Patient Demographics

BPIA
BACK PAIN INTERVENTIONS ASSOCIATED, P.A.

Mark Brown, M.D.
1111 Hwy 6, Ste. 240
Sugar Land, TX 77498
P: (281) 494-6900
F: (832) 532-7782

Today's Date: _____

First Name: _____ Middle: _____ Last Name: _____

Date of Birth: _____ Gender: M / F SSN: _____

Please answer both question #1 and question #2 below:

1. Race: ☐ White ☐ Asian ☐ Black or African American ☐ Hispanic or Latino
   ☐ Native Hawaiian or other Pacific Islander ☐ Patient Declined

2. Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient Declined

Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (if different): _____

Home Phone: _____ Mobile: _____

Preferred Contact: ☐Home ☐Mobile ☐Work Okay to leave a message? Y / N Okay to Text? Y / N

e-mail: _____ Okay to send e-mail? Y / N

Emergency Contact Name: _____

Relationship: _____ Phone Number: _____

How did you hear about us?
Check all that apply. Please specify, if asked. We would really love to know exactly how you heard about us.

☐Physician ..... Dr. _____

☐Insurance ☐Internet ☐Other Specify: _____

Preferred Pharmacy

Name: _____ Phone Number: _____

Insurance Information

☐ Commercial Insurance

Primary Insurance: _____ ID#: _____

Group #: _____

Primary Card Holder: _____ Primary Card Holder's Date of Birth: _____

Secondary Insurance: _____ ID#: _____

Group #: _____

Primary Card Holder: _____ Primary Card Holder's Date of Birth: _____

☐ Prescription Coverage

Insurance: _____ ID#: _____

Phone Number: _____

☐ Motor Vehicle Accident Claim:

Please make sure you have your Letter of Protection for the front office staff to copy.

Company: _____ Date of Accident: _____

Claim Number: _____

Adjuster Name: _____

Adjuster Number: _____ Fax: _____

Attorney Name: _____ Number: _____

Attorney Address: _____ State: _____ Zip: _____

☐ Work Related Accident:

Date of Injury: _____ Compensable Injury: _____ Disputed: Y / N

Insurance Company: _____

Address: _____

Phone: _____ Fax: _____

Adjuster: _____ Phone: _____

Claim Number: _____

Pre-Auth Company: _____ Number: _____

Fax: _____ Treating Dr. _____

Phone: _____ Fax: _____ In Network Claim: Y / N

HIPAA Notice of Privacy Practices (Page 1 of 2)

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 notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information," is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.
Uses and disclosures of protected health information.

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected, health information as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activities: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

We may use or disclose health information about you to support the programs and activities of **Back Pain Interventions Associated, PA** such as quality and service improvement; health care delivery review; staff performance evaluation; competence or qualification review of health care professionals; education and training of physicians and other health care providers; and business planning and development, business management and general administrative activities. We use this information to continuously improve the quality of care for all patients we serve. For example, we may combine health information about many patients to evaluate the need for new services or treatments. We may disclose information to doctors, nurses, and other students for educational purposes. And we may combine health information we have with that of other facilities to see where we can make improvements.
Additionally, we may share your health information with other health care providers and payors for certain of their business operations if the information is related to a relationship the provider or payor currently has or previously had with you, and if the provider or payor is required by federal law to protect the privacy of your health information.

Other Permitted and Required Use and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken on action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information.
You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information can be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

You may contact our privacy officer, Cathy Brown RN at 281-494-6900 Cathy@yourpaindoc.com for further information about the complaint process.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published, and becomes effective on/or before April14, 2003.
We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal responsibility.

Acknowledgement of receipt of Notice of Privacy Practices

I have been given a copy of the notice of privacy practices for Back Pain Interventions Associated, P.A. This notice describes my legal rights regarding my health information and informs me of the legal duties and privacy practices of Back Pain Interventions Associated, P.A. with respect to health information created for services generated by Back Pain Interventions Associated.

Signature of Patient or Patient's Qualified Personal Representative* Date

*In the event the patient is legally unable to sign, please print the name of the patient's qualified personal representative and the individual's legal authority to act on behalf of the patient.

Printed Name of Qualified Personal Representative: _____

Legal Authority to Act on Behalf of the Patient: _____

Consent to Treat

I voluntarily consent to the physicians and other clinical personnel of Back Pain Interventions Associated, P.A., for the evaluation and treatment of the conditions for which I present myself to this office. I give Back Pain Interventions Associated, P.A. consent to request my medication history.

I acknowledge that I am legally responsible for all reasonable charges in connection with the medical care the treatment provided by representatives of Back Pain Interventions Associated, P.A. and promise to pay whatever charges are not paid by my health plan or insurance in return for the medical care and services that are provided to the patient.

I understand that this consent form will be valid and remain in effect as long as I receive my medical care at Back Pain Interventions Associated. P.A. or from Mark Brown, M.D. I understand that this consent may be revoked in writing at any time.

Printed Patient Name Patient Date of Birth

Signature of Patient Date Signed

Assignment of Benefits

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERICES RENDERED.

I hereby authorize my insurance benefits to be paid directly to Back Pain Interventions Associated, P.A., realizing I am responsible to pay non-covered services. I certify that the information given by me to Back Pain Interventions Associated, P.A., in applying for payment under insurance coverage or other protection is correct and complete. I authorize any holder of medical information about me, to release to the insurance company or its agents, any information needed to determine the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A Photocopy of this assignment is to be considered as valid as the original.

