having a surgery of any kind, I will let you know ahead of time if possible. I agree not to obtain any opioids from friends or other people. I will get my mediations from only one pharmacy, and will inform you of any change in my pharmacy. I will not give or sell my opioid medications to anyone else to use, not even my family. I will keep my medications in a safe, secure place to prevent theft, loss or accidental ingestion by other individuals (children).

If my opioid medication is lost, stolen, destroyed, etc…or used up early, I understand that it will ***NOT BE REPLACED OR REFILLED*** until the date of my next regular refill. I agree to NOT change my dose (self escalate) without first discussing it with you, either by phone or in person. I understand that it is my responsibility to plan ahead and call in my prescriptions to the office 5 days ahead of time in order to give you ample time to authorize a refill for me. I agree not to destroy my opioid medication without first discussing it with you.

I agree to make efforts to improve my functioning, and if I do not, I understand that my medications may be discontinued.
I understand that medications are not filled after hours, weekends or holidays.

Patient:_____/ Witness_____

Date:_____ Time:_____

Patient Name _____
Last *First* *Middle*

Address _____
Street *City* *State* *ZIP Code*

Home Phone ( )_____ Cell Phone ( )_____

Date of Birth _____ Social Security No. _____

Drivers License No: _____State _____ Expiration Date: _____

Email address: _____

Preferred language: ☐ English ☐ Spanish ☐ Other _____

Preferred Reminder Method: ☐ Mail ☐ Home Phone ☐ Cell Phone ☐ Email ☐ Patient Portal*
(*must sign consent form)

Gender: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Race: ☐ Declined ☐ White ☐ Black or African American ☐ Asian ☐ Other _____

Ethnic Group: ☐ Declined ☐ Hispanic ☐ Not Hispanic or Latino ☐ Other _____

Emergency Contact :_____Phone: ( )_____
Last *First* *Middle*

Are you seeking treatment for an injury related to ☐ WORK ☐ MOTOR VEHICLE ACCIDENT ☐ OTHER _____

Primary Insurance _____

Address _____

Telephone _____

Policy # _____ Group # _____

Subscriber _____

Subscriber Date of Birth _____

Relation to patient: ☐ self ☐ spouse ☐ parent

Secondary Insurance _____ ☐ none

Address _____

Telephone _____

Policy # _____ Group # _____

Subscriber _____

Subscriber Date of Birth _____

Relation to patient: ☐ self ☐ spouse ☐ parent