PAIN & SPINE CARE
MASROOR AHMED, M.D.
NEW PATIENT INFORMATION

WELCOME TO OUR OFFICE

Referred By: _____ Phone: _____
Patient Name: _____ SSN: _____
Address: _____
City: _____ State: _____ Zip: _____
Gender: F / M DOB: _____/_____/_____ Age: _____ Marital Status: M S W D S
Home Phone: _____ Alternate Phone: _____
Employer: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip: _____
E-Mail: _____

NEAREST RELATIVE NOT LIVING WITH YOU:
Name: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip: _____

IN CASE OF EMERGENCY:
Name: _____ Phone: _____
Alternate Phone: _____

INSURANCE INFORMATION:
PRIMARY INSURANCE TYPE: □W/C □PPO □HMO □MEDICARE □OTHER_____
INSURANCE_____ POLICY #_____
GROUP #_____ GUARANTOR_____
DATE OF INJURY_____CLAIM#_____
SECONDARY INSURANCE TYPE: □PPO □HMO □MEDICARE □MEDICAID
INSURANCE_____ POLICY #_____
GROUP #_____ GUARANTOR_____
DATE OF INJURY _____ CLAIM#_____

NOTE: PLEASE PROVIDE US WITH CURRENT I.D. AND INSURANCE CARD AT THE TIME OF VISIT. PLEASE READ THE PARAGRAPH BELOW CAREFULLY, THEN SIGN AND DATE YOUR CONSENT:

Dr. Masroor Ahmed D.B.A. Pain & Spine Care is here assigned all legal rights with respect to the enforcement to medical benefit provision under your insurance. Dr. Masroor Ahmed D.B.A. Pain & Spine Care has the right to any cause that exists in my favor against any insurance company for benefits to the extent of medical charges for total service rendered to me. This is a limited assignment of rights solely for the purpose of collecting fees and outstanding medical services are hereby to be sent to Pain & Spine Care.

_____

(Patient Signature) (Date)

AUTHORIZATION OF PAYMENT

I hereby authorize Masroor Ahmed, M.D., P.A., Pain & Spine Care to release my medical information acquired in the course of my examination or treatment.

I also hereby authorize payment of insurance benefits under the terms of my policy payable directly to Masroor Ahmed, M.D., P.A., Pain & Spine Care for charges. I am financially responsible for charges not covered by my insurance plan.

Signature of patient _____
Date _____

AUTHORIZATION OF PAYMENT

I hereby authorize Westside Anesthesia to release my medical information acquired in the course of my examination or treatment.
I also hereby authorize payment of insurance benefits under the terms of my policy payable directly to Westside Anesthesia for charges. I am financially responsible for charges not covered by my insurance plan.

Signature of patient _____
Date _____

PAIN AND SPINE CARE
MASROOR AHMED, M.D.

AUTHORIZATION FOR MEDICAL/ HOSPITAL RECORDS & REPORTS

Patient Name: _____
Last First MI

Patient Social Security Number: _____/_____/_____

Date of Birth: _____/_____/_____

TO WHOM IT MAY CONCERN:

I, (patient) _____ authorize you to release any and all of my Medical/Hospital Records and Reports of the past and present to my current Doctor. This may include my History & Physical, X-Rays, MRI's, CT Scans, EKG's and Lab Results. This authorization extends to any other party (Insurance Companies, prior or present employers, etc.) who may have my Medical information. A photocopy is accepted with the same authority as the original.

_____

Patient Signature Date

PAIN AND SPINE CARE
MASROOR AHMED, M.D.

PATIENT RESPONISBILITY AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications (I.E. Narcotics, Tranquilizers and barbiturates) are useful but have a high potential for misuse and are, therefore, closely controlled by local, state and federal government. They are intended to relieve pain, thus improving function and/or ability to work. Because my Physician is prescribing Controlled Substance Medications to help manage my pain, I agree to the following conditions:

