# SA PAIN CLINIC

**5522 Lone Star Parkway, Bldg. 2, Suite 101**
**San Antonio, TX 78253**
**Telephone: 210-298-4900 Fax: 210-298-6631**

**Larina V. Gutenberg, D.O.**
**Roberto J. Diaz, M.D.**
**Adam Fish, D.O.**
**Ma Luo, M.D.**

## Information on New Consultation Appointments

The Providers of SA Pain Clinic are pleased that you have been referred to our office. As part of the initial appointment, we will need you to fill out paperwork that pertains to your medical history, insurance coverage and contact information. We request that you have this paperwork filled out by the time you check into our office to make this process easier for you. If you do not fill out the new patient packet before arrival, arriving 45 minutes before your appointment time should allow enough time to fill out paperwork and check-in. We request that you bring all your medical records, medications, including over the counter medications, picture identification, and insurance cards. If your address in the identification card is not correct, we will need a recent utility bill with the correct address.

At your initial appointment, our purpose is to perform a complete evaluation, to include a clinical review of radiographic reports that have been taken recently that relate to your pain concerns. Without this information, we cannot conduct a comprehensive evaluation or review options for your care. If medical records are not provided by you or your referring doctor before your initial appointment, a second appointment may be required after the medical records have been received to complete the medical evaluation. We may also need to order current radiological examinations, lab work, etc., to complete our evaluation.

Please note it is not our protocol to prescribe medication during the evaluation process. If medication is part of your treatment plan, then we will discuss the protocols on how these medications are managed through our office.

In the event you test positive for a Schedule 1 drug such as THC or illicit drugs, including but not limited to methamphetamines, heroin, cocaine, etc., opioid medication will be withdrawn from your treatment plan.

Once a complete evaluation is performed, we will discuss treatment options. If you wish to proceed with our plan of care and we accept you as a patient, then the doctor-patient relationship will begin. Be assured that the evaluation is kept in the strictest confidence. We understand that you have the option to not pursue a relationship as a patient. We also reserve the right to accept you as a patient once we determine that we can be of assistance.

We hope this information is helpful and we look forward to working with you.

Sincerely,

Management
SA PAIN CLINIC

_____ _____

Signature of Patient, Parent or Guardian Date

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## PATIENT INFORMATION

REFERRED BY: _____ SOC. SEC. #: _____/_____/_____

LAST NAME (PASADO): _____ FIRST NAME (PRIMERO): _____ MI: ___

ADDRESS (DIRECCION): _____

CITY (CIUDAD): _____ STATE (ESTADO): ____ ZIP: _____

PHONE #: _____AGE: _____ DATE OF BIRTH: _____/_____/_____ SEX: ___M ___F

E-MAIL ADDRESS_____

MARITAL STATUS: ☐ S ☐ M ☐ D ☐ W SPOUSE'S NAME: _____

EMERGENCY CONTACT NAME: _____ CONTACT #: _____

## EMPLOYER INFORMATION

OCCUPATION: _____

EMPLOYER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

BUSINESS PHONE#: _____ FAX #: _____

## INSURANCE INFORMATION

**TYPE OF INSURANCE ☐ PRIVATE HEALTH ☐ MEDICARE ☐ NONE**

INSURED'S NAME: _____ DATE OF BIRTH: ____/____/_____

SS#: _____/____/_____

PATIENT'S RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER _____

NAME OF INSURANCE CO: _____ POLICY #: _____

## SECONDARY INSURANCE

INSURED'S NAME: _____ DATE OF BIRTH: ____/____/_____

SS#: _____/____/_____

PATIENT'S RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER _____

INSURANCE CO: _____ POLICY #: _____

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## CONSENT TO SPEAK WITH APPROVED INDIVIDUALS, LEAVE TELEPHONE MESSAGES, AND/OR SEND E-MAIL CONCERNING PATIENT CARE

When it comes to your medical treatment, the Providers of SA Pain Clinic strive to communicate with you in a timely and professional manner. As a patient there are certain occasions when you will want our staff to leave messages for you or communicate directly with family members, friends, or any other individuals that might be involved in your care.

In order to protect the privacy of your personal health information, please indicate below the manner in which we may leave message(s), including the names of any other individuals with whom we can discuss your protected health information.

I, _____, authorize SA Pain Clinic to communicate with _____, my _____ (relationship) concerning my care and treatment provided by the by doctors or mid-level staff.

### VOICE MESSAGE

I, _____, authorize SA PAIN CLINIC to contact me through the telephone number(s) I have listed below for appointment reminders, to schedule appointments or to provide other confidential healthcare communications. If I am unavailable to answer my telephone, I give SA Pain Clinic Providers or staff permission to leave a **detailed** message on the answering machine of the telephone numbers I have listed below.

Home Telephone No: _____

Cellular No: _____

Work Telephone No: _____

### LEAVE MESSAGE WITH A PERSON

I, _____, authorize SA PAIN CLINIC Providers or staff to contact me through the telephone number(s) I have listed below for appointment reminders, to schedule appointments or to leave other confidential healthcare communications. If a person, other than myself, answers the telephone for any of the numbers I have listed below, I give SA Pain Clinic permission to leave a message with the person(s) designated below.

