



Thank you for choosing Precision Pain Consultants. Please completely fill out this form to ensure the fastest and best healthcare service. We may ask you to look over this information from time to time to make sure it stays up-to-date.

Patient Name: _____ Date of Birth: _____
Address: _____ Sex: ___ Male ___ Female
City, State, Zip: _____ Marital Status: M S D W
Social Security Number: _____ Employer: _____
Home Number: _____ Work Phone Number: _____
Mobile Number: _____
Emergency Contact: _____ Emergency Contact Phone Number: _____

Insurance company name and policy number
Primary (See Insurance Card): _____ Insurance company name and policy number/
Secondary (See Insurance Card): _____
Ins. Name: _____ Ins. Name: _____
Policy Holder: _____ Policy Holder: _____
Policy Number: _____ Policy Number: _____
Group Number: _____ Group Number: _____

Primary Care Physician (if applicable): _____

If you are covered under the policy of a spouse, partner, parent, or legal guardian, please tell us about them:

Name of Insured: _____ Social Security Number: _____
Date of Birth: _____ Address: _____
Home Phone Number: _____ Work Phone Number: _____
Mobile Phone Number: _____
Employer: _____ Sex: ___ Male ___ Female
Referring Physician: _____ Referring Physician Phone Number: _____

Dear _____

Your appointment is on _____

At _____ am/pm with:

- Dr. Mihnea Dumitrescu

The attached patient information forms are sent to you to complete at your convenience. Please bring them to your next office visit.

Please Note:

- ❖ If the patient is a minor, we will need their social security number.
- ❖ If the patient is a minor, they will need to be accompanied by their legal guardian.
- ❖ Be sure to list all drug allergies.
- ❖ We will need all guarantor/ responsible party information.
- ❖ A complete list of all medications is needed.
- ❖ Bring your insurance card(s) and your co-payment.
- ❖ Bring any medical records, x-rays, MRI's, CT Scans, etc.
- ❖ All canceled appointments must be called in at least 24 hours prior to your scheduled appointment.

**** IN THE EVENT YOU FORGET YOUR XRAYS OR MRI SCANS, THE OFFICE WILL RESCHEDULE YOUR APPOINTMENT!!!!****

Should you have any other questions, please call us at (512) 892-0490.

Also, please be advised that due to our practice being a specialty, there may be a wait. We do ask for your patience in the event that a delay in your scheduled time occurs.

Thank you,

Precision Pain Consultants



Insurance Verification From Patient

I _____ am currently insured by:

- 1) _____ - Primary Insurance
- 2) _____ - Secondary Insurance
- 3) _____ - Tertiary Insurance

Cobra patients must provide documentation of active coverage on a month-to-month basis provided by employer.

I _____ am currently on a Cobra plan through my employer and am aware that I am responsible for verification of coverage. In the event that I am unable to provide the necessary documentation and my coverage is not valid, I understand that I am personally responsible for all charges incurred at the time services are rendered.

Patient Signature

Date



Workers Compensation Form

Date of Injury: ____/____/____

WC Carrier: _____

Address: _____

Phone: () _____

Fax: () _____

Adjuster: _____

Phone: () _____

Fax: () _____

Claim#: _____

Employer Information

Employer: _____

Address: _____

Phone: _____

WC Contact: _____

Phone: _____

Attorney Information

Do you have representation: ____ YES ____ NO

Attorney's Name: _____

Phone: () _____



Patient Financial Policy

Precision Pain Consultants is dedicated to providing the best possible care and service to you. We regard your understanding of all your financial responsibilities as an essential element of your care and treatment.

