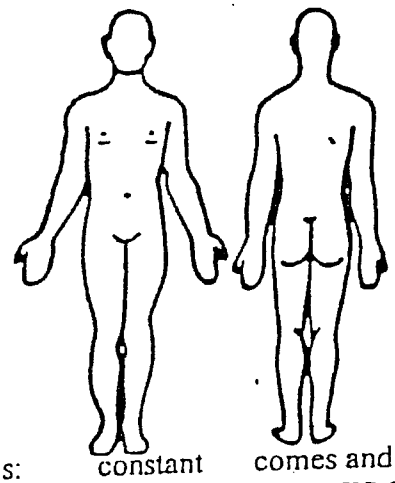
PAIN ASSESSMENT QUESTIONAIRE

DATE:_____
NAME:_____
AGE:_____
LOCATION OF PAIN_____
Place an X to describe the location of your pain



Pain is: constant comes and goes
RATE YOUR PAIN USING THIS SCALE:

0 1 2 3 4 5 6 7 8 9 10
no pain moderate severe
at your worst times:___ at your best times:___

DESCRIBE YOUR PAIN: (circle all that apply)
Throbbing shooting stabbing sharp cramping
Aching burning gnawing dull sore crushing
Heavy tingling numb pressing squeezing

WHAT MAKES THE PAIN BETTER?
_____
WHAT MAKES THE PAIN WORSE?
_____
ARE YOU SLEEPING WELL? YES NO
IS YOUR INJURY WORK RELATED?
YES NO
IF YES, DATE OF INJURY:_____
ARE YOU INVOLVED IN A LAWSUIT?
YES NO
NAME OTHE TREATING PHYSICIANS
_____
_____
_____

REFERRING MD_____

MEDICAL TREATMENTS FOR PAIN
(circle all that apply)
bed rest physical therapy chiropractic
acupuncture TENS traction ultrasound
massage . pool biofeedback

List previous pain medications
_____
_____
Injections: epidural steroids
Others_____

Imaging Studies: (circle all that apply)
X-rays MRI
CT scan Myelogram
EMG/nerve conduction test
Bone scan other_____

PAST MEDICAL PROBLEMS
_____
_____
_____
PAST SURGERIES
_____
_____
_____
ALLERGIES TO MEDICATIONS
_____
MEDICATIONS
_____
_____
_____
_____
FAMILY HISTORY
_____
_____
_____

_____

SOCIAL HISTORY

OCCUPATION:_____
MARITAL STATUS: SINGLE___ MARRIED___ WIDOWED___DIVORCED__
DO YOU SMOKE? YES/NO HOW MUCH?_____ IF A FORMER SMOKER, WHEN DID YOU QUIT?_____
DO YOU DRINK ALCOHOL?_____ IF YES, HOW MUCH?_____
DO YOU HAVE A HISTORY OF ALCOHOL OR DRUG ABUSE? YES___ NO___
DO YOU EXERCISE?_____ HOW OFTEN? _____

REVIEW OF SYSTEMS (please circle if any of the following apply)

Constitutional-
- Fever
- Chills
- Nausea
- Vomiting
- Unusual tiredness

Endocrine-
- Unusual sweating
- Loss of appetite
- Unexplained weight loss

Skin-
- Rashes
- Itching

ENT-
- Hearing loss
- Oral/nasal discharge
- Sore throat
- Sinus problems

Cardiovascular-
- Chest pain
- Shortness of breath
- Arrhythmia

Respiratory-
- Heavy cough
- Trouble breathing
- Change in Sputum

Hematologic/Lymphatic-
- Easy bruising or bleeding
- Abnormal lumps or bumps
- Swollen glands

GI/GU-
- Change in bowel/bladder habits
- Blood in urine or stool
- Impotence

Eyes-
- Change in vision
- Abnormal discharge

Neuro-
- Seizures
- Syncope
- Tingling
- Weakness

Musculoskeletal-
- Traumatic injury
- Joint swelling

Mood-
- Depression
- Changes in mood
- Sleep problems

PRIVACY NOTICE

To our patients:

Effective April 14, 2003, to comply with the Health Insurance Portability and Accounting Act (HIPAA), this office must inform you of the following:

You, as our patient, have a right to have your medical record information kept confidential, however, we reserve the right to use the information in those records for treatment, payment, and health care operations. We will disclose information in your medical records to only yourself and (if you wish) to one other person you so designate. If you wish this person to also have access to your medical records, please fill in the following information so that we can verify his or her identity:

Name of other person _____
Date of birth of other person _____
City of birth of other person _____

If at any time, you wish to withdrawal this person's access to your medical records, please inform us immediately.