Home Telephone No:_____

Name of person(s) allowed to receive messages:_____

Cellular No.: _____

Name of person(s) allowed to receive messages: _____

### E-MAIL

I, _____, authorize SA PAIN CLINIC to send appointment reminders or to provide or leave confidential healthcare communications or **send my medical records electronically via E-mail** to the following email address:_____

_____ _____

Signature of Patient, Parent or Guardian Date

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## ASSIGNMENT OF INSURANCE BENEFITS/ RIGHT FOR DIRECT PAYMENT TO DOCTOR

In consideration of services rendered I hereby transfer and assign to Larina V. Gutenberg, D.O., PLLC an assumed name for SA PAIN CLINIC and other licensed providers who perform services for my care and treatment all right title and interest in any payment due me for services described herein as provided in any health insurance or similar policy or employee benefit plan. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.**

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay any balance of said professional service charges over and above this insurance payment in full, except in instances where No-Fault or Workers' Compensation insurance fee schedules apply.

This assignment of benefits does not release me from my obligation to pay professional fees. I understand that I am responsible for providing SA Pain Clinic with my current insurance information before the time of each visit to allow for verification of benefits prior to my being seen.

I further understand that if my insurance should lapse or I do not provide my current health information, that I am personally responsible for the payment of all services rendered, including reasonable collection costs, if any.

**A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.**

I authorize the release of confidential health information pertinent to my care to any insurance company and/or their representative.

_____ _____

Signature of Patient, Parent or Guardian Date

## MEDICARE ASSIGNMENT OF BENEFITS/RIGHTS FOR DIRECT PAYMENT TO DOCTOR

I certify that the information given by me in applying for payment under TITLE XVIII of the Social Security Act is correct. I authorize the release of information concerning me to the Centers for Medicare and Medicaid Services or its intermediaries, agents or carriers as well as any information needed to determine benefits or for filing a Medicare claim or the benefits payable for related services.

I request and assign payment of authorized benefits to be made on my behalf to SA Pain Clinic, or the physician or entity submitting a claim on my behalf, for services furnished to me by the provider.

_____ _____

Signature of Patient, Parent or Guardian Date

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## APPOINTMENT POLICY

In an effort to provide efficient treatment to all of our patients, it is the policy of SA Pain Clinic that if you are unable to make your scheduled appointment, you must call to cancel and/or reschedule the appointment no later than 24 business hours before the scheduled time.

The cancellation call must be made during normal business hours (Monday through Thursday between 8:00 a.m. and 4:59 p.m. and Friday between 8:00 a.m. and 12:59 p.m.), as the answering service does not have a protocol for non-emergent messages nor do they have a mailbox for you to leave a message.

In addition to the above, if you fail to show up to an appointment, you will be charged a **No Show fee per occurrence**. You will be solely responsible for payment of this charge. Repeated No Shows and cancellations of your scheduled appointments may result in your being Discharged from care. If you have any question about this form, please talk to our staff before signing.

**Effective January 1, 2020**

**No Show/Same Day Cancellation Policy Fees**

**1st-2nd** Office Visit no show and/or same day cancellation – **$25.00**
**3rd to 4th** Office Visit no show and/or same day cancellation- **$50.00**
**5th** Office Visit no show and/or same day cancellation - **$75.00**
**6th** Office Visit no show and/or same day cancellation - **$100.00**
After the 6th no show and/or same day cancellation of an office visit - **$100.00**

**Procedure** appointments no show and/or same day cancellation - **$75.00**

_____ _____

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## Financial Policy

Thank you for choosing us as your Provider. We are committed to your successful treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy which we require you to read and sign prior to your treatment.

Full payment if due at the time of service.

We accept Cash, Check, Visa, Mastercard, Discover, American Express.

We do not offer payment plans.

## Insurance

We require all deductibles, co-pays, outstanding account balances, treatment not covered by insurance, missed appointment fee, insufficient fund or declined check or credit card fee and any other patient out of pocket expense, fee or charge be paid no later than the time of service.

We are a third party to your insurance contract. We file claims to your health insurance carrier as a courtesy to you. We must receive from you the correct insurance information to obtain eligibility information and to bill your health plan carrier. It is ultimately your responsibility to know and understand your health insurance, i.e., coverages, including copays and deductibles, etc. If your insurance company refuses to pay your account, the balance becomes your responsibility. Please be aware that some of the services provided and/or recommended may be non-covered by your insurance carrier or not considered reasonable and necessary by your insurance company.

## Usual and Customary Rates

Our practice is committed to providing the best possible care to our patients. Our fees are based on what is usual and customary for our area.

## Missed Appointments

Please see document entitled Appointment Policy in New Patient Packet From 05.

## Waiver of Confidentiality

Please understand that if we receive a chargeback on your credit card or your account is submitted to an attorney, collection agency, taken to court, or if your past due status is reported to a credit reporting agency, your treatment record and the invoices from our office may become a matter of public record.

Thank you for understanding our financial policy. Please let us know if you have any questions.

I have read and understand this financial policy.

_____ _____

Patient or Representative **Printed Name** Patient or Representative **Signature**

Date _____

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## OFFICE PROTOCOL AGREEMENT

The following protocols are necessary to provide appropriate care to all our patients. Please review, initial each entry and sign below indicating that you understand these office protocols and agree to abide them. Lack of signature does not invalidate these protocols.

Initials

_____ I understand that refills are given at the time of the office visit, and not by request via telephone call.

_____ I understand with controlled substance therapy (narcotics), I need to undergo random urine drug testing as part of my treatment plan, and that urine drug tests confirm the presence of prescribed medications, as well as THC, cocaine, methamphetamines, etc.

