EL PASO PAIN CENTER
Comprehensive Health & Wellness

Patient Registration For

Patient Information

Last Name:	First Name: M.I.:
Physical Address:	Mailing Address (if different than physical):
City/State/Zip:	City/State/Zip:

Home Phone:	Cell Phone:	Work Phone:

Who is your primary care physician?

How Did You Hear About Us? ☐ Billboard ☐ Flyer ☐ Friend ☐ Google / Internet ☐ Magazine ☐ Radio
☐ Doctor: ____________________ ☐ Other: ____________________

Referring Physician:	Date of Birth:	Gender:

Social Security #:	Emergency Contact Name:
Emergency Contact Phone:	Relationship to Patient:

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance
Insurance Company Name:	Insurance Company Name:
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

Additional Information

Email Address:

Race

☐ African American ☐ Asian ☐ Caucasian ☐ Declined to Specify ☐ Other: ______________

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to Specify ☐ Other: ______________

Preferred Language

☐ English ☐ Spanish ☐ Other: ________________________________

Would you prefer appointment reminders via text or voice call? ☐ Text ☐ Voice

What is your preferred phone number to receive reminders? ☐ Cell Phone ☐ Home Phone

Preferred Pharmacy & Location:

Patient Signature

In an effort to make communication seamless and allow open access to your medical records EPPC and its affiliates will use, but not share, your email for correspondence to include but not limit it's use to the following: appointment reminders, prescriptions, medical records access and newsletter updates. By signing our treatment agreement you authorize the use of your email for such purposes.

Signature: ________________________________ Date:________________

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Name:
Date of Birth:
Date of Visit:

Additional Information

Where is your most severe pain located?	
Have you had any imaging studies in the past: ☐ No ☐ Yes	If so, when?
Where?	What type of imaging?
Have you been treated by a pain specialist in the past? ☐ No ☐ Yes	Name of pain specialist:
Do you have an implanted pain pump?: ☐ No ☐ Yes	
Do you reside in a nursing home? ☐ No ☐ Yes	Where?

Please list all medications you take, including over-the-counter (OTC) medications and vitamins.

Medication Name	Dose	Times Per Day

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FINANCIAL RESPONSIBILITY

We charge what is usual and customary for our area of practice.

1. Full private payment or insurance co-pays/co-insurance and/or deductible for office visits, labs, toxicology screens, and/or any other service provided within El Paso Pain Center are due at the time of service. Furthermore, account balances are due at the time of service unless prior arrangements have been made.

Initial___________

2. If I know I will be unable to make my appointment, I will notify the El Paso Pain Center as soon as possible. I understand that cancellations must be made at least 24 hours before the scheduled appointment or I will be charged $25. This fee is not charged to your insurance company.

Initial___________

3. Please note we only bill insurance companies that we are contracted with. Furthermore, it is your responsibility to follow up with the insurance company to ensure the claim is paid within 60 days of the date of service. We must emphasize that as healthcare providers, our relationship is with you, our patient, and NOT with your insurance company. You are responsible for knowing what your insurance benefits are, including what your insurance will and will not pay for; and how to access your benefits, including obtaining referrals, etc. If you are unsure please contact your insurance carrier. This office assumes no responsibility for your lack of knowledge regarding your insurance benefits. **You are responsible for any remaining unpaid charge(s) as determined by your insurance company regardless of cause.**

Initial___________

This agreement is necessary in order to accept your insurance without having to bill you upfront. An account past due 90 days or more and payment plans that are not kept current, may be subject to collection and associated fees. By signing the agreement below, you assign insurance benefits to be paid directly to El Paso Pain Center's parent company, EPMed, PA, and authorize the release of any information which may be needed for processing of all claims; certification/case management/quality improvement; and/or other purposes related to the benefits of your health plan. Furthermore, understand that it is your responsibility to ensure that proper referrals or authorizations are obtained for each visit. **Finally, we require notification of insurance changes at least one week prior to your scheduled appointment to avoid appointment delays and/or private pay expenses.**

By signing below, you are stating that you understand and agree to all of the above.

