ArchPoint Pain Institute of North Houston

FOR OFFICE USE ONLY

MRN:_____

Dear Patient,

Welcome to ArchPoint Pain Institute of North Houston! We are excited and dedicated to delivering excellent compassionate care in helping you manage your current symptoms.

You are scheduled for a new patient appointment located at 9638 Huffmeister Road, Suite A, Houston, Texas 77095.

Prior to your appointment, please email the following to our office at info@archpointpain.com:

- Attached New Patient forms completely filled out
- Current Insurance Card and Driver's License (or other government issued identification)
- Medical records including any X-Ray or MRI/CT scans you have had done

Please obtain a referral from your PCP & any prior authorizations required by your insurance carrier.

**** Note: Arrive 45 minutes prior to your scheduled appointment if the New Patient Paperwork is not completed prior to your appointment ****

On your scheduled appointment, please bring:

- All prescription medications in their original containers
- All medical records and imaging reports pertaining to your reason for visit

Should you have any questions or concerns about your appointment, please contact our office via email at info@archpointpain.com or call our office at 281-214-2121.

We look forward to seeing you.

Archpoint Pain Institute

How did you hear about ArchPoint Pain Institute?

☐ Facebook

☐ Google

☐ Yelp

☐ My Primary Care Doctor: _____

☐ My Specialist Doctor: _____

☐ My Chiropractor or Therapist:_____

☐ Other: _____

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Patient Registration

First Name: _____ **Date of Birth:** _____

Last Name: _____ **Social Security Number:** _____

Address: _____ **Gender Identity:** _____

City, State, Zip: _____ **Primary Phone:** _____

Email: _____ **Secondary Phone:** _____

Occupation/Employer: _____ **Employer Phone:** _____

Emergency Contact: _____ **Emergency Contact Phone:** _____

Primary Care Doctor: _____

Race (click): ○ Caucasian ○ African-American ○ Native American ○ Asian ○ Other: _____

Ethnicity (click): ○ Hispanic or Latino ○ Non-Hispanic or Latino

Marital Status (click): ○ Single ○ Married ○ Separated ○ Divorced ○ Widowed ○ Other: _____

Work status (click): ○ Employed ○ Unemployed ○ Disabled ○ Retired

Smoking Status (click): ○ Never Smoker ○ Former (quit date _____) ○ Current Smoker (packs/day _____)

Do you drink alcohol (click): ○ No ○ Yes (drinks per week _____)

Do you use illegal drugs (click): ○ No ○ Yes (please specify _____) (last use_____)

Primary Insurance:

Insurance Name: _____

Subscriber's Name: _____

Subscriber's DOB: _____

Policy ID #: _____

Group #: _____

Relationship to patient: _____

Secondary or Part D Insurance:

Insurance Name: _____

Subscriber's Name: _____

Subscriber's DOB: _____

Policy ID #: _____

Group #: _____

Relationship to patient: _____

Primary reason and/or illness for visit: _____

_____

Primary Pharmacy: Name: _____ **Phone:** _____

Primary Laboratory Used: Name: _____ **Phone:** _____

Allergies & Reaction: _____

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Current Medications:

Medication:	Dosage (mg)	How Often?	What Purpose?	Over the counter or supplement?

Vaccination and Immunization status: (please hover over "Y" for yes or "N" for no)

Pneumococcal: 1. Are you currently up to date on this vaccination? Y / N

-If yes, please record the date _____

2. **If not**, do you intend on getting this vaccination? Y / N

3. Are you currently 60 years of age or older? Y / N

Influenza: 1. Are you currently up to date on this vaccination? Y / N

-If yes, please record the date _____

COVID-19: 1. Are you fully vaccinated for the COVID-19 virus? Y / N

-If yes, please record the date _____

2. **If yes**, have you received the COVID-19 booster? Y / N

-Please record the date _____

3. **If no to #1**, do you intend on getting this vaccination? Y / N

In case of an emergency, you are unable to make a medical decision, who would you designate as your decision maker?: _____

Family History (illness or disease)**:**

Father: _____

Mother: _____

Other: _____

Past Surgical History (surgery name & date)**:**

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Past Medical History (click the box beside any past or continuing illness):