1. I am responsible for the Controlled Substance Medications prescribed to me. If my prescription is **LOST, MISPLACED, STOLEN OR I "RUN OUT EARLY,"** I understand that it **WILL NOT** be replaced. **IF STOLEN, A POLICE REPORT WILL NEED TO BE FILED WITH YOUR LOCAL POLICE.**
2. Refills of Controlled Substance Medications **WILL BE MADE ONLY DURING REGULAR OFFICE HOURS,** during a scheduled visit. Refills **WILL NOT** be made at night, over the weekend, or during Holidays. **NO REFILLS WILL BE MADE OVER THE PHONE FOR ANY TYPE OF PAIN MEDICATION.** I am responsible for taking the medication in the dose prescribed and for keeping track of how many are remaining. I will call in at least 24 hours ahead if I realize I'm about to run out over the weekend or Holiday. If the Doctor agrees to write a prescription **I MUST** come pick it up **IN PERSON** at the office.
3. It may be deemed necessary by my Doctor that I see a Medication-Use Specialist at any time while I am receiving Controlled Substance Medications. I understand that if I **DO NOT** attend such an appointment, my medication may be discontinued or may not be refilled beyond a tapering dose to completion. I understand that if the Specialist feels that I am at risk for Psychological Dependence (addiction), my medications will no longer be refilled.
4. I agree to comply with random urine, blood, or breath testing, documenting the proper use of my medications as well as confirming compliance. I understand that driving a motor vehicle may not be allowed while taking Controlled Substance Medications and that it is my responsibility to comply with the Laws of the State while taking the prescribed medications.
5. Quality and effective pain treatment relies heavily on off label use of numerous drugs. Any physician may prescribe any marketed drug for an indication or in a dosage that he/she deems appropriate even though it may not be listed in publish indication.
6. I understand that the main treatment goal is to reduce pain and improve any ability to function and/or work. I agree to help myself by following better health habits, exercise, weight control and avoidance of the use of tobacco and alcohol. I understand that the long-term advantages and disadvantages of Chronic Opiod use have yet to be scientifically determined and my treatment may be changed at any time and my Physician will advise me of any advances in the field, or make treatment changes as needed.
7. I understand that **IF I VIOLATE ANY OF THE ABOVE CONDITIONS,** my prescription for Controlled Substance Medication may be terminated immediately. If the violation involves obtaining Controlled Substance Medication may be terminated immediately. If the violation involves obtaining Controlled Substance Medication from another individual, or the use of illicit (illegal) drugs, I may also be reported to ALL my Physicians, Medical Facilities and appropriate authorities.

_____ _____
Patient Signature Date

_____ _____
Office Employee Date

PAIN & SPINE CARE
MASROOR AHMED, M.D.

CONTROLLED SUBSTANCE AGREEMENT

I have been fully informed by Dr. Masroor Ahmed and his staff regardingPsychological Dependence (addiction) of Controlled Substance Medications, which I understand is rare.

I know that some individuals may develop a tolerance to the medications, necessitating a dose increase to achieve the desired effect, and that there is a risk of becoming physically dependent on the medication. I must do so slowly and under the Medical Supervision or I may have withdrawal symptoms.

I have read this contract and the same has been explained to me by Dr. Masroor Ahmed. In addition, I fully understand the consequences of violating this agreement.

_____ _____

Patient Signature **Date**

_____ _____

Employee Signature **Date**

PAIN & SPINE CARE
MASROOR AHMED, M.D.

PATIENT PHOTO IDENTIFICATION

I hereby give permission to the staff of Pain & Spine Care Center to take my Photo ID and to maintain it in my Patient History. I understand that this Photo ID will not be used for any other purpose than as part of my Medical Records.

_____ _____
Patient Signature **Date**

_____ _____
Employee Signature **Date**

Notice of Privacy Practices
PAIN AND SPINE CARE

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, to obtain payment for treatment, for administration purposes, and to evaluate the quality of care that you receive.
This notice describes our privacy practices. 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. You can request a paper copy of this notice, or any revised notice. For more information about this notice or our privacy practices and polices, please contact the person listed at the end of this document.

A. 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 physician in this practice is a specialist. When we provide treatment we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat your medical conditions, if any.

Payment
We are permitted to use and disclose you medical information to bill and collect payment for the services we provide to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. That form will contain medical information, such as description of the medical services provided to you, that your insurer of HMO needs to approve payment to us.

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 programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law," Or "we may ask another physician to review this practice's charts and medical records to evaluate our performance so that we may ensure that this practice provides only the best health care."

B. Disclosures That Can Be Made Without Your Authorization
There are situations in which we are permitted to disclose or use your medical information without your written authorizations or an opportunity to object. In other situations, we will ask for your written authorizations before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or that rely on that 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 (like 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 a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.
Because Texas Law requires physicians to report child abuse or neglect. We may disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law also requires a person having cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation to report the information to the state, and HIPAA privacy regulations 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 applications and inspections, which are all government activities undertaken to monitor the health care 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 decision-maker) or other 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 limited circumstances provided:

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

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

Workers' Compensation

We may disclose your medical information as required by workers compensation law.

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 is permitted to allow the institution to provide you with medical care, to protect your health or the health and 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, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the president of the United States, other authorized government officials, or foreign heads of state.

Research, 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 examiner to identify a deceased person or a cause of death. Further, we may release your medical information to a funeral director when such a 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.

C. Your Rights Under Federal Law

The U.S. 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 may exercise. We will not retaliate against patients who exercise their HIPAA rights.

Requested Restrictions

You may request or limit how your protected health information is used or disclosed for treatment,

payment, or health care operations**. We do NOT have to agree** to this restriction, but we do agree, we will comply with your request except under emergency circumstances.
You also may request that we limit disclosure to family members, other relatives, or close personal friends who 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, disclosure of information, or both), and (c) to whom the limits apply. Please send the request to the address and person listed at the end of this document.