Patient Signature: ____ Date: _________________

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Name:
Date of Birth:
Date of Visit:

RELEASE OF MEDICAL RECORDS AUTHORIZATION

I authorize the custodian of records to release the following:

☐ My medical records, including but not limited to; office visit notes, all imaging and all laboratory reports.

List any additional records or provide any restrictions on records to be forwarded:

____

____

____

Please fax or mail indicated records to:

Fax:
(915) 633-6598

EPMed, PA
Medical Records Department
3215 Gateway Blvd West
El Paso, TX 79903

This information may be used/disclosed for the purpose of my healthcare.

Patient Signature: ______________________________ Date: ____________________

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Name:
Date of Birth:
Date of Visit:

HIPAA ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS

By signing below, I acknowledge that I have read and understand El Paso Pain Center's Notice of Privacy Practices. Upon my request I can be provided a copy for my records.

I consent to the use and disclosure of my medical information as set forth herein, except as expressly stated below. I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

____

Patient Signature: ______________________________ Date: ____________________

HIPAA PRIVACY AUTHORIZATION FORM

☐ I do not authorize the use and/or disclosure of my Protected Health Information.

☐ I authorize El Paso Pain Center to use and/or disclose the Protected Health Information (PHI) selected below:

Name	DOB	Prescriptions Pick Up Only	All PHI*
______________________	____________	☐	☐
______________________	____________	☐	☐
______________________	____________	☐	☐
______________________	____________	☐	☐

*All PHI is defined as the following: medical records, health information, billing information, appointments, prescription pick up and all other purposes as I may direct.

This authorization is valid for the following:

☐ All past, present, and future appointments.

☐ Only from ______________ to ________________
Date Date

I understand that I have the right to revoke this authorization, in writing at any time.

Patient Signature: ______________________________ Date: ____________________

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CONSENT TO LABORATORY TESTING & USE OF RESULTS

In consideration of services rendered, I transfer and assign any benefits of insurance to El Paso Pain Center and it's affiliates (known collectively hereafter as EPPC) and authorize EPPC to submit claims on my behalf directly to my health insurance provider/plan. I acknowledge that EPPC may submit laboratory specimens to a licensed reference laboratory to perform testing. I authorize EPPC to release to my insurance carrier, or any health plan of which I am a member, any medical information needed for claim processing. I understand that EPPC may be an out of network provider and my practitioner may hold an ownership interest in this laboratory, and as such, may receive a return of investment from this interest. I understand that I have the option of obtaining lab services from another facility and that upon my request will be provided a list of alternative laboratory facilities. I understand that if the insurance company pays me directly for services rendered by EPPC, I am responsible to forward the payment to EPPC. I agree that this Consent to Testing & Use of Results will cover all medical services rendered by EPPC to me until such authorization is revoked in writing by me.

Patient Signature: ______________________________ Date: ____________________

PHYSICIAN DISCLOSURE
As required by Section § 102.006 of the Texas Occupation Code

Texas law requires a physician to disclose to a patient those arrangements permitted under applicable Texas law whereby such physician accepts remuneration to secure or solicit a patient or patronage for a person licensed, certified or registered by a Texas health care regulatory agency. The purpose of this Disclosure is to notify you, the patient, that your attending physician(s) may receive remuneration for referring you to certain diagnostic testing laboratories, pharmacies, and/or other ancillary healthcare providers, for certain toxicology and pharmacogenetic testing services, compounding pharmacy products, diagnostic imaging services and other ancillary healthcare service including, but not limited to Gateway Surgical Center, El Paso Pain Center Pharmacy, and El Paso Pain Center Laboratories.

Accordingly, the undersigned hereby acknowledges that my attending physician(s) have disclosed to me, at the time of initial contact and at the time of referral (i) his or her affiliation, if any, with the diagnostic testing laboratory, pharmacy, ambulatory surgery center or other ancillary healthcare provider for whom, I, the patient, am being referred, and (ii) that he/she will receive, directly or indirectly, remuneration for the referral to such diagnostic testing laboratory, pharmacy, or other ancillary healthcare provider. I understand that I, the patient, have the right to choose the providers of my healthcare services and/or products and, as such, I have the option of receiving ancillary healthcare services from any ancillary healthcare provider and/or facility that I choose.