☐	AIDS/HIV	☐	Depression	☐	Hepatitis *Type =	☐	Rheumatoid arthritis
☐	Anemia	☐	Diabetes *Type =	☐	High Cholesterol	☐	Thyroid Disease
☐	Anxiety disorder	☐	Emphysema	☐	Hypertension	☐	Osteoporosis
☐	Asthma	☐	Fibromyalgia	☐	Hip replacement	☐	Seizures/Epilepsy
☐	Bleeding disorder	☐	Gastrointestinal bleed	☐	Knee replacement	☐	Sleep Apnea
☐	Cancer *(Active or Past)	☐	Gastrointestinal disease	☐	Kidney disease Stage =	☐	Stents
☐	COPD	☐	Glaucoma	☐	Liver disease	☐	Stroke
☐	Dementia	☐	Heart attack (MI)	☐	Nephropathy (deteriorated kidney function)	☐	Vascular Disease

Other: _____

Have you been treated for Addiction or Alcoholism? Y / N

Any Psychiatric or Psych treatments? Y / N

Have you had any recent falls? Y / N **If yes, please ask our front desk for the "Short Falls Form" to fill out.**

Do you have any impairments with your (click all that apply): ○ Ankle. ○ Hand. ○ Wrist. ○ Elbow. ○ Shoulder.

For female patients only;

Have you had a bone fracture in your lifetime? Y / N -If yes, please record the date _____

If yes, have you been screened for osteoporosis? Y / N -If yes, please record the date _____

Review of Systems (Please click any that apply CURRENTLY):

Constitutional	☐	Fever	☐	Night Sweats	☐	Significant Weight Gain	☐	Significant Weight Loss
EENT	☐	Snoring	☐	Dry Mouth	☐	Frequent Nosebleeds		
Cardiovascular	☐	Chest Pain	☐	Ankle swelling				
Respiratory	☐	Cough	☐	Wheeze	☐	Shortness of Breath		
Gastrointestinal	☐	Nausea	☐	Vomiting	☐	Constipation	☐	Bloody Stools
	☐	Diarrhea	☐	Bloody Vomit	☐	Heartburn	☐	Black Tarry stools
Genitourinary	☐	Urinary Incontinence					☐	Difficulty Urinating
Musculoskeletal	☐	Joint Pain	☐	Back Pain	☐	Neck Pain	☐	Difficulty Walking
	☐	Cramps	☐	Muscle Aches	☐	Joint Swelling		
Neurological	☐	Headache	☐	Seizures	☐	Weakness	☐	Numbness
Psychiatric	☐	Foggy Thinking	☐	Depressed Mood	☐	Suicidal Thoughts	☐	Frequent Anxiety
					☐	Sleep Disturbances		
Endocrine	☐	Fatigue	☐	Frequent Urination			☐	Excessive Thirst
Hematologic / lymphatic	☐	Excessive Bleeding					☐	Excessive Bruising
Allergic / immunologic	☐	Recent Allergic Reaction						

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History Of Present Illness

Where is your pain (such as neck, low back, knee, etc)? _____

Do you remember a specific accident or injury that started your pain? Y / N

How long ago did your pain first begin? _____Is your pain constant or intermittent? _____

What makes the pain worse? _____

What makes the pain better? _____

What words best describe your pain (click all that apply):

Ache ☐ Stiff ☐ Sharp ☐ Dull ☐ Shooting ☐ Stabbing ☐ Cramping ☐

Tingling ☐ Burning ☐ Numb ☐ Feels "asleep" ☐ Electric ☐ Lancinating ☐ Tender ☐

What does your pain interfere with (click all that apply):

Sleeping ☐ Dressing ☐ Using Bathroom ☐ Cooking ☐ Cleaning ☐ Shopping ☐ Hobbies ☐ Working ☐

*Only complete this section if you have **NECK** pain:*

Which arm does the pain go down? _____

If yes, how would you describe this pain (click all that apply):

Tingling ☐ Burning ☐ Numb ☐ Feels "asleep" ☐

Electric ☐ Lancinating ☐ Shooting ☐ Weakness ☐

Have you ever had an X-ray, MRI, or CT scan of your **neck**? _____If so, when & where_____