Our physicians and nurses will use the information to treat you; our billing office will use the information to bill you and your insurance company; our office will use the information for business purposes such as quality improvement and to send you information.

If you as our patient wish to have a family member, alternate physician or legal representation obtain information regarding your healthcare, we ask that you sign a medical release before we can release any information to them.

The right to access your medical records
Patients have the right to see and get copies of their own records. We do charge for making copies of your records to cover our cost and staff time involved.

You have the right to view your records within a certain time limit after requesting them. 15 days for records kept on-site and 30 days for records kept off-site. The office can ask a patient for an extension in writing and by stating the reason for the request.

The right to request restrictions
Patients have the right to restrict who sees their records. For example, the patient may ask that a spouse or family member not see the record. Sometimes the request is not feasible. If a family member works at the office, they will have limited access to the record. If this is the case, you will have the option of changing to another physician.

The right to confidential communication
Patients have the right to receive communication about their records in a confidential manner. Please let our staff know where you prefer to be contacted. On the intake form you are asked for a daytime phone number. If this is your work number and you prefer we do not contact you there, please list only your home phone number.

The right to amend the re

Patients have the right to request amendments to their records when they disagree with the content. At the same time, doctors have the right to deny those requests. Remember that once written, a record cannot be changed. The doctor will be able to draw a line through the disputed entry, initial and date it, and write an addendum, or the doctor can add a statement that this is the patient's view of the situation.

The right to an accounting of disclosures

Patients have the right to know everyone to whom the office discloses record information for purposes other than treatment, payment, and health care operations.

I request the following restrictions to the use or disclosure of my medical information:

_____

_____

_____

I have read and understand the privacy policy.

Signature of Patient_____

Date _____

WOODLANDS PAIN CONSULTANTS

MEDICATION AGREEMENT FORM

We are committed to doing all we can do to treat your pain condition. In some cases, controlled substances are used as a therapeutic option in the management of pain, which is strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and the physician by establishing guidelines, within the laws, for proper and controlled substance use. The words 'we' and 'our' refer to the facility and the words 'I', 'you', 'me', or 'my' refer to you, the patient.

1. All controlled substances must come from the physician whose name appears below or, during his/her absence, by the covering physician, unless specific authorization is obtained for an exception. I understand that I must tell the physician whose name appear below all drugs that I am taking, have purchased, or have obtained, even over-the-counter medications. Failure to do so may result in drug interactions or overdoses that could result in harm to me, including death. I will not seek prescriptions for controlled substances from any other physician, healthcare provider, or dentist. I understand that it is unlawful to obtain or to attempt to obtain a prescription for a controlled substance by knowingly withhold facts from a physician or his/her staff (including failure to inform the physician or his/her staff of all controlled substances that I have been prescribed).
2. All controlled substances must be obtained at the same pharmacy. Should the need arise to change pharmacies, our office must be informed. The pharmacy you have selected is:_____ Phone:_____
3. You may not share, sell, or otherwise permit others; including spouse or family members, to have access to any controlled substances that you have been prescribed.
4. Unannounced urine or serum toxicology specimens may be requested from you, and your cooperation is required. Presence of unauthorized substances in urine or serum toxicology screens may result in your discharge from this facility. New patients will be required to provide a specimen on the day of his/her first consultation visit.
5. I will not consume excess amounts of alcohol in conjunction with controlled substances. I will not use, purchase, or otherwise obtain any other legal drugs except as specifically authorized by the physician whose name appears below or during his/her absence, the covering physician, as set forth in Section 1 above. I will not use, purchase, or otherwise obtain illegal drugs, including marijuana, cocaine, etc. I understand that driving while under the influence of any substance, including prescribed controlled substance, or any combination of substances (e.g alcohol and prescription drugs) which impairs my driving ability, may result in DUI charges.
6. Medications or written prescriptions may not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, etc. if your medication has been stolen it will not be replaced unless explicit proof is provided with direct evidence from authorities. A report narrating what you told authorities is not enough.
7. Early refills will not be given. Renewals are based upon keeping scheduled appointments. Please do not phone prescriptions after hours, on weekends, and on holidays. Please do not call for a refill or ask the pharmacy to fax a refill request unless an exception has been made by the physician whose name appears below. Please allow 48 hours for refills to be completed.
8. In the event that you are arrested or incarcerated related to legal or illegal drugs(including alcohol), refills on controlled substances will not be given.
9. I understand that some prescription medications in the treatment of pain may be habit forming and dependence can occur.
10. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substances by this physician and other physicians at the facility and that law enforcement officials may be contacted.
11. I affirm that I have full right and power to sign and be bound by this agreement, and that I have read it and understand and accept all of its terms. A copy of this document has been given to me.

Patient's Full Name:_____

Patient's Signature:_____ Date:_____

Physician's Name: LENNY Q. JUE, M.D.

PATIENT NAME:_____ DATE OF BIRTH:_____

*** THIS INFORMATION MUST BE PROVIDED BEFORE YOUR APPOINTMENT***

PHARMACY INFORMATION

PHARMACY NAME:_____

ADDRESS:_____

_____

PHONE:_____ FAX:_____

WOODLANDS PAIN CONSULTANTS

Lenny Jue, M.D.

1441 Woodstead Court Suite 260
The Woodlands, TX 77380
Tel: (281) 825-4390
Fax: (281) 825-4393

FINANCIAL POLICY

Thank you for choosing us as your surgical care facility. Our goal is to provide you with the highest quality surgical care at affordable cost. To make our services available to as many patients as possible on an affordable basis, we have adopted the financial collection policy outlined below. We ask you to read the policy carefully and sign prior to any treatment.

- **WE MAY ACCEPT ANY ASSIGNABLE INSURANCE WITH APPLICABLE COVERAGE.**
- **WE OFFER FINANCIAL ASSISTANCE (DISCOUNT, WAIVER, OR REDUCTION OF DEDUCTABLES, CO-PAYS AND CO-INSURANCE) UNDER OUR INDIGENCY POLICY TO ALL ELIGIBLE PATIENTS ON CASE TO CASE BASIS.**
- **FULL PAYMENT IS DUE AT TIME OF SERVICE UNLESS ARRANGED OTHERWISE.**
- **WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD, AND AMERICAN EXPRESS CARD.**
- **WE OFFER EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.**

Dishonored checks will be charged back to the patient's account with a service fee of $25.00. Dishonored checks not redeemed within 20 working days of written notice to the maker will be referred to the prosecutor of collection.

Regarding Insurance

We may accept assignment of insurance benefits at our discretion if acceptable insurance identification is provided. Acceptable insurance identification is defined as a valid insurance card, policy/plan with applicable coverage, or telephone verification. As a courtesy to our patients, verifiable and assignable insurance will be billed by this surgeon's office. However, you will be personally responsible for your account balance regardless whether or not if your insurance will pay for your total balance of your claims, unless you're eligible for discounts under our indigency policy pre-determined before the services are rendered. Your insurance policy/employee benefits plan is a contract between you and your insurance company/employee benefits plan. We are not a party to that contract. In the event we do not accept assignment of benefits we require that you be pre-approved on our extended payment plan by providing a credit card or personal checking account with authorization to charge that amount for the balance due, if your insurance company/employee benefits plan has not paid your account in full within 45 days or has determined your claim to be your responsibility for the reasons of annual deductible, co-payment, non-covered services, and non-medically necessary.

If a patient chooses or is required to bill his/her own insurance, the office will provide an itemized statement and a HCFA-1500 Form to the patient, but will treat the account as self-pay.

Regarding Discount

We may offer discounts, reduction or waiver of deductibles, coinsurance and co-pay to may eligible patients based on medical needs and ability to pay on a case-by-case basis under our Corporate Indigency Policy in accordance with applicable federal and state laws. You may apply for financial indigency discount assistance by asking our staff to determine if you're eligible.

Regarding Surgeon and Facility Charges

We will disclose to every patient our surgeon charges as practically possible before your medical or surgical procedures if it is known to us. Please feel free to ask our staff if you have any questions about charges and your payment responsibilities.

As you are aware, your insurance company requires your doctors and surgeons to charge and bill the services separately from surgical facilities or hospitals. You shall not be surprised that you will receive separate surgeon, anesthesiologist, diagnostic labs, radiologists,

pathologist, and others in addition to the surgical facility bills for your surgery. If you have any questions about your surgical facility bills, please direct your questions to that surgical center.

While we don't anticipate any unforeseeable circumstances, we have no control over any such event(s) that may arise. Should you require additional medical or surgical care in any event of the post-surgical complications and reactions, you may incur additional expenses at this facility or outside this facility, such as a hospital.

The charges only include the stated date of services at this facility and do not include any other date of service from us or other providers and facilities.

Regarding PPO and HMO Network Participation

As you may know, you may have choice to choose a surgeon or surgical facilities with or without PPO or HMO participation under different insurance coverage and benefits levels. We are dedicated to providing highest quality care to every patient. However we have no power to charge your insurance coverage or network limitations. Most health care plan or insurance policies may provide surgical coverage to non-PPO providers and facilities, but at lower percentage of insurance reimbursement. Although it is your responsibility to verify your insurance coverage for non-PPO/HMO providers, we will always disclose to you as to our participation status to your insurance plan. We also provide every patient with financial assistance or discount with high deductibles and coinsurance for our Corporate Indigency Policy in accordance with applicable federal and state laws.

At this time, we don't participate in any managed care networks other than Medicare Fee-for-Service Plans (Medicare Part B). Most health plans or Insurance Policies may have coverage for out-of-network providers or facilities, but at different or lower percentage or level of reimbursement rates.

We will verify your insurance coverage and obtain per-certification if applicable for all services as a courtesy to you before your surgery.

Please understand that all insurance verification is not a guarantee of insurance payment.

Compliance & Disclosure under Texas Occupation Code- Section 120.006

In compliance with Section 102.006 of Texas Occupations Code in connection with my information consent and personal choice of doctors and facility solely based on the quality and safety of care, reputation and patient satisfaction, and my knowledge in my decision-making in exercising my rights with respect to the in-network or out-of-network coverage and cost sharing, my attending doctor(s) and /or clinic (facility) have disclosed to me at the time of initial contact ad at the time of referral with respect to the choice of a doctor or facility solely in the interest of my healthcare quality and safety, as a result of my informed consent and personal choice of doctor(s) and/or facility: (A) his/her affiliation, if any, with the doctor or facility for whom the patient is referred and (B) that he/she will receive, directly or indirectly, remuneration for referring upon my such request and excising my rights of freedom of choice for the provider(s) and facility under the in-network or out-of-network coverage as provided by my health plan, in compliance with all applicable federal and state laws, Medicare, ERISA,PPACA and the Section 102.006 of Texas Occupations Code.

Doctor or Facility with affiliation and remuneration:_____

Your Responsibility for Cooperation

If we accept your insurance assignment as a payment from your insurance reimbursement, you agree to timely cooperate with your insurance company or health plan in the course of insurance claim processing, such as insurance inquires, requests for additional information, claims status verification or any inquiries for the purpose of your claim processing. You also agree to notify us immediately of any insurance inquiry or request for additional information and provided us with a copy of any documentation received from the insurance company or submitted to insurance company from you.

In an event that you do receive insurance payment checks for your surgeries rendered by this doctor, you agree to submit such insurance reimburse check to our office within five (5) business days after your receipt of insurance checks. In a failure or refusal to forward or send us the insurance reimbursement checks for the medical services from this provider, all of your discount arrangement will be voided, and the total balance is due immediately, as there is no justification for your to keep the insurance payment for our services as you promised to pay for our services. You further agree to compensate us for any legal fees if we have to retain any legal services to collect past dues.

We are committed to serving you with highest quality care possible at affordable cost. Every staff member at our office is ready to help you at all times.

If you have any question regarding our financial policies, please do not hesitate to ask us at any time. We thank you for your co-operation.

I have read the Financial Policy. I understand and agree to this Financial Policy.

X_____ Date:_____

Signature of Patient or Responsible Party Patient Name (print)

X_____ Date:_____

Signature of Co-Responsible Party Your Name (print)

PATIENT INFORMATION

PATIENT _____ DATE OF BIRTH _____
(LAST) (FIRST) (MI)

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE ( ) _____ SOCIAL SECURITY # _____ DRIVERS LICENSE # _____

EMPLOYER _____ WORK PHONE ( ) _____

EMPLOYER'S ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE'S NAME _____ SOCIAL SECURITY # _____
(LAST) (FIRST) (MI)

SPOUSE'S EMPLOYER _____ WORK PHONE ( ) _____

EMERGENCY CONTACT _____ EMERGENCY PHONE # ( ) _____

WORKMEN'S COMPENSATION YES ☐ NO ☐ DATE OF INJURY _____

REFERRING PHYSICIAN _____

INSURANCE INFORMATION

PRIMARY	SECONDARY
INSURANCE NAME _____	INSURANCE NAME _____
ADDRESS _____	ADDRESS _____
_____	_____
PHONE # ( ) _____	PHONE # ( ) _____
INSURED'S NAME _____	INSURED'S NAME _____
RELATION TO PATIENT _____	RELATION TO PATIENT _____
CLAIM # _____	CLAIM # _____
GROUP # _____	GROUP # _____

INSURANCE VERIFICATION

ADJUSTOR _____ PERSON VERIFYING _____

DEDUCTABLE _____ % OF COVERAGE _____

COMMENTS: _____

_____

AUTHORIZATION

I authorize the release of any medical information necessary to process my insurance claim and request payment of medical benefits be made to Woodlands Pain Consultants,P.A./Lenny Q. Jue, M.D.

_____ _____
PATIENT SIGNATURE DATE