_____ I understand that I may only treat with one pain management doctor/clinic, and that if I seek medication and/or treatment from another pain management clinic and their physicians, that I will be discharged from SA Pain Clinic.

_____ I understand that I am an active participant in my health care and agree to abide by the treatment plan given and reviewed with me at each visit. I understand that any changes in condition may need an office visit for reassessment, and acute changes in my condition, I may need to access care through the emergency room.

_____ I understand that this practice utilizes mid-level practitioners such as Physician Assistants and/or Nurse Practitioners. The mid-level practitioners provide care in terms of assessing new patients, routine follow-ups, changes in conditions, education of patient on condition, joint injections, pump refills, medication refills, referrals to other providers or consultants, treatment options, etc.

_____ I understand that my access to care on site or via telephone will require my behavior to be in a manner that is not abusive to staff. I agree to refrain from abusive behavior that reflects yelling, cursing, name-calling or multiple telephone calls in the same day. I understand that this type of behavior may terminate my relationship with SA Pain.

_____ I understand that my access to care via on site or telephone will require that the behavior of anyone I appoint to speak to the Clinic on my behalf, interact with providers and staff in a non-abusive manner, and refrain from yelling, name calling or multiple telephone calls in the same day. I understand that this type of behavior may cause my care to be terminated with the Clinic.

_____ I agree to the cancellation of my previously scheduled appointment to benefit other patients that are in need of earlier appointments.

_____ I understand that I am to arrive 15 minutes before my appointment time to check in for follow up appointments and 45 minutes before a new patient appointment.

Name of Patient: _____
(print name)

_____ _____
Signature of Patient, Parent or Guardian: Date:

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## LONG-TERM CONTROLLED SUBSTANCE THERAPY AGREEMENT & PAIN MANAGEMENT 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 benefits. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Our policy regarding narcotic prescribing for CHRONIC NON-MALIGNANT (non-cancerous) pain is strict and non-negotiable, and based on medical research and clinical experience. Narcotics should be used ONLY as a last resort and ONLY as an adjuvant to other therapies. The physician will provide physical resources to improve your function, as well as medical therapies and injections. Our goal is to minimize narcotic use. The rules regarding narcotic use are outlined below. These rules were developed with the patient's welfare in mind. If these rules are unacceptable or at odds with your medical goals, we will honor your request to be referred to another pain management physician.

Because narcotic drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason, the following policies are agreed to by you, the patient, as consideration for, and a condition of the willingness of the physician to consider the initial and/or continued prescription of controlled substance to treat your chronic pain. Medical treatment including prescription medication is initially a trial, and that continued prescriptions are contingent on evidence of benefit.

1. All controlled substances must be prescribed by a SA PAIN CLINC provider who is assigned to your care or, during his or her absence, by the covering provider, unless specific authorization is obtained for an exception. You, the patient, are not to receive prescriptions for narcotic or sedative drugs from any other provider.

2. 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 continuity of care.

3. All controlled substances must be obtained at the same pharmacy, whenever possible. Should the need arise to change pharmacies, or add another pharmacy, SA PAIN CLINIC must be informed. The pharmacy that you have selected is: _____
Telephone: _____. Alternate Pharmacy: _____
Telephone: _____.

4. You are required to cooperate with unannounced urine or serum toxicology screens. The presence of **unauthorized or illegal substances (including THC)** in your urine may prompt the termination of your opioid treatment. After confirmation of a UDT that indicates unauthorized drugs in your urine, you will be counseled and may be offered a referral to rehab or a psychologist.

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5. Long-acting narcotics will be prescribed to patients with a diagnosis of a chronic pain condition. Our goal is to discontinue short acting narcotics and narcotic mixtures (i.e., Percocet, Lortab, Vicodin, etc.). Therefore, "rescue doses" of short acting narcotics will not be routinely supplied.

6. Prescription medication refills occur on a monthly basis, and only after an office visit and physical examination.

7. NO REFILLS will be approved over the telephone, after hours, on weekends, or holidays.

8. If prescription medication refill requests are made after hours, you will be instructed by the answering service to go to an emergency room of your choice.

9. 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.

10. Prescription medication refills **may be** issued early if the prescribing SA PAIN CLINIC provider or patient will be out of town when a refill is due. The early refill prescription(s) for medication(s) will contain instructions to the pharmacist that they not to be filled prior to the appropriate date.

11. Any evidence of false or forged prescriptions, tampering with urine cups, substance abuse, or aberrant behavior (including verbal abuse to our office staff) by you, your family member or anyone you designate to speak on your behalf, will result in termination of the patient-physician relationship.

12. Prescription medication(s) will not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. It is **your responsibility** to protect your prescription medications. If your medication has been stolen and you make a timely police report regarding the theft, an exception may be made.

13. Prescription medication(s) should be taken according to the written instructions on the prescription. Use of an increased amount of medication, without consultation with the prescribing physician, will not be allowed.

14. You may not share, sell, or otherwise permit others to have access to your prescription medication.

15. DO NOT abruptly stop taking prescription medication(s) unless instructed to do so by a physician, as an abstinence syndrome will likely develop.

16. Bring your medication, in the original container, to each office visit.

17. You must keep prescription medication out of the reach of other people, as the medication may be hazardous or lethal to a person who is not tolerant to their effects, especially a child.