I ACKNOWLEDGE COPAYS, CO-INSURANCE AND DEDUCTIBLES ARE MY FINANCIAL RESPONSIBILITY PER PAYER CONTRACTS AND FEDERAL LAW, THESE FEES CAN NOT BE WAVED.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ AND UNDERSTAND THE INFORMATION.

Printed Patient Name

Signature of Patient Date Signed

Pain/History Questionnaire

Patient Name: _____ DOB: _____ Age: _____

Where is your pain? _____

How long have you had this pain? _____

What side of your back are you having pain? ☐Entire back/neck ☐Right side ☐Left side

1. Describe your pain.										
☐	Achy	☐	Burning	☐	Crampy	☐	Dull	☐	Sharp	☐	Shooting
☐	Sore	☐	Stabbing	☐	Stiff	☐	Throbbing	☐	Tightness	☐	Pressure
☐	Spasms										

Does your pain radiate or move to another part of your body? ☐ Yes ☐ No

If so, where? _____

1. What makes your pain worse?										
☐	Nothing	☐	Sneezing	☐	Coughing	☐	Starting Stool	☐	Bending	☐	Lying
☐	Sitting	☐	Standing	☐	Walking	☐	Everything	☐	Exercising	☐	Twisting
☐	Bright Light	☐	Medication	☐	Cold Exposure	☐	Other:				
2. What makes your pain better?										
☐	Nothing	☐	Lying Down	☐	Resting	☐	Sitting	☐	Bending Forward	☐	Heat/Ice
☐	Massage	☐	Bracing	☐	Position Change	☐	Physical Therapy	☐	Standing	☐	Walking
☐	Dark Room	☐	Medication	☐							

On a scale of 0-10 (0 = no pain 10 = worst pain ever) how strong is your pain? _____

Is your pain ☐ present all the time or ☐ comes & goes

How did it start? ☐ Slowly ☐ Suddenly

Do you have numbness or tingling? ☐ Yes ☐ No Where? _____

Do you have numbness in your groin area? ☐ Yes ☐ No

Have you noticed any weakness in your arms or legs? _____

Have you had problems being able to control your urine or bowel movements? ☐ Yes ☐ No

Have you had an injury to your back or neck? ☐ Yes ☐ No

Have you had surgery to your back or neck? ☐ Yes ☐ No

Does your pain occur at night? ☐ Yes ☐ No

Does your pain affect your ability to sleep? ☐ Yes ☐ No

Is your pain Work related? ☐ Yes ☐ No

Is your pain a result of an auto accident? ☐ Yes ☐ No If yes, is there litigation involved? ☐ Yes ☐ No

Patient Name: _____ DOB: _____ Age: _____

3. Does your pain affect your daily activities?

Activity	Independent	Require Assistance	Dependent on Others
Feeding			
Meal Preparation			
House Work			
Transportation			
Ambulation			
Dressing/Bathing			
Toileting			

Which of the following pain **treatments** have you tried?

Tried	Use		Tried	Use	
☐	☐	Ice	☐	☐	Brace
☐	☐	Heat	☐	☐	Biofeedback/Relaxation
☐	☐	TENS Unit	☐	☐	Injections
☐	☐	Massage	☐	☐	Alcohol
☐	☐	Traction	☐	☐	Bedrest
☐	☐	Exercise	☐	☐	Spinal Stimulator
☐	☐	Physical Therapy	☐	☐	Other
☐	☐	NSAIDS	☐	☐	Chiropractor Therapy

Please list any **medications** you have tried for your pain**.**
*This information is required if a prior authorization is needed for any pain medications ordered.

	Medication	Results
1.		
2.		
3.		
4.		

What diagnostic studies (X-rays, MRI's nerve studies, etc…) have you had?

Type of Study	Date	Ordering Physician

Surgical History: Please list any surgeries that have been performed.

	Operations	Year
1.		
2.		
3.		

Patient Name: _____ DOB: _____ Age: _____

Please list ALL medications you are currently taking, including over the counter vitamins, herbs & supplements

Medication	Strength	How often	Prescribed by

Are you currently taking any of the following blood thinners?

☐Aspirin ☐Ibuprofen ☐Coumadin ☐Levenox ☐Fragmin ☐Plavix ☐Other:_____

List all drug and non-drug allergies and sensitivities

Allergy:	Reaction

Social History:

Employment Status: ☐Full Time ☐Part Time ☐Retired ☐Un-Employed ☐On Disability

Occupation or Former Occupation: _____

Do you live alone? ☐ Yes ☐ No

Do you live with: ☐Spouse ☐Partner ☐Children ☐Other: _____

Do you smoke? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No if yes, what type: ☐Occasional ☐Light ☐Heavy

Do you do recreational or illicit drugs? ☐ Yes ☐ No If yes, what type: _____

Were you ever in the military? ☐ Yes ☐ No If yes, what is your status: _____

Family History:

Please list any significant medical conditions, such as stroke or diabetes, of immediate family members.

Relative			**List medical condition. If deceased list cause of death.**
Mother	Alive/Deceased	Living and well	
Father	Alive/Deceased	Living and well	