Jon-Paul Harmer, M.D. • Mike Martinez II, .D.O
907 E. Eureka St. Ste. B, Weatherford, TX 76086
Phone: 817-599-4901 Fax: 817-599-4902

At Lone Star Pain Medicine, you'll find a caring group of highly-trained physicians and staff dedicated to the treatment of patients with chronic pain.

We do our best to use the least invasive and most advanced therapies available, as we strive to aid our patients in restoring their quality of life and regaining function and independence in a compassionate environment.

How do you become a patient?

1. Complete and return the attached "Patient Qualification Packet", following the instructions exactly.

2. ***In your initial consultation at our office, you and one of our physicians will review your situation in detail to further determine if our practice can help you – if we both agree that we can, THEN you'll become a patient***

3. Once a treatment plan has been established between you and the physician, the physician and their assistant with jointly manage your care.

Thank You,

Jon-Paul Harmer, M.D.
Mike Martinez, D.O.

Important Notice

If you need to reschedule or cancel your New Patient appointment, you must call and give 24 hour notification. Failure to do so will result in a $75.00 no-show fee and must be paid before scheduling another appointment.

At Lone Star Pain, we believe in treating pain and we will evaluate each individual before accepting them into our practice. In good faith, we make every reasonable effort to follow federal and state guidelines on using controlled medications to treat pain. This means we will ask our patients to help us satisfy these legal requirements. If you are not able to do so, please call and cancel your appointment. (817) 599-4901

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Patient Qualification Packet Instructions

1. **Complete** ALL requested information within the packet
2. **Return** the packet to Lone Star Pain Medicine **PRIOR** to your scheduled appointment.
    a. **To Fax:** Dial 817-599-4902
    b. **To Mail:** Send to the following address

    Lone Star Pain Medicine
    PO Box 2499
    Weatherford, Texas 76086

    c. **Failure to return** your packet as requested may result in your appointment being cancelled or rescheduled.
    d. We cannot see you without a complete packet. Please fill out ALL the information.

3. **Bring** the following to your appointment:
    - **ALL** your current medications (actual bottles)
    - MRI films and reports.
    - Insurance card and prescription discount cards.
    - Driver's License or State ID.
    - Proof of current address – Ex: Utility bill

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Patient Information Update (NPP)

Name: _____ DOB: _____ SS#: _____-_____-_____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

E-mail Address: _____

Race: American Indian or Alaska Native Asian Black or African American Hispanic White
Native Hawaiian or Other Pacific Islander Other Race

Ethnicity: Hispanic or Latino Not Hispanic or Latino **Preferred Language:** _____

Emergency Contact: _____ Relationship: _____Phone:_____

Primary Care Physician: _____ Referring Physician: _____

Primary Insurance: _____

Policy holder: _____DOB:_____

Relationship: _____ SSN: _____

ID#: Group #:

Secondary Insurance:
_____

Policy holder: _____DOB:_____

Relationship: _____ SSN: _____

MEDICATION LIST:

Please list all of your **current** medications, **including any vitamins and over the counter medications** (i.e. – Omega 3, Vitamin C, Aspirin, Ibuprofen, Methadone, Lyrica)

MEDICATION NAME	DOSE	FREQUENCY	PRESCRIBING PHYSICIAN	REASON	PHARMACY

ALLERGIES:

Are you **ALLERGIC** to any medications? Please list below.

Medication	Reaction

Have you ever had a reaction to **Iodine, Shellfish, or Contrast Dye?**

O No O Yes (If so, please explain) _____

Have you been on any **Blood Thinners** recently? (i.e. Coumadin, Warfarin, Heparin, Aspirin, Lovenox, or Plavix)

O No O Yes, if so please list medications, dosage, and name of prescribing physician.

_____

Duration: When did your current pain problem begin? _____

Onset: How did your pain problem first start? _____

Describe the speed of onset of your pain. O Sudden/Abrupt O Gradual

Severity (0 – No pain, 10 – Worst pain imaginable):

Rate the severity of your pain at its **worst** (0 – 10): _____ Rate your pain **on average** (0 – 10):_____

PAST SURGICAL HISTORY:

Please list all **surgeries and hospitalizations** within the last **5 years** or that may be **relevant to your initial visit**.