Patient Signature: ______________________________ Date: ____________________

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SOAPP® VERSION 1.0-14Q

The following set of questions are given to all patients of El Paso Pain Center. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment plan.

Please answer the questions below using the following scale:

0 = Never 1 = Seldom 2 = Sometimes 3 = Often 4 = Very Often

1. How often do you have mood swings?	0	1	2	3	4
2. How often do you smoke a cigarette within an hour after you wake up?	0	1	2	3	4
3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	0	1	2	3	4
4. How often have any of your close friends had a problem with alcohol or drugs?	0	1	2	3	4
5. How often have others suggested that you have a drug or alcohol problem?	0	1	2	3	4
6. How often have you attended an AA or NA meeting?	0	1	2	3	4
7. How often have you taken medication other than the way it was prescribed?	0	1	2	3	4
8. How often have you been treated for an alcohol or drug problem?	0	1	2	3	4
9. How often have your medications been lost or stolen?	0	1	2	3	4
10. How often have others expressed concern over your use of medication?	0	1	2	3	4
11. How often have your felt a craving for medication?	0	1	2	3	4
12. How often have you been asked to give a urine screen for substance abuse?	0	1	2	3	4
13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0	1	2	3	4
14. How often, in your lifetime, have you had legal problems or been arrested?	0	1	2	3	4

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Date of Visit:

PATIENT EDUCATION: SUICIDE RISK PREVENTION

AN IMPORTANT MESSAGE TO THE PATIENT AND/OR PATIENT'S LOVED ONES

If you or a loved one notice these warning signs listed below, seek help **immediately** and/or call one of the available suicide telephone hotlines listed below. Please know that if you have access to firearms or know your loved one has access to firearms, it is important to secure those safely away from reach NOW.

TWO (2) telephone numbers are provided for you today. One number is a national toll-free Suicide Prevention Hotline that is available 24 hours per day, 7 days per week.

- **Suicide Prevention Lifeline: 1-800-273-TALK (8255).** This national crisis hotline number serves English and Spanish speaking callers.
- **El Paso Crisis Hotline: 915-593-7300**

Please Initial the Following Statements

_________ I understand that driving can be dangerous if I am not fully alert and oriented and I will not drive if I feel impared.

_________ I understand that managing my medications may be difficult if I am distracted, angry, or confused and I will ask for help with managing my medications if needed.

_________ I understand that it is important that I am not alone and I will call one of the numbers above if I am feeling lonely, unsafe, or need someone to talk to.

_________ I understand that I should not use drugs, alcohol, or medication not currently prescribed to me in any other way than how my doctor has prescribed them to me.

Suicide risks and warning signs- Please call for help IMMEDIATELY if you experience any of the following warning signs:

* Seeking access to guns, pills, or other potentially harmful items or substances
* Talking or writing about death/dying or suicide when out of the ordinary
*Feeling of hopelessness
* Acting recklessly
* Feeling trapped as if there is no way out
* Increasing alcohol or drug use
* Withdrawl from family and friends
* Feeling anxious, agitated, unable to sleep or sleeping all of the time
* Dramatic Mood chabges
* Seeing no reason for living or having no sense of purpose in life
* Giving away possessions to others that are of importance to the individual
* Cutting one's self or exhibiting other self-destructive or self-harming actions.

I have received my suicide risk prevention education above and I understand it's contents and my duties in regards to the information provided. I have had my questions answered to my satisfaction.

Patient Signature: ______________________________ Date: ____________________

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AGREEMENT AS TO GOVERNING LAW AND FORUM

The patient or the patient's representative and health care provider, including employees and agents of the health care provider, rendering or providing medical care, health care, or safety or professional or administrative services directly related to health care to patient agree: (1) that all health care rendered shall be governed exclusively and only by Texas Law and in no event shall the law of any other state apply to any health care rendered to patient; and (2) in the event of a dispute, any lawsuit, action, or cause of which in any way relates to health care provided to the patient shall only be brought in a Texas Court in the county/district where all or substantially all of the health care was provided or rendered and in no event will any lawsuit, action, or cause of action ever be brought in any other state. The choice of law and forum selection provisions of this paragraph are mandatory and are not permissive.

Patient Signature: ______________________________ Date: ____________________