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.

1. ***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***

1. 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.

Michael Balderamos, M.D.

**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 $100 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**

**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.
3. **To Fax:** Dial 817-599-4902
4. **To Mail:** Send to the following address

**Lone Star Pain Medicine**

**PO Box 2499**

**Weatherford, Texas 76086**

1. **Failure to return** your packet as requested may result in your appointment being cancelled or rescheduled.
2. 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.

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Insurance:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| 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** |
|  |  |  |  |  |  |
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**MEDICATION LIST:**

**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? О Yes О No

Are there children living with you? О Yes О NoIf yes, how many? **\_\_\_\_\_\_\_\_\_\_\_**

**Education/Employment:**

Highest level of education completed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

What is or was your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you being treated under Worker’s Compensation? О Yes О No

Are you currently receiving disability benefits? О Yes О No If yes, full or partial? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Habits:**

Have you ever or do you now smoke? О Yes О No О Never Packs per day \_\_\_\_\_\_\_\_\_ # of years \_\_\_\_\_\_\_\_\_

Do you drink alcoholic beverages? О Yes О No О Never How many per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use any “recreational” or “street” drugs? О Yes О No О Never If yes, list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Personal History:**

Is there a history of substance abuse in your family? О Yes О No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a personal history of substance abuse? О Yes О No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Do you have a history of pre-adolescent sexual abuse? О Yes О No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been diagnosed with ADD, OCD, bipolar, or schizophrenia? О Yes О No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a history of depression? О Yes О No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

General Gastrointestinal Neurology cont.

 О Fatigue О Abdominal pain О Mental illness

 О Loss of appetite О Constipation О New numbness

 О Sleep disturbance О Heartburn О Paralysis

 О Hepatitis О Seizures Eyes О Laxative use О Stroke

 О Diplopia-double vision О Nausea О Syncope “fainting”

 О Eye pain О Vomiting О Tingling

 О Loss or blurring vision О Tremors

 О Swelling Musculoskeletal

 О Antalgic gait-painful walking Psychiatric

Cardiovascular О Back pain О Anxiety

 О Arrhythmia О Joint pain О ADD

 О Chest pain О Joint stiffness О Depression

 О Cold extremities О Joint swelling О Disturbing thought or feelings

 О Dyspnea-difficulty breathing О Muscle cramps О Suicidal thought or attempts

 О Hypertension О Neck pain

 О Murmurs О Osteoarthritis Endocrine

 О Scoliosis О Diabetes

Respiratory О Weakness

 О Asthma Hematologic/Lymphatic

 О COPD Neurology О Abnormal bleeding

 О Emphysema О Blackouts О Anemia

 О Shortness of breath О Dizziness О Past blood transfusions

 О Sleep apnea О Head trauma

 О Snoring О Memory loss

**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.

1. 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 Name/Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name/Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name/Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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

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