Have you ever had neck surgery? _____

Last time you had Physical therapy for neck pain?_____

*Only complete this section if you have **BACK** pain:*

Which leg does the pain go down? _____

If yes, how would you describe this pain (click all that apply):

Tingling ☐ Burning ☐ Numb ☐ Feels "asleep" ☐

Electric ☐ Lancinating ☐ Shooting ☐ Weakness ☐

Have you ever had an X-ray, MRI, or CT scan of your **back**? _____ If so, when & where _____

Have you ever had back surgery? _____

Last time you had Physical therapy for back pain?_____

*Only complete this section if you have **KNEE** pain* (click all that apply):

Shaking ☐ Stiffness ☐ Temperature changes (one warm side/one cold) ☐ Color changes (red/blue/white) ☐ Swelling ☐

Hair (thicker or darker) ☐ Skin (dry, discolored) ☐ Things that didn't hurt before, now hurt (ie: touch, mvmt, pressure) ☐

Have you had knee surgery? _____ Have you had Physical Therapy for your knee pain? _____

What medication(s) do you currently take for pain & how often? _____

What does this medication(s) allow you to do that you would not be able to do otherwise? _____

Do you have any side effects with your current pain medications (such as constipation or nausea)? _____

Do you take any blood thinners, if so which ones? _____

Have you ever seen a Pain Management Doctor (name)? _____

Last time you had a pain injection or procedure (when & where)? _____

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Have you taken any of these medications recently for your pain (click all that apply):					
☐	Acetaminophen (Tylenol)	☐	Ibuprofen (Advil, Midol, Motrin, Duexis)	☐	Naproxen (Aleve, Vimovo)
☐	Meloxicam (mobic)	☐	Diclofenac (Voltaren, Flector, Pennsaid)	☐	Celecoxib (Celebrex)
☐	Amitriptyline (elavil)	☐	Gabapentin (Neurontin)	☐	Pregabalin (Lyrica)
☐	Duloxetine (Cymbalta)	☐	Carisoprodol (Soma)	☐	Cyclobenzaprine (Flexeril)
☐	Methocarbamol (Robaxin)	☐	Tizanidine (Zanaflex)	☐	Baclofen
☐	Lidoderm				

Conservative Care:	**Have you used this therapy?**	**Did it help?**	**Any side effects? (please specify):**
Ice/ cooling pack	Y / N	Y / N	
Heat/ heating pad	Y / N	Y / N	
TENS unit	Y / N	Y / N	
Behavioral therapy	Y / N	Y / N	
Exercise regimen	Y / N	Y / N	
Yoga, tai chi	Y / N	Y / N	
Weight loss	Y / N	Y / N	
Acupuncture	Y / N	Y / N	
Massage	Y / N	Y / N	
Chiropractic	Y / N	Y / N	

Physical Therapy:

Have you had physical therapy for your chronic pain? Y / N

If yes, what body areas were treated? _____

Were you able to participate fully? _____

When was your most recent session? _____

How many sessions and/or how many weeks did you complete? _____

Did it improve your pain and/or functionality? _____

Did it worsen your pain and/or functionality? _____

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Pain Questionnaire: (All questions are mandatory to be filled)*

Age between 16 and 45 years old?..... Y/N
History of alcohol abuse?..... Y/N
History of illegal drug abuse?..... Y/N
History of prescription drug abuse?..... Y/N
History of depression?..... Y/N
History of ADHD, OCD, bipolar, or schizophrenia?..... Y/N
History of pre-adolescent sexual abuse?..... Y/N
Family history of alcohol abuse?..... Y/N
Family history of illegal drug abuse?..... Y/N
Family history of prescription drug abuse?..... Y/N

Total 0

Pain Questionnaire: (All questions are mandatory to be filled)*

Pain Scale: 0 = No pain / interference & 10 = Severe Pain/Completely Interferes

What number best describes your pain on average in the past week?
Select one

What number best describes how, during the past week, pain has interfered with your enjoyment of life?
Select one

What number best describes how, during the past week, pain has interfered with your general activity?
Select one