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 made in writing to the person listed below. 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 directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information

You may inspect and/or copy health information that is within the designated record set, which is 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 requests to the person listed as the end of this document.
We may ask that a narrative of that information be provided rather than copies. However, if you do not agree to our request, we will provide copies at a reasonable charge as law permit.
We can refuse to provide some of the information you ask to inspect or ask to be copied for the following reasons:
▪ The information is psychotherapy notes.
▪ The information reveals the identity of a person who provided information under a promise of confidentiality.
▪ The information is subject to the Clinical Laboratory Improvements Amendments of 1988.
▪ The information has been compiled in anticipation of litigation.
We can refuse to provide access to our copies of some information for other reasons, provided that we arrange for a review of our decision on your request. Any such review will be made by another licensed health care provider who was not involved in the prior decision to deny access.
Texas law requires us to be ready to provide copies or a narrative within 15days of your request. We will inform you when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.
HIPAA permits us to charge a reasonable cost-based fee.

Amendment of Medical Information

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed at the end of this document. We will respond within 60 days of your request. We may refuse to allow an amendment for the following reasons:
▪ The information wasn't created by this practice or the physicians in this practice.
▪ The information is not part of the designated record set.
▪ The information is not available for inspection because of an appropriate denial.
▪ 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, 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 now have the incorrect information.

D. Appointment Reminders, Treatment Alternatives, and Other 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.

E. Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below.

You may also send a written complaint with to the U.S. Department of Health and Human Services. We will not retaliate against you or filing a complaint with us or the government.

F. 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.

G. Questions and Contact Person for Requests

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

ACKNOWLEDGEMENT OF REVIEW OF
NOTICE OF PRIVACY PRACTICES

I HAVE REVIEWED THE 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 OR PERSONAL REPRESENTATIVE

_____
DATE

_____
NAME OF PATIENT OR PERSONAL REPRESENTATIVE

_____
DESCRIPTION OF PERSONAL REPRESENTATIVE AUTHORITY

PAIN AND SPINE CARE
MASROOR AHMED, M.D.
HISTORY AND PHYSICAL

CHIEFCOMPLAINT:_____
_____
_____
_____

Date: _____ DOB: _____ Age: _____ Occupation_____
Have you had any of the following Conditions? Ht: ____ Wt: _____ B/P: _____ P: _____R:_____

	Yes	No
Epilepsy	____	____
Bronchitis, Lung Disease	____	____
Thyroid Disease	____	____
Jaundice or Liver Disease	____	____
Psychiatric Disorder	____	____
Tuberculosis	____	____
Heart Disease	____	____
Kidney Disease	____	____
Discharge from Urethra, Penis	____	____
Bowel problems	____	____
Hearing problems	____	____
Visual problems	____	____
Stroke	____	____
Diabetes	____	____
Ulcers, Stomach problems	____	____
Skin Rash	____	____
Cancer	____	____
Joint Disease, Arthritis	____	____
Hepatitis	____	____
HIV +	____	____
Blood Transfusion	____	____
Speech problems	____	____

Other _____

____ Ambulatory Cane___Crutch
____ Wheelchair ____ Prosthesis
____ History of Falls ____ Walker

Have you had Nerve Blocks
(injections for pain relief)
____ Yes ____ No
Name of Doctor who performed
Blocks:_____
Did they relieve your pain?
____ Yes ____ No
How long did you get relief?
1. Less than one day
2. A few days
3. A few weeks
4. More than a month

Surgical History_____
_____
_____

Drug Allergies and Reactions: _____
_____

Current Medications and Name of Prescribing Physician: _____
_____
_____
_____

PAIN & SPINE CARE
MASROOR AHMED, M.D.

RATE YOUR PAIN

Pain Rating VAS Numerical Score 0-100
Your pain at the PRESENT time _____
Your pain at its WORST _____
Your pain at its LEAST _____

Do you have:	**Yes**	**No**
Numbness	____	____
Tingling, Pins & Needles	____	____
Weakness	____	____
Coldness	____	____
Increased Sweating	____	____
Muscle Spasms, Tightness	____	____
Skin Discoloration	____	____

What makes your pain worse?
_____

What makes your pain better?
_____

Have you had Physical Therapy before? _____

Do you drink Alcohol? ____Yes ____No
If yes, how much?_____
If yes, do you drink it to relieve pain? ____Yes ____No
Have you ever used Street Drugs? ____Yes ____No
Do you smoke? ____Yes ____No
If yes, how much?
_____
If yes, how many years?
_____
Are you sleeping well? ____Yes ____No

Describe your Pain: _____
_____
_____

Does your Pain travel throughout your body? If yes, explain._____
_____
_____

PAIN & SPINE CARE
MASROOR AHMED, M.D.

Patient Name:_____ Date:_____

On the drawing below, please shade in the areas where you feel pain: