CEDAR HILL PAIN & REHAB
716 North Hwy 67
Cedar Hill TX 75104
Phone 972-291-9165 Fax 469-575-9975

Patient Information

Patient Name _____ Social Security Number _____

Date of Birth _____ Gender: ____ Female ____ Male Email _____

Address _____ City _____ State ____ Zip _____

Home Phone Number _____ Work Phone Number _____ Cell Phone Number _____

Pharmacy _____**Location** (street/city) _____**Phone**_____

Primary Care Physician _____ Referring Physician _____

Employer _____ Employer Phone Number _____ Employer Address _____

Responsible Party Information

Name _____ Social Security Number _____ Date of Birth _____

Address _____City _____ State ___ Zip _____Relationship to patient_____

Employer_____ Employer Phone Number _____ Employer Address _____

WC Claim #_____ DOI _____

Attorney (LOP only) _____Phone_____

Nearest Relative Information and HIPAA Release Compliance

This information will be used when we are unable to contact the patient. For example: if your doctor is called out in an emergency and your appointment has to be rescheduled.

Name _____ Patient's Relationship: Self __ Spouse ___ Child ____ other ___

Home Phone Number _____ Cell Phone Number _____

1-Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY.
_____ Phone _____ Cell phone_____

_____Phone _____ Cell phone _____

2-Can confidential messages (ie. appointment reminders) be left on your home answering machine or voicemail ◯ Yes ◯ No
3-Can confidential messages (ie. appointment reminders) be left on your cell phone voicemail ◯ Yes ◯ No
4-If you do not have voicemail, can a confidential message be left at your place of employment? ◯ Yes ◯ No

5-Please list the family members or other persons, if any, whom we may inform about your scheduled appointment.
_____, _____, _____

Authorization to Release Information

I hereby authorize the above named agency to release any treatment information requested by attorneys, physicians, insurance companies, employers, health care providers or any other entity which may be concerned with the payment of charges incurred for the treatment services of Cedar Hill Pain & Rehab and hereby authorize payment directly to Cedar Hill Pain & Rehab for services rendered. I accept responsibility for payment of any charges not paid for or accepted by my insurance.

Patient Name _____ Date _____
Patient (parent or Guardian if patient is a minor)

I have reviewed this office's NOTICE OF PRIVACY PRACTICES which explains how my medical information will be used and disclosed. I understand I am entitled to receive a copy of this document.

Patient Name _____ Date _____ Print Name_____

Cedar Hill Pain & Rehab 716 N. Hwy 67 Cedar Hill TX 75104

Insurance Information

Primary Insurance

Group Insurance (through employer) ____ *Medicare* _____ *Private Insurance* _____ *Work Comp* ____ *Date of Injury* _____
Insurance Company Name _____ Phone Number _____
Address _____ City _____ State _____ Zip _____
Patient's Relationship to Policy Holder: Self __ Spouse ___ Child ____ other ___
Policy or Subscriber ID Number _____ Group Number _____

Secondary Insurance

Insurance Company Name _____ Policy ID Number _____Group Number_____
Address _____ Phone Number _____

Patient's Relationship to Policy Holder: Self __ Spouse ___ Child ____ other ___

Financial Policy

Thank you for choosing Cedar Hill Pain & Rehab as your health care provider. The following statement is our financial policy, which we require you to read and sign prior to treatment.
We accept assignment of Insurance benefits at the time of coverage. We accept certain letters of protection and patient liens for personal injury claims.

We cannot bill your insurance company unless full and precise billing information is provided by you at the time of service. Every effort will be made on our part to obtain insurance information from you prior to the time of your visit. You are required to bring supporting documentation with you at the time of your visit. If you fail to bring this information, you may be required to pay at the time of service or reschedule.

Please be aware that some or all services provided may not be covered by your particular plan. Should your plan not cover all services, you will be billed for the services not covered. Payment plans are available.

If your plan requires a co-payment, has a deductible or percentage you must pay, this amount is due at the time of visit, unless other arrangements are made with the business office. Failure to keep the account current will result in our being unable to provide additional medical services to you unless prepayment is made for services.

There is a $25.00 service fee for checks returned for insufficient funds or closed accounts. We accept cash, check, or credit cards.

Please notify us within 24 hours if you must cancel your appointment so that we may let another patient have your appointment time. **No Shows will not be tolerated as this hinders the continuum of your care, and restricts the availability of care to others**. There is a fee for missed appointments.

I have read and agree to the above policy. I understand that regardless of my insurance, I am financially responsible for payment of services rendered by Cedar Hill Pain & Rehab. I authorize release of my information to my insurance company for payment of claims for services rendered. I assign all insurance benefits to Cedar Hill Pain & Rehab. This Authorization will remain in effect until revoked by me in writing.

CONSENT TO RECEIVE TREATMENT

In some circumstances, you may be prescribed treatment at a physician-owned facility and/or pharmacy. Your physician has an option to invest in these businesses and therefore may have a small financial interest.

I have been informed of this possibility and do not have any objection to this arrangement. I understand that I am free to ask my doctor any additional questions about this matter.

_____ _____
Signature Date

_____ _____
Parent Signature (If Minor) Date

Patient Name_____ DOB_____

Patient responsibility agreement for controlled substance prescriptions

Controlled substance medications (ie, narcotics, tranquilizers and barbiturates) are very useful but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. 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 pain, I agree to the following conditions:

I am responsible for the controlled substance medications prescribed tome. If my prescription is lost, misplaced, or stolen, or if I "run out early", I understand that it will not be replaced.

1. Refills of controlled substance medications:
    a. Will be made only during regular office hours, Monday through Thursday, in person, once a month, during a scheduled office visit. Refills will not be made at night, on weekends or during holidays. No refills by phone.
    b. Will not be made if I "run out early", "lose a Prescription", or "spill or misplace my medication". I am responsible for taking medication in the dose prescribed and for keeping track of the amount remaining.
    c. Will not be made as an "emergency", such as on a Thursday afternoon because I suddenly realize I will "run out tomorrow". I will call at least 24 hours ahead if I need assistance with a refill, which must be refilled in person in the office.
2. 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.
3. I agree to comply with random urine, blood or breathe testing, documentation 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.
4. I understand that if I violate any of the above conditions, my prescription for controlled substance medications may be terminated immediately. If the violation involves obtaining controlled substance medications from another individual, or the concomitant use of non-prescribed illicit (illegal) drugs, I may also be reported to all my physicians, medical facilities and appropriate authorities.
5. I understand that the main treatment goal is to reduce pain and improve any ability to functions and/or work. In consideration of this goal and the fact that I am being given a potent medication to help me reach my goal, I agree to help myself by following better health habits: exercise, weight control and avoidance of tobacco and alcohol use. I must also comply with the treatment plan as prescribed by my physician. I understand that a successful outcome to my treatment will only be achieved by following a healthy lifestyle.
6. I understand that the long-term advantages and disadvantages of chronic opioid use have yet to be scientifically determined, and my treatment may change at any time. I understand, accept and agree that there may be unknown risks associated with the long-term use of controlled substances, and that my physician will advise me of any advances in this field and will make treatment changes as needed.

I have been fully informed by Cedar Hill Pain & Rehab physicians and staff regarding psychological dependence (addiction) of controlled substance medication, 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. I know that there is a risk of becoming physically dependent on the medication. I know that it may be necessary to stop taking the medication. If so, I know I must slowly decrease the dose while under medical supervision or I may have withdrawal symptoms.

I have read this contract and the same has been explained to me by Cedar Hill Pain & Rehab. In addition, I fully understand the consequences of violating this agreement.

_____ _____ _____

Patient Signature Date Witness signature

Pharmacy_____street/city_____Phone_____

Patient Name_____ DOB_____

PARTIAL ASSIGNMENT OF CAUSE OF ACTION, ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN AND TREATMENT AGREEMENT

Cedar Hill Pain & Rehab

Consideration. In order to facilitate the ability of the Office to collect its Charges directly from various Payers and thereby to enhance the patient-provider relationship, I, the undersigned, as consideration for the Offices services, agree to the following and direct all Payers as follows:

Partial Assignment of the Cause of Action, Assignment of Proceeds, and Contractual Lien. I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to the Office, as well as any and all causes of action that I might have now or in the future against any Payer to the extent of my Charges, the right to prosecute such causes of action either in my name or in the Offices name, and the right to settle or otherwise resolve such causes of action as the Office sees fit. I further assign my right to receive any Proceeds from any Payer to the Office and further grant a contractual lien to the Office with respect to my Charges. I understand that these assignments of rights and contractual lien may effectuate, automatically or otherwise, a secured interest under the applicable Uniform Commercial Code. I intend for this Agreement to effectuate such a lien and hereby authorize the Office to file the form(s) normally filed with the secretary of state or other governmental agency in order to perfect such lien. Except as provided herein, nothing in this Agreement shall be construed as an election or waiver by the Office to a secured interest under any other statutory lien law. Consistent with these rights, I hereby direct any and all Payers, to pay the Proceeds directly and immediately to, and exclusively in the name of, the Office in the amount of my Charges.

Other Terms. I understand that I remain personally responsible for my Charges. I agree to pay the full amount of my Charges to the Office upon its demand at time of service. Unless mutually agreed to in writing, the receipt and processing of partial payments by the Office shall not constitute a waiver of the Offices right to receive payment-in-full upon demand and shall not constitute an accord and satisfaction of my Charges, irrespective of any restrictions indicated on any payments. I understand that at any time, I can request a copy of my total Charges. I hereby waive any statute of limitations which may apply to the collection of my Charges. In the event that I retain one or more attorneys to assist me in collecting any Proceeds, I direct each attorney to issue an irrevocable letter of protection to the Office regarding my Charges. I further direct (and the Office hereby requests) each attorney to provide immediate notice to the Office regarding any Proceeds received by the attorney, to promptly pay the Office in-full out of such Proceeds, and to provide a full accounting of such Proceeds to the Office. I authorize and direct the Office to submit my Charges to any and all Payers including, without limit, my health benefit plan. I understand, however, that in the event that my Charges are submitted to more than one Payer, I hereby authorize and direct the Office to apply any Proceeds received from one Payer to any reductions, write-offs, or discounts, issued by another. I authorize the Office to endorse or sign my name on any and all checks listing me as a payee which are received by the Office for payment of Charges incurred by me, my spouse or my dependents. I further authorize the Office to apply any credit balances on my Charges to any other outstanding Charges still owed by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

This Agreement shall not be modified or revoked without the mutual written consent of the Office and myself. I hereby revoke the terms of any previously signed documents to the extent those terms conflict with the terms of this Agreement. This Agreement shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of the Office and myself.

Definitions. For the purposes of this Agreement, the following terms shall have the following meaning: Office shall refer to: **Cedar Hill Pain & Rehab 630 North J. Elmer Weaver Freeway, Cedar Hill, TX 75104.** Payer shall refer to, without limit, any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, at-fault party, tortsfeasor, individual, and any other entity, which may elect or be obligated to pay or disburse Proceeds to me, either now or in the future, for any reason; Proceeds shall include, without limit, the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to pay or reimburse, and the proceeds relating to the following benefits, plans, or coverages: individual and group health benefits, Medicare, Medicaid, workers compensation, disability, liability, uninsured and underinsured motorist, no-fault, medical payments benefits, personal injury protection, lost wages, lost services, property damage, and malpractice; Charges shall include, without limit, the full fees for the Office services (including, without limit, treatment, medical equipment, supplies, supplements, narrative reports, depositions, and testimony), any Collection Costs incurred by the Office, 18% interest on outstanding Charges, and any other charges incurred by me at the Office; Collection Costs shall include, without limit, any pre- and post-judgment court costs, filing fees, service of process charges, attorney's fees, and any other costs of collection incurred by the Office in any effort or action to collect my Charges either from me or from any Payer.

Patient Name (please print): _____Date of Birth: _____

Patient Signature: _____ Date: ___/___/___

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (please print): _____

Parent/Guardian Signature: _____ Date: ___/___/___

Patient Name_____ DOB_____

Patient Health Information Consent Form

We want you to know how your Patient Health Information **(PHI)** is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow Cedar Hill Pain & Rehab to use their Patient Health Information **(PHI)** for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, Cedar Hill Pain & Rehab. has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Signature Date

_____

Social Security Number (SSN)

Patient Name_____ DOB_____