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18. Both the prescription and prescription bottle containing narcotic medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. Prescription medication should not be left where others might see or otherwise have access to them.

19. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.

20. Termination terms will include a written letter to you, emergency treatment for 30 days, and depending on the reason for dismissal, possibly a narcotic prescription(s) for 30 days after the date of termination. You will be presented with the option, in lieu of termination, to receive an evaluation for drug dependency and, if appropriate, be referred for detoxification.

Your pain is your responsibility. Making appointments for medication refills is also your responsibility. SA PAIN CLINIC will provide medical support in you quest to minimize your pain. You must try to improve your sleep habits, nutrition, body weight, conditioning, and psychological state. Narcotics are not the answer to chronic pain but can be used effectively to improve your pain.

You affirm, by signing below, that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

I,_____, have read and accept the conditions of this contract.

Signature of Patient, Parent or Guardian: _____

Social Security Number: _____ Date: _____

Witness: _____ Date: _____

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## Consent for Chronic Opioid Therapy

*A consent form from the **American Academy of Pain Medicine***

A SA PAIN CLINIC physician may be prescribing opioid medicine, sometimes called narcotic analgesics, to me for a diagnosis that is causing me to experience pain. This decision was made because my condition is serious or other treatments have not helped my pain. I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and possibility that the medicine will not provide complete pain relief.

I am aware about the possible risks and benefits of other types of treatments that do not involve the use of opioids. The other treatments discussed included:

(1) Making no change to current medical regimen.
(2) Discontinue current regimen completely.
(3) Seeking psychological and/or psychiatric evaluation and treatment in addition to other options.
(4) Initiation of physical and/or occupational therapy.
(5) Seeking surgical consultation.
(6) Proceeding with interventional therapy.
(7) Using only non-opioid agents.

I will tell and keep my provider updated about all other medicines and treatments that I am receiving.

I agree not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly.

I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include, but are not limited to, using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself.

I am aware that certain other medicines such as nalbuphine (Nubain™), and pentazocine (Talwin™), buprenorphine (Buprenex™), and butorphanol (Stadol™), may reverse the action of the medicine I am using for pain control. Taking any of these other medicines while I am taking my pain medicines can cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of these medicines and to tell any other doctors that I am taking an opioid as my pain medicine and cannot take any of the medicines listed above.

I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that

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the chance of becoming addicted to my pain medicine is very low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge.

I understand that physical dependence is a normal, expected result of using these medicines for a long time. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine use is markedly decreased, I may experience some or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening.

I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain; however, it has been seen and may occur to me. If it occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment.

**(Males Only)** I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire, and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

**(Females Only)** If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medicines; the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects, however, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

_____ _____

Signature of patient, parent or guardian Date

_____ _____

Witness Date

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## NOTICE OF PRIVACY PRACTICE

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This practice uses and discloses health information about you for treatment. This information is used to obtain payment for treatment, administrative purposes, and to evaluate the quality of care that you receive. This notice describes our privacy practices. You can request a copy of this notice at any time. For more information about this notice or our privacy practices and policies, please contact our office.

### Treatment, Payment, Health Care Operations

**Treatment:**
We are permitted to use and disclose your medical information to those involved in your treatment. For example: the physicians in our office are specialists. When we provide treatment, we may request that your primary care and/or referring physician share your medical information with us. Also, we may provide your primary care and/or referring physician information about your condition so that he or she can appropriately treat you for other medical conditions, if any.

**Payment:**
We are permitted to use and disclose your medical information to bill and collect payment for services provided to you. For example, we may complete a claim form and/or be required to submit medical information to obtain payment.

**Health Care Operations:**
We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we may engage the services of a professional to aid this practice in its compliance with regulations and the law.

**Disclosures That Can Be Made Without Your Authorizations:**
There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you may later revoke that authorization in writing to stop future uses and disclosures. However, revocation will not apply to disclosures or uses already made in reliance on that initial authorization.

**Public Health, Abuse or Neglect. and Health Oversight:**
We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to disease or may be at risk for contraction or spreading a disease or condition. We may disclose your medical information to report reactions to medication, or problems with products that may be recalled.

## NOTICE OF PRIVACY PRACTICE

We may also disclose medical information to a public agency authorized to receive reports on child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure application and inspections which are all government activities undertaken to monitor the healthcare delivery system and compliance with other laws, such as civil rights laws.

**Legal Proceedings and Law Enforcement:**
We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decisionmaker) or of the appropriate legal process. Certain requirements must be met before the information is disclosed. If asked by a law enforcement official, we may disclose your medical information under the limited circumstances provided that the information:

1. is released pursuant to legal process, such as a warrant or subpoena
2. pertains to a victim of crime and you are incapacitated
3. pertains to a person who has died under circumstances that may be related to criminal conduct
4. is about a victim of crime and we are unable to obtain the person's agreement
5. is released because of a crime that has occurred on these premises, or
6. is released to locate a fugitive, missing person or suspect

We may also release information if we believe the disclosure is necessary to prevent or relieve an immediate threat to the health or safety of a person.

**Workers' Compensation:**
We may disclose your medical information as required by the Texas Worker's Compensation Act.

**Inmates:**
If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release of records is permitted to allow the institution to provide you with medical care, to protect your health, the safety of others or for the safety and security of the institution.