Count: 0 **/ 3 = Total:** 0

How often do you have mood swings?
Select one

How often do you smoke a cigarette within an hour after you wake up?
Select one

How often have you taken medication other than the way that it was prescribed?
Select one

How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?
Select one

How often, in your lifetime, have you had legal problems or been arrested?
Select one

Total 0

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INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT AS REQUIRED BY THE TEXAS MEDICAL BOARD REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9, CHAPTER 170 4th Edition: Developed by the Texas Pain Society, August 2017

NAME OF PATIENT: _____ DATE: _____

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug(s) after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to use the drug(s) recommended to you by me, as your physician. For the purpose of this agreement the use of the word "physician" is defined to include not only my physician but also my physician's authorized associates, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat my condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request ArchPoint Pain Institute of North Houston to treat my condition which has been explained to me as chronic pain, which is a state of pain that persists beyond the usual course of an acute disease or healing of an injury. I hereby authorize and give my voluntary consent for my physician to administer or write prescription(s) for dangerous and/or controlled drugs (medications) as an element in the treatment of my chronic pain. It has been explained to me that these medication(s) include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I have discussed the risks and benefits of the use of controlled substances for the treatment of chronic pain, including an explanation of the following: (a) diagnosis; (b) treatment plan; (c) anticipated therapeutic results, including realistic expectations for sustained pain relief and improved functioning and possibilities for lack of pain relief; (d) therapies in addition to or instead of drug therapy, including physical therapy or psychological techniques; (e) potential side effects and how to manage them; (f) adverse effects, including the potential for dependence, addiction, tolerance, and withdrawal; and (g) potential complications and impairment of judgment and motor skills. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT HAVE BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT (THIS IS SOMETIMES REFERRED TO AS "OFF-LABEL" PRESCRIBING). MY DOCTOR WILL EXPLAIN HIS OR HER TREATMENT PLAN(S) FOR ME AND DOCUMENT IT IN MY MEDICAL CHART.

I HAVE BEEN INFORMED AND understand that I will undergo medical tests and examinations before and during my treatment. Those tests include random unannounced checks (urine, blood, saliva, or any other testing indicated and deemed necessary by my physician at any time) for drugs and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances or absence of authorized substances may result in my being discharged from your care.

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension (low blood pressure), arrhythmias (irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I will 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 times 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.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medication(s) for the treatment of my chronic pain.

The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and functional life. I realize that I may have a chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual

withdrawal from the use of all medication(s). My treatment plan will be tailored specifically for me. I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time and that I will notify my physician of any discontinued use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

I understand that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of medications to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment; risks of nontreatment and the drug therapy; medical treatment or diagnostic procedure(s) to be used to treat my condition; and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

I UNDERSTAND AND AGREE TO THE FOLLOWING: That this pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called "narcotics, painkillers," and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand that there are federal and state laws, regulations, and policies regarding the use and prescribing of controlled substance(s). Therefore, medication(s) will only be provided so long as I follow the rules specified in this Agreement.

The term "pain management physician" below means your primary pain management physician or another physician covering for the primary pain management physician.

My pain management physician may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior:

Patient Shall Indicate All Provisions by Initialing:

_____ I am aware that all controlled substance prescriptions are now being monitored by the Texas State Board of Pharmacy and that information will be accessed by my pain management physician each time a prescription is written

_____ I agree to submit to laboratory tests for drug levels upon request, including urine and/ or blood screens, to detect the use of nonprescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), such as marijuana, speed, cocaine, etc., treatment for chronic pain may be terminated. Also, a consultation with, or referral to, an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an addictionologist or a physician who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.

_____ Refill(s) will not be ordered before the scheduled refill date. However, early refill(s) are allowed when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out. My pain management physician may limit the number and frequency of prescription refills.

_____ I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money. If either are lost or stolen, they may NOT BE REPLACED

_____ My pain management physician will manage all of my acute and chronic pain symptoms. Only my pain management physician may prescribe dangerous and scheduled drugs for the treatment of chronic pain. I will receive controlled substance medication(s) only from ONE pain management physician, unless it is for an emergency or the medication(s) that is being prescribed by another physician is approved by my pain management physician. Information that I have been receiving medication(s) prescribed by other physicians that has not been approved by my pain management physician may lead to a discontinuation of medication(s) and treatment. All other health related issues must be managed by my primary care physician.