Date	Procedure/Illness	Date	Procedure/Illness

Past History-Bubble in all that apply

O AIDS
O Arthritis
O Bleeding problems
O Cancer
O Dementia
O Diabetes
O Head Injury
O Heart Problems
O Hepatitis A
O Hepatitis B
O Hepatitis C
O High Blood Pressure
O Infectious Disease
O Kidney Problems
O Migraines
O Neurological Disease
O Respiratory Problems
O MRSA
O Pace Maker
O Pain Pump
O Parkinson's
O Seizures
O Stroke
O Ulcer

Social History:

What is your current marital status? _____ Has marital status changed since pain began? O Yes O No

Are there children living with you? O Yes O No If yes, how many? _____

Education/Employment:

Highest level of education completed? _____

Are you currently working? O Yes O No O Retired Has pain forced you to stop working? O Yes O No

What is or was your occupation? _____

Are you being treated under Worker's Compensation? O Yes O No

Are you currently receiving disability benefits? O Yes O No If yes, full or partial? _____

Habits:

Have you ever or do you now smoke? O Yes O No O Never Packs per day _____ # of years _____

Do you drink alcoholic beverages? O Yes O No O Never How many per day? _____

Do you use any "recreational" or "street" drugs? O Yes O No O Never If yes, list:_____

Do you drink caffeinated beverages (including energy drinks)? O Yes O No If yes, how many per day? _____

Personal History:

Is there a history of substance abuse in your family? O Yes O No _____

Do you have a personal history of substance abuse? O Yes O No _____

Are you between the age of 16 and 45? O Yes O No

Do you have a history of pre-adolescent sexual abuse? O Yes O No _____

Have you ever been diagnosed with ADD, OCD, bipolar, or schizophrenia? O Yes O No _____

Do you have a history of depression? O Yes O No _____

Review of Systems: Fill in the appropriate circle for each area

General
- O Fatigue
- O Loss of appetite
- O Sleep disturbance

Eyes
- O Diplopia-double vision
- O Eye pain
- O Loss or blurring vision
- O Swelling

Cardiovascular
- O Arrhythmia
- O Chest pain
- O Cold extremities
- O Dyspnea-difficulty breathing
- O Hypertension
- O Murmurs

Respiratory
- O Asthma
- O COPD
- O Emphysema
- O Shortness of breath
- O Sleep apnea
- O Snoring

Gastrointestinal
- O Abdominal pain
- O Constipation
- O Heartburn
- O Hepatitis
- O Laxative use
- O Nausea
- O Vomiting

Musculoskeletal
- O Antalgic gait-painful walking
- O Back pain
- O Joint pain
- O Joint stiffness
- O Joint swelling
- O Muscle cramps
- O Neck pain
- O Osteoarthritis
- O Scoliosis
- O Weakness

Neurology
- O Blackouts
- O Dizziness
- O Head trauma
- O Memory loss

Neurology cont.
- O Mental illness
- O New numbness
- O Paralysis
- O Seizures
- O Stroke
- O Syncope "fainting"
- O Tingling
- O Tremors

Psychiatric
- O Anxiety
- O ADD
- O Depression
- O Disturbing thought or feelings
- O Suicidal thought or attempts

Endocrine
- O Diabetes

Hematologic/Lymphatic
- O Abnormal bleeding
- O Anemia
- O Past blood transfusions

General Conditions of Treatment

1. CONSENT TO TREATMENT: Each patient of Lone Star Pain Medicine (hereinafter referred to as L.S.P.M) is treated pursuant to orders of the attending medical practitioner. I, the undersigned, acknowledge that I have been informed by my attending practitioner or his/her designees, to perform or administer all tests and treatments which, in the judgment of such practitioners, are advisable.
2. FINANCIAL AGREEMENT AND ASSIGNMENT AND ASSIGNMENT OF BENEFITS: In consideration for the services to be rendered to me, I hereby promise to pay for those services in accordance with the rates and terms now in effect at L.S.P.M. to the extent I am legally responsible for such payment. I hereby assign to L.S.P.M. and any practitioner providing care and treatment to me, any and all benefits and all interests and rights (including causes of action and the right to enforce payment) for services rendered under any insurance policies or any reimbursement or prepaid health care plan. I acknowledge that any balance not covered or paid by such policy or plan and not covered by Medicare, Medicaid or Worker's Compensation is my legal responsibility. IF I AM A MEDICAID PATIENT, I understand that, in the opinion of L.S.P.M., the services or items that I have requested to be provided to me on this date my not be covered under the Texas Medical Assistance Program as being reasonable and medically necessary for my care. I understand that the Texas Department of Human Services or its health insuring agent determines the medical necessity of the services or items that I request or receive. I also understand that I am responsible for payment of the services or items that I request or receive if these services or items are determined not to be reasonable and medically necessary for my care. If I am a Medicaid Star patient these provisions may not apply.

X_____

FOR MEDICARE PATIENTS ONLY: My signature only acknowledges my receipt of this information, (date) _____ and does not waive my rights to request to review or make me liable for any payment.

THIS IS A LEGAL CONSENT AND ASSIGNMENT OF BENEFITS FORM.
PLEASE BE SURE YOUR QUESTIONS, PERTAINING TO THIS FORM,
HAVE BEEN ANSWERED BEFORE SIGNING.