**Military. National Security and Intelligence Activities, Protection of the President:**
We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, request by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized government officials, or foreign heads of state.

**Organ Donation, Coroners, Medical Examiners, and Funeral Directors:**
When a research project and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes. We may

release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased individual or a cause of death. Further, we may release your medical information to a funeral director where such disclosure is necessary for the director to carry out his duties.

**Required by Law:**
We may release your medical information when the disclosure is required by law.

**Your Rights under Federal Privacy Regulations:**
The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients my exercise. We will not retaliate against a patient that exercises their HIPAA rights.

**Requested Restrictions:**
You may request that we restrict or limit how your protected health information is disclosed for treatment, payment, or healthcare operations. We do NOT have to agree to the restriction(s), but if we do agree, we will comply with your request except under emergency circumstances. You may also request that we limit disclosure to family members, other relatives, or personal friends that may or may not be involved in your care. To request a restriction, submit the following in writing: (a) the information to be restricted, (b) what kind of restriction you are requesting (i.e. on the use of information, disclosed information or both), and (c) to whom the limits apply. Please send the request to SA Pain Clinic, Attn: Privacy Officer. (see full contact information on page 5)

**Receiving Confidential Communications by Alternative Means:**
You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be addressed, in writing, to the SA Pain Clinic Privacy Officer (see Page 5 for contact information). We are required to accommodate only reasonable requests. Please specify in your correspondence exactly how you want us to communicate with you and if you are directly sending it to a particular place, the name of the contact and/or address information.

**Inspection and Copies of Protected Health Information:**
You may inspect and/or copy health information that is within the designated record set or the information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing and we ask that requests for inspection of your health information also be made in writing. Please send your request to the SA Pain Clinic Privacy Officer.

We can refuse to provide some of the information you ask to inspect, or ask to be copied, if the information: (1) includes psychotherapy notes, (2) includes the identity of a person who provided information if it was obtained under a promise of confidentiality, (3) is subject to the Clinical Laboratory Improvements Amendments of 1988, or (4) has been compiled in anticipation of litigation.

## NOTICE OF PRIVACY PRACTICE

We can refuse to provide access to or copies of some information for other reasons, provided we share a review of our decision, on your request. Another licensed health care physician who was not involved in the prior decision to deny access will make such review.

Texas law requires that we will be ready to provide copies or a narrative within 15 business days of receiving your request. We will inform you of when the records are ready, or if we believe access should be limited. If we deny access, we will inform you in writing.

**Amendment of Medical Information:**
You may request an amendment of your medical information in the designated record set. And such request must be made in writing and submitted to SA Pain Clinic Attn: Privacy Officer (see Page 5 for full contact details). We will respond within 60 days of receipt of such request. We may refuse to allow an amendment if the information: (1) was not created by this practice or the physicians here in this practice, (2) is not part of the Designated Record Set, (3) is not available for inspection because of an appropriate denial, (4) if the information is accurate and complete.

Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment to the medical record, we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know they have the incorrect information.

**Accounting of Certain Disclosures:**
HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to SA Pain Clinic Attn: Privacy Officer. Your first accounting of disclosures (within a 12-month period) will be free. For additional requests made within that period we are permitted to charge for the cost of providing the list. If there is a charge, we will notify you and you may choose to withdraw or modify your request before any costs are incurred.

**Appointment Reminders, Treatment Alternatives, and Other Health-related Benefits:**
We may contact you by telephone, mail, or both to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

**Complaints:**
If you are concerned that your privacy rights have been violated, you may contact the SA Pain Clinic Privacy Officer. You may also send a written complaint to the United States Department of Health and Human Services, HIPAA Complaint, 7500 Security Blvd., CS-24 -04, Baltimore, MD, 21244. We will not retaliate against you for filing a complaint with the government or us.

# SA Pain Clinic

**Phone: 210-298-4900 Fax: 210-298-6631**

**Larina V. Gutenberg, D.O.**
**Roberto J. Diaz, M.D.**
**Adam Fish, D.O.**
**Ma Luo, M.D.**


## NOTICE OF PRIVACY PRACTICE

### Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information and to abide by the terms of the notice of privacy practices in effect.

### Questions and Contact Persons for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact:

**SA Pain Clinic**
**Privacy Officer**
**5522 Lone Star Parkway, Building 2, Suite 101**
**San Antonio TX 78253**
**Phone: 210-298-4900**
**Fax: 210-298-6631**

This notice is effective on January 1, 2020.

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.

**SA PAIN CLINIC**
**5522 Lone Star Parkway Building 2, Suite 101**
**San Antonio TX 78253**
**Phone: 210-298-4900**
**Fax: 210-298-6631**

### Acknowledgment of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient, Parent or Guardian _____ Date _____

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## CONSENT TO AUTHORIZE RELEASE OF MEDICAL RECORDS

I, _____, Date of Birth: _____, who resides at
(patient name)

_____ hereby authorize
(Address, City, State and ZIP)

_____ to release my health information to:

| | | |
|---|---|---|
| _____ Dr. Gutenberg | Clinic: | **SA PAIN CLINIC** |
| _____ Dr. Diaz | Address: | 5522 Lone Star Pkwy, Bldg 2, Ste 101 |
| _____ Dr. Fish | City, State, Zip: | San Antonio, TX 78253 |

The purpose of this disclosure to SA PAIN is for continuation of medical care.

Information to be released in (Circle one) ELECTRONIC FORMAT or PAPER FORMAT, shall be the protected health information as designated below.

| | | | | | |
|---|---|---|---|---|---|
| ☐ | All clinical and progress notes | ☐ | Image Reports | ☐ | Admission/Discharge Summary |
| ☐ | Procedure/Operative Reports | ☐ | Consultations | ☐ | _____ |
| ☐ | Physical Therapy Reports | ☐ | Laboratory Reports | ☐ | _____ |

☐ I specifically authorize the release of information pertaining to drug and alcohol abuse, diagnosis or treatment. (42 CFR Part 2)

☐ I specifically authorize the release of information pertaining to mental health diagnosis or treatment. This authorization does not include psychotherapy notes.

The purpose of this release is at the request of the patient or patient representative, who understands the patient's rights as follows:

1. That this authorization is voluntary, and that treatment, payment enrollment or eligibility for benefits may not be conditioned on signing this authorization, except if it is for: (a) conducting research; (b) obtaining information in connection with eligibility or enrollment in a health plan; (c) determining an entity's obligation to pay a claim; or (d) creating health information to provide to a third party.
2. Under no circumstances am I required to authorize the release of mental health records.
3. I may revoke this authorization at any time in writing by submitting a letter to the attention of the Privacy Officer, 5522 Lone Star Pkwy, Bldg. 2, Ste. 101, San Antonio, TX 78253, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
4. I understand that I may make a written request to view my designated record set or I can submit a written HIPAA compliant authorization to obtain a copy of the records described on this form.
5. I am entitled to receive a copy of this authorization, after I sign it.
6. This records request is on-going and will expire one year from the date of the request.
7. Many other organizations and individuals such as physicians, hospitals, and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

| Signature of Patient, Parent or Guardian | Printed Name | Date |
|---|---|---|

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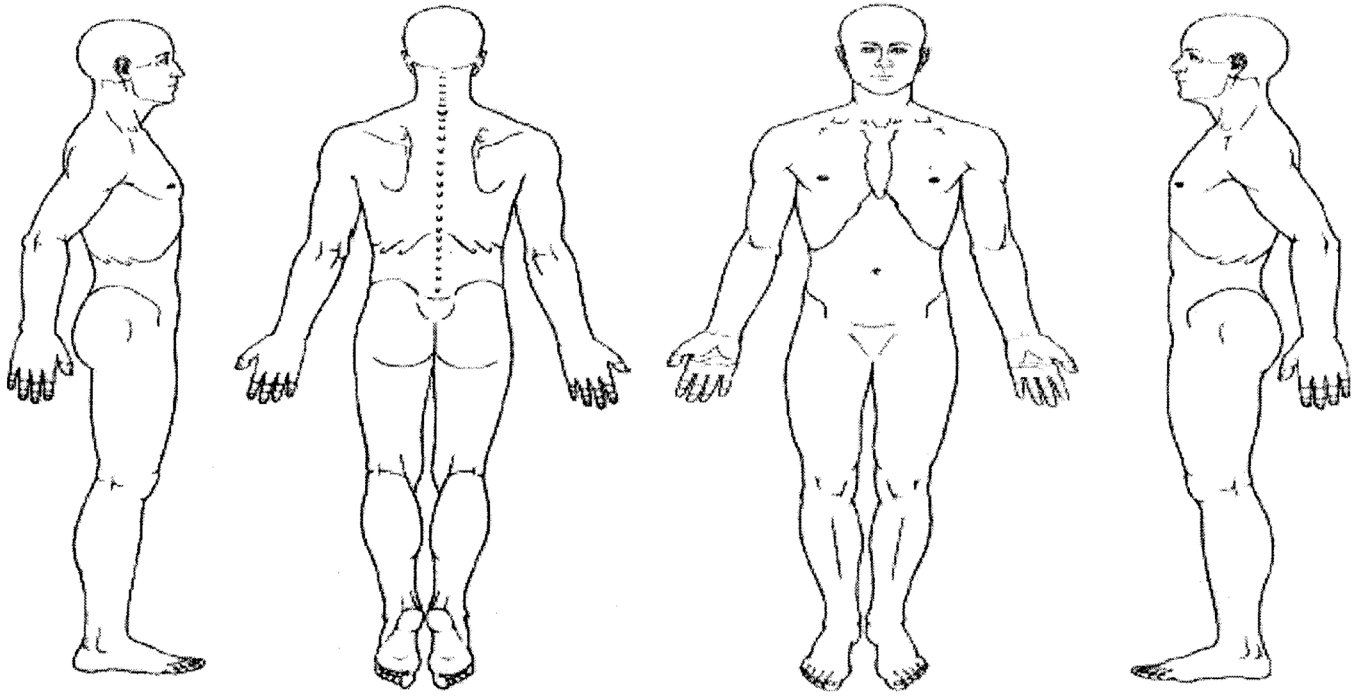
## CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

Patient Name: _____ DOB: _____

MARK ON THE PICTURE WHERE YOU ARE HAVING PAIN. ALSO MARK (**X**) FOR NUMBNESS, (**T**) FOR TINGLING, (**B**) FOR BURNING.