_____ I agree that I shall inform any physician who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.

_____ I hereby give my pain management physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s). I give my pain management physician permission to obtain any and all medical records necessary to diagnose and treat my painful conditions.

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_____ I will use the medication(s) exactly as directed by my pain management physician. Any unauthorized increase in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.

_____ If anyone other than my pain management physician prescribes me medication(s) to treat acute or chronic pain, then I will disclose this information to my pain management physician at or before my next date of service, which must include at a minimum the name and contact information for the person who issued the prescription, the date of the prescription, the name and quantity of the drug prescribed, and the pharmacy that dispensed the medication.

_____ All medication(s) must be obtained at one pharmacy designated by me, with exception for those circumstances for which I have no control or responsibility, that prevent me from obtaining prescribed medications at my designated pharmacy. Should the need arise to change pharmacies, my pain management physician must be informed at or before my next date of service regarding the circumstances and the identity of the pharmacy. I will use only one pharmacy, and I will provide my pharmacist a copy of this agreement. I authorize my pain management physician to release my medical records to my pharmacist as needed.

_____ My progress will be periodically reviewed and, if the medication(s) are not improving my function and quality of life, the medication(s) may be discontinued.

_____ I must keep all follow-up appointments as recommended by my physician or my treatment may be discontinued.

_____ I understand I will be responsible for all late charges or penalties resulting from a 15 minute late arrival after my original set appointment time and from no-showing my scheduled appointments.

_____ I understand I will be responsible for all late charges or penalties resulting from a procedure cancellation without notifying the office 24 hours prior to procedure appointment.

_____ I agree not to share, sell, or otherwise permit others, including my family and friends, to have access to these medications.

_____ I will not allow or assist in the misuse/diversion of my medication; nor will I give or sell it to anyone else.

_____ If it appears to my pain management physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then my pain management physician may try alternative medication(s) or may taper me off all medication(s). I will not hold my pain management physician liable for problems caused by discontinuance of medication(s).

_____ I recognize that my chronic pain represents a complex problem that may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize that my active participation in the management of my pain is extremely important. I agree to actively participate in all aspects of the pain management program recommended by my pain management physician to achieve increased function and improved quality of life.

_____ I understand many prescription medications for chronic pain produce serious side effects including drowsiness, dizziness, and confusion. Alcohol will enhance all of these side effects and should be discontinued before starting these medications.

I certify and agree to the following (Patient Shall Indicate All Provisions by Initialing):

_____ 1) I am not currently using illegal drugs or abusing prescription medication(s), and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

_____ 2) I have never been involved in the sale, illegal possession, misuse/diversion, or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.).

_____ 3) No guarantee or assurance has been made as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life.

_____ 4) I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain. I fully understand the explanations regarding the benefits and the risks of these medication(s), and I agree to the use of these medication(s) in the treatment of my chronic pain.

_____ 5) If I become a patient in this clinic and receive controlled substances to control my pain, this pain management agreement supersedes any other agreement that I may have signed in the past.

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For female patients only All of the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s), i.e. opioids/narcotics, to ensure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo/fetus/baby.

_____ To the best of my knowledge I am NOT pregnant.

_____ If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment. I accept that it is MY responsibility to inform my physician immediately if I become pregnant.

_____ If I am pregnant or am uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY.

Consents:

Initial _____ Patient Portal Consent

The Patient Portal offers access to part of your medical record, the ability to manage appointments, and secure communication. The Portal should not be used for urgent communication. The system is secured and encrypted, but all forms of communication have risk of compromise. In order to minimize that risk, please provide accurate information, and do not allow unauthorized users from accessing your account. I acknowledge and agree to the Patient Portal Consent.

Initial _____ Phone & Text Consent

ArchPoint Pain Institute of North Houston would like to contact you via Phone calls or text messaging using your personal phone regarding appointment reminders. Some limited personal information may be included. I agree to receive phone calls and/or text messages from ArchPoint Pain Institute of North Houston, data charges may apply.

Initial _____ Privacy Policy & Social Media Policy

ArchPoint Pain Institute of North Houston has a duty to protect your personal health information (PHI). I authorize ArchPoint Pain Institute of North Houston to obtain or disclose PHI for the purposes of treatment, healthcare operations, and payment. This may include communication with other healthcare professionals, insurance companies, health information exchanges, or other entities involved with providing your healthcare. Your PHI will not otherwise be disclosed unless at your request, or as required by law. I have received and reviewed the HIPAA Privacy Policy.

Photos/Images, videos, and/or testimonials may be used for educational, informational, advertising purposes on social media sites. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) privacy regulation. I understand I may revoke this authorization at any time in writing.

Informed Consent and Pain Management Agreement

By typing my full name on the signature line, I understand this will be accepted as the Electronic Signature Acknowledgment and Consent Form, that all electronic signatures are the legal equivalent of my manual/handwritten signature and I consent to be legally bound to this agreement.

I acknowledge and agree to the Informed Consent and Pain Management Agreement.

*Patient Signature (Mandatory): _____ Date: _____

Financial Responsibility & Assignment of Benefits

Payment is due at the time of service. The patient is responsible for all copays, co-insurance, deductibles, or non-covered charges. We verify your insurance benefits as a courtesy and necessary forms will be filed with insurance carriers. We cannot guarantee coverage or payment. All charges are your responsibility whether your insurance company pays or not. Returned checks are subject to a $35.00 collection charge. Unpaid balance over 180 days may be subject to collections via a collection agency. We understand temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your outstanding balance.

I hereby assign all medical and surgical benefits, and authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health plan, to issue payment directly to ArchPoint Pain Institute of North Houston for services rendered to myself and/or my dependents regardless of my insurance benefits. I understand that I am responsible for any amount not covered by insurance. I am responsible for notifying ArchPoint Pain Institute if my insurance coverage changes.

*Patient Signature (Mandatory): _____ Date: _____

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Health Insurance Portability & Accountability Act (HIPAA) Privacy Policy

What is HIPAA?

- HIPAA was signed into law in 1996 and is intended to help protect your rights and privacy to your medical information.

What Information Is Protected?

- Information your doctors, nurses, and other health care providers put in your medical record
- Conversations your doctor has about your care or treatment with nurses and others
- Information about you in your health insurer's computer system
- Billing information about you at your clinic
- Most other health information about you held by those who must follow these laws

Patient Privacy is Important to Us

- We value our relationship with our patients and we have a duty to protect your personal health information (PHI). All employees are given training on HIPAA and on our policies to ensure that your PHI remains protected.
- Your PHI is only accessed in order to provide treatment services, healthcare coordination, or payment, or as otherwise required by law.
- Patient information is not publicly accessible.
- Strong passwords are used to access the electronic medical record. The electronic medical record is HIPAA compliant.
- Physical records are behind lock and key when unattended.

What Rights Do I Have Over My Health Information?

Health insurers and providers who are covered entities must comply with your right to:

- Ask to see and get a copy of your health records. Written request required.
- Have corrections added to your health information
- Receive a notice that tells you how your health information may be used and shared
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as for marketing
- Get a report on when and why your health information was shared for certain purposes
- If you believe your rights are being denied or your health information isn't being protected, you can
  - File a complaint with your provider or health insurer
  - File a complaint with HHS:

US Department of Health & Human Services: Office of Civil Rights 200 Independence Ave S.W. Washington DC 20201

Authorization to Release Personal Health Information/ HIPAA Authorization (**Optional**)

I authorize ArchPoint Pain Institute of North Houston to release personal health information to the person(s) listed below. I understand that this may include medical and billing information. This may be revoked at any time with a written request.

Full name	Date of Birth	Relationship

I certify that the information completed in this form is accurate to the best of my knowledge. I will not hold my doctor or any member of staff responsible for any errors or omissions that I may have made in the completion of this form.

By typing my full name on the signature line, I understand this will be accepted as the Electronic Signature Acknowledgment and Consent Form, that all electronic signatures are the legal equivalent of my manual/handwritten signature and I consent to be legally bound to this agreement.

*Patient Signature (Mandatory): _____ Date: _____

Physician Signature: _____ Date: _____