GUARANTY: I hereby personally guarantee the payment of the account of the above patient.

X_____ _____ _____AM/PM
Signature of patient/Legal Representative Date Time

X_____ _____
Signature of Guarantor Witness to Signing

A Legal Representative includes ONLY the following: for minor patient, the parent or legal guardian, or other person authorized by law to consent; for an incompetent or incapacitated adult patient, a court appointed guardian, Agent under a Medical Power of Attorney or other person authorized under Texas law to consent to medical treatment on behalf of the patient.

Dismissal Agreement

If a member of your immediate family, same household, is dismissed from the clinic it will necessitate that all household members that are patients be dismissed as well. _____ (Initial)

Patient Behavior Protocol

I understand that my access to care via telephone, internet, or on site will require my behavior to be in a manner that is not abusive to staff. I agree to refrain from behavior that reflects yelling, cursing, name calling or multiple calls or web-encounters regarding the same subject in the same day. I understand that engaging in this type of behavior may result in my termination from this practice. _____ (Initial)

Patient Health Information Request Form

Patient Name: _____ Date: _____

1. Release of information:

I consent and authorize Lone Star Pain Medicine, (hereinafter referred to as L.S.P.M.) to release all information contained in my financial and medical records including diagnoses and test results, to (a) any of my treating practitioners, (b) my insurance company or health care plan or its representatives, or its agents or independent contractors, or (c) any other person or entity that is responsible for paying or processing for payment any portion of my bill, (d) to any person or entity affiliated with L.S.P.M. for the purpose of administration, billing, collection and quality and risk management, (e) any regulatory or inspecting agency or to any other person or entity what L.S.P.M. deems necessary for my medical treatment. This consent applies to all records created in the course of and relating to my treatment, including those related to alcohol and/or substance abuse diagnosis or treatment, mental health treatment, and/or communicable disease, if any. In order to provide the L.S.P.M. practitioners who will treat me with access to my prior medical history, I also consent and authorize the L.S.P.M. to release to any of the L.S.P.M. practitioners who treat me, all of the information in my medical records from any prior medical treatment.

2. How may L.S.P.M. communicate with you? May we leave a message?

☐ Home phone: _____ ☐ Yes ☐ No

☐ Cell Phone: _____ ☐ Yes ☐ No

☐ Work Phone: _____ ☐ Yes ☐ No

☐ Other: _____ ☐ Yes ☐ No

☐E-mail: _____

3. Other than your insurance, whom may we talk to about your healthcare information? (REQUIRED)

Name/Telephone: _____Relationship:_____
Name/Telephone: _____Relationship:_____
Name/Telephone: _____Relationship:_____

4. Release of information for billing: If I am the patient or patient's legal guardian, I also consent to the release of billing and medical records to my primary care physician, _____, M.D./D.O. and his/her medical group. This release shall remain valid until I notify the physician, in writing, of my desire to revoke it.

5. I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my Protected health information.

6. THIS IS A LEGAL CONSENT AND ASSIGNMENT OF BENEFITS FORM. PLEASE BE SURE YOUR QUESTIONS, PERTAINING TO THIS FORM, HAVE BEEN ANSWERED BEFORE SIGNING.

7. I acknowledge that I have been given the opportunity to read LSPM's "Notice of Privacy Practices". _____ (initial)

8. I give permission for Lone Star Pain Medicine to take my picture for proper identification for my electronic medical chart. _____ (initial)

X_____ _____ _____

Patient or Personal Representative Signature Printed Name Date

_____

Witness to Signing

Lone Star Pain Medicine, PLLC

907 E. Eureka St. Suite B. Weatherford, TX. 76086
Phone 817-599-4901 ~ Fax: 817-599-4902

FINANCIAL DISCLOSURE NOTICE TO PATIENTS

This is a notice informing you that **Lone Star Pain Medicine, PLLC** owns and operates **Town Creek Pharmacy** for the convenience of our patients. You always have a choice in pharmacies and are in no way obligated to use our pharmacy.

By signing below, you are acknowledging that you have received notice of the information provided above.

Signature of Patient or Authorized Representative Date

One stop is all you need…

Town Creek Pharmacy

- Pick up your prescriptions after your appointment.
- Transfer all of your prescriptions. No need to make two stops or wait in long lines.
- Friendly and personalized service. We know you and your needs.

Hours: Monday thru Thursday 8:00am to 5:30pm and Friday 8:00am to 1:00pm

Please list any medications you are currently taking and would like Town Creek Pharmacy to stock for your convenience

Provide us with the following information and we will do the rest.

Your name: (Please print) _____

DOB: _____ Phone #: _____

RX numbers and medication name: _____

_____ _____

_____ _____

_____ _____

_____ _____

Pharmacy name & phone #: _____

_____

Special request: _____

_____