**Pain is mostly in your:** ☐ neck ☐ arm ☐ about the same **OR** ☐ back ☐ leg ☐ about the same

**How bad are your symptoms?**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Today: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Best: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Worst: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

**Duration of pain:**

☐ < 1 week ☐ 1-4 weeks ☐ 1-3-months
☐ 3-6 months ☐ 6-12 months

**How and when did the pain begin?** _____ (month/year)

☐ Work Accident ☐ Following surgery
☐ >1 year ☐ Home Accident
☐ Other accident or injury
☐ Auto Accident ☐ Unknown
☐ Other _____

**How has your pain intensity changed since it began?**

☐ Continuously ☐ Constantly (76%-100% of the day) ☐ Frequently (51-75% of the day)
☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)
☐ less than daily ☐ Weekly ☐ Monthly

**Select one or more items below to describe the nature of your pain:**

☐ Throbbing ☐ Shooting ☐ Sharp ☐ Cramping ☐ Hot/Burning
☐ Aching ☐ Stabbing ☐ Tingling ☐ Numbing ☐ Dull ache ☐ Electrical jolts

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## CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

Patient Name: _____ DOB: _____

**How do the following factors affect your pain?**

| | Better | Worse | No effect | | Better | Worse | No effect |
|---|---|---|---|---|---|---|---|
| Heat | ☐ | ☐ | ☐ | Climate | ☐ | ☐ | ☐ |
| Cold | ☐ | ☐ | ☐ | Fatigue | ☐ | ☐ | ☐ |
| Lying down | ☐ | ☐ | ☐ | Coughing | ☐ | ☐ | ☐ |
| Sitting | ☐ | ☐ | ☐ | Massage | ☐ | ☐ | ☐ |
| Walking | ☐ | ☐ | ☐ | Alcohol | ☐ | ☐ | ☐ |
| Sneezing | ☐ | ☐ | ☐ | Lifting | ☐ | ☐ | ☐ |
| Sleeping on back | ☐ | ☐ | ☐ | Sleeping on stomach | ☐ | ☐ | ☐ |
| Sex | ☐ | ☐ | ☐ | | | | |

**Which of the following activities are affected by your pain?**

☐ Mood ☐ Activities of daily living ☐ Social interactions ☐ Household chores ☐ Sexual Activity
☐ Work ☐ Falling asleep ☐ Staying asleep ☐ Leisure ☐ Ability to enjoy life

**Do you have any**: ☐ Urinary incontinence ☐ Stool incontinence ☐ Sexual dysfunction

**Check the treatments you have had for pain, please provide treatment dates:**

☐ Acupuncture: _____ ☐ Physical Therapy: _____
☐ Biofeedback: _____ ☐ Exercise: _____
☐ Psychotherapy: _____ ☐ TENS unit: _____
☐ Facet Blocks: _____ ☐ Epidurals: _____
☐ Nerve Blocks: _____ ☐ Trigger Points: _____
☐ Massage: _____ ☐ Hypnosis: _____
☐ Chiropractor: _____ ☐ Brace: _____
☐ Surgery: _____ ☐ Spinal Cord Stimulator: _____
☐ Intrathecal Pump: _____ ☐ Botox: _____
☐ Radiofrequency: _____ ☐ Light therapy: _____
☐ Traction devices: _____ ☐ Pain Management? If so, Dr. _____
☐ Prior Use of Opioids for pain? Yes >>No ☐ Outcome of opioid therapy? _____

### PAST MEDICAL HISTORY

**Musculoskeletal**

☐ Arthritis ☐ Fibromyalgia ☐ Muscle Spasms
☐ Numbness ☐ Weakness

**Neurological**

☐ Headache ☐ Seizures
☐ Stroke ☐ Migraines

### REVIEW OF SYSTEMS

**Constitutional**

☐ Chills ☐ Fever ☐ Fatigue
☐ Obesity ☐ Weight loss ☐ Weight gain
☐ Night Sweats ☐ Loss of appetite

☐ Confusion ☐ Dizziness ☐ Light Sensitivity
☐ Chewing ☐ Sense of Smell ☐ Swallowing
☐ Loss of balance ☐ Memory Loss ☐ Change in facial
☐ Change in voice/speech/appearance

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## CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

Patient Name: _____ DOB: _____

**PAST MEDICAL HISTORY** **REVIEW OF SYSTEMS**

**Psychiatric**

☐ Depression ☐ Substance abuse ☐ Suicidal thoughts ☐ Fatigue
☐ Anxiety ☐ Bipolar ☐ Schizophrenia ☐ Difficulty Sleeping ☐ Mood Swings

**Cardiovascular**

☐ Angina ☐ Heart Attack ☐ Heart Stent ☐ Chest Pain ☐ Palpitations
☐ Pacemaker ☐ Hypertension
☐ Valve issues that require pre-procedure antibiotic prophylaxis

**Respiratory**

☐ Asthma ☐ Emphysema ☐ Chronic Bronchitis ☐ Cough ☐ Shortness of Breath ☐ Bloody Cough
☐ Any hospitalizations for respiratory problems

**Gastrointestinal**

☐ Reflux ☐ Hepatitis ☐ Ulcers ☐ Diarrhea ☐ Constipation ☐ Abdominal Pain
☐ Incontinence ☐ Cirrhosis ☐ Colon Cancer ☐ Heartburn ☐ Bloating ☐ Painful BM
☐ Diverticulitis ☐ GI bleeding ☐ IBS ☐ Vomiting ☐ Bloody Stools ☐ Nausea
☐ Inflammatory bowel disease ☐ Portal hypertension ☐ Hepatic encephalopathy

**Genitourinary**

☐ Impotence ☐ Kidney Stones ☐ Incontinence ☐ Decreased Libido ☐ Urinary frequency
☐ Cancer ☐ Kidney Disease ☐ UTI ☐ Prostate Problems ☐ Urinary Hesitancy
☐ Bloody Urine ☐ Hemodialysis, days Hemodialysis is done _____

**Integumentary**

☐ Herpes Zoster/Shingles ☐ Skin Cancer ☐ Rash/Hives ☐ Itchy Skin ☐ Swelling

**Endocrine, Hematologic, Allergy/Immunologic**

☐ Diabetes ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Easy Bruising ☐ Ringing in Ears
☐ HIV ☐ Lymphoma ☐ Leukemia ☐ Visual Changes
☐ Multiple Myeloma ☐ Adrenal Issues ☐ Pituitary issues ☐ Low platelets
☐ Von Willebrand disease ☐ Cancer: _____
☐ Problems with blood clotting immunodeficiencies ☐ Any recent immunosuppressive therapies?

**PAST MEDICAL HISTORY** **REVIEW OF SYSTEMS**

**Rheumatologic**

☐ Lupus ☐ Sjogren's ☐ Scleroderma ☐ Painful joints ☐ Blurry Vision ☐ Polymyalgia Rheumatic
☐ Rheumatoid Arthritis ☐ Multiple Sclerosis ☐ Other: _____

**Sleep Behavior**

Have you ever been evaluated for sleep apnea with a sleep study? ☐Yes ☐ NO
Were you diagnosed with sleep apnea? ☐ Yes ☐ NO
If yes, are you currently using a CPAP machine or Bi-PAP machine? ☐ Yes ☐ NO

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## CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

Patient Name: _____ DOB: _____

**Implantable devices:** Please, let us know if you have any of the following:

☐ Pacemaker ☐ Defibrillator ☐ Deep Brain Stimulator ☐ Peripheral Nerve Stimulator
☐ Bladder Stimulator ☐ Insulin Pump ☐ Spinal Cord Stimulator
☐ Intrathecal Pumps: medication in the pump_____ date pump was refilled: _____

**Do you have ALLERGIES to any medications?** ☐ YES ☐ NO If yes, please list: _____

**SOCIAL HISTORY**

Do you smoke? ☐ YES ☐NO How many packs per day?_____ How many years? _____
Do you drink alcohol? ☐ YES ☐NO How much per day?_____ How many years?_____
Do you have a history of drug use, addiction, or abuse? ☐ YES ☐ NO If yes, explain: _____
Have you ever been treated for addiction or alcoholism? ☐ YES ☐ NO If yes, explain: _____
Have you ever had an issue with prescription medications (misuse, abuse, addiction, etc.)? ☐ YES ☐ NO
If yes, explain: _____

**Marital Status**

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced with Family

**Living situation**

☐ Alone ☐ Spouse ☐ Friend ☐ Long Term/Assisted Living Facility

**Employment Status**

☐ Currently Employed ☐ Full time ☐ Part time ☐ Never If currently working what type of work: _____
If in the past: ☐ Retired ☐ Disabled ☐ Unemployed

**Safety:** Do you feel safe in your home or place of residence? YES NO

**PAST SURGICAL HISTORY** (mark and/or list surgeries that you have had and provide approximate date):

☐ Appendectomy: _____ ☐ Tonsillectomy/Adenoids: _____ ☐ Gallbladder surgery:_____
☐ Coronary Bypass: _____ ☐ Hernia Repair: _____ ☐ Hemorrhoid: _____
☐ Tubal Ligation: _____ ☐ Mastectomy: _____ ☐ Breast Biopsy: _____
☐ Prostate: _____ ☐ Vasectomy: _____ ☐ Hysterectomy and ovaries: _____
☐ Knee Replacement: _____ ☐ Hip Replacement: _____ ☐ Knee Surgery: _____
☐ Shoulder Surgery: _____ ☐ Cataracts: _____ ☐ Colon: _____
☐ Back Surgery: _____ ☐ Neck Surgery: _____ ☐ Other: _____

**WOMEN:** ARE YOU PREGNANT? ☐YES ☐NO ☐NOT SURE PATIENT'S INITIALS: _____

**FAMILY HISTORY**

| | DIABETES | HEART | ANXIETY | KIDNEY | CANCER | DEPRESSION | BACK | OTHER CONDITIONS |
|---|---|---|---|---|---|---|---|---|
| MOTHER | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐_____ |
| FATHER | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐_____ |
| BROTHER(S) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐_____ |
| SISTER(S) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐_____ |

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## CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

Patient Name: _____ DOB: _____

**List All Medications You Are Currently Taking:**

| Medication | Dose | Medication | Dose |
|---|---|---|---|
| **1.** | | **9.** | |
| **2.** | | **10.** | |
| **3.** | | **11.** | |
| **4.** | | **12.** | |
| **5.** | | **13.** | |
| **6.** | | **14.** | |
| **7.** | | **15.** | |
| **8.** | | **16.** | |

If not stated before, primary care doctor name _____ and

address_____

**I ACKNOWLEDGE THAT I HAVE COMPLETED THIS QUESTIONNAIRE ACCURATELY AND TO THE BEST OF MY KNOWLEDGE.**

_____ _____

Signature of Patient, Parent or Guardian Date