- We have made prior arrangements with many insurers and health plans (HMO & PPO) to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the authorized copayment, coinsurance and/or deductible at the time of service. **The office policy is to collect this copayment, coinsurance and/or deductible when you arrive for your appointment.** This amount is an estimate and is based on the most recent insurance verification obtained by our office staff.
- If your insurance policy requires a referral from your Precision Pain Consultants, please understand we will request this referral prior to your appointment, but it is ultimately your responsibility to obtain this referral. If your services are denied because the referral was not received, you will be responsible for the full charged amount.
- **Private Pay patients are required to pay in full at the time of service.** A quote will be provided for any and all procedures prior to your appointment.
- For your convenience we accept VISA, Mastercard, Discover, and American Express. Please be advised that there is a \$20 service charge on all returned checks.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you, if you assign the benefits to our doctor. If your insurance company does not pay our office within 90 days, you will be responsible for payment. If we later receive a check from your insurer we will refund any overpayment.
- All health plans are not the same and do not cover the same services. In the event that your health plan determines a service to be “not covered” you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- If you have a medical procedure performed by our physician at a location other than this office you and/or your insurance company will receive two bills, one from our physician for his professional services and one from the facility where the procedure was performed.
- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.
- If you receive a statement from Precision Pain Consultants the balance needs to be paid in full within 30 days of receipt unless prior arrangements have been made. Any remaining balances due after 90 days will be considered delinquent and will be turned over to an outside collection agency. Future appointments will not be scheduled until balances have been paid in full or a written payment plan has been agreed to by our office. Please be sure to update any contact changes with our office staff. If we are unable to contact you regarding your balance, after 90 days it will be considered delinquent and turned over to an outside collection agency.
- In order to provide the best possible service and availability to all our patients, please call us as early as possible if you know you will need to reschedule your appointment. There will be a \$50.00 cancellation fee charged for all procedure appointments that are missed without advanced notice. This fee must be paid in full before the missed appointment will be rescheduled.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time-to-time.

Patient /Responsible Party Signature

Date



Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier (s), including Medicare, private insurance and other health/medical plan, to issue payment check (s) directly to **Precision Pain Consultants** for medical services rendered to myself and/ or my dependents regardless of my insurance. In the event, that I receive the insurance payment, I realize that I will be billed personally until the balance is paid.

Authorization to Release Information

I hereby authorize Precision Pain Consultants to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Precision Pain Consultants on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Consent to Treat

I authorize the Physicians of Precision Pain Consultants to provide me with reasonable and proper medical care according to today's standards.

Patient/Responsible Party Signature

Date

Witness

Date



Authorization for Release and Disclosure of Protected Health Information

In accordance with state law and regulator agency requirement, the health record is the property of Precision Pain Consultants (PPC). I hereby authorize the PPC Medical Records Custodian to release information from the medical records of:

Patient Name: _____ DOB: _____ SSN: _____

Address: _____ City/ State/ Zip: _____

Telephone: _____ Alternate Contact Number: _____

Information May Be Released To:

Precision Pain Consultants
4613 Bee Caves Rd., Ste 105
Austin, Texas 78746
(512) 892-0490

Facility or Physician:

Name: _____
Address: _____
City/State/Zip: _____
Phone: _____

Please release the following information:

- Problem List, X-Ray Reports, Mental Health, Outside Reports, Progress Notes, X-Ray Films, Drug/ Alcohol, Immunizations, EKG Reports, Lab Reports, HIV/AIDS Test, Medications, History & Physical Exam, Other Reports (Specify)

This information is necessary for the following purpose:

- Continued Patient Care, Personal Use, Attorney/ Legal, Insurance, Other (Specify)

- 1. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol/drug abuse.
2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been release in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:
3. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this in order to assure treatment. I understand that with certain exceptions, I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact the Health Information Management Manager at (512) 892-0490.

Signature of Patient or Legal Representative

Date

Relationship to Patient

Witness

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I, _____, understand that as part of my health care, Precision Pain Consultants originates and maintains paper and/ or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, as well as plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means to facilitate communication among the many healthcare professionals who contribute to my care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided; and
- A tool for healthcare operations of Precision Pain Consultants such as assessing quality of care and reviewing the competence of healthcare professionals.

I understand that as part of Precision Pain Consultants treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity for the purposes stated above.

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of how Precision Pain Consultants may use and disclosure my protected healthcare information. I further understand that Precision Pain Consultants reserves the right to change its *Notice of Privacy Practice*. Should Precision Pain Consultants change its *Notice of Privacy Practices*, an amended copy will be posted in a prominent location in the practice site, or, upon my request, and an amended copy will be sent to the address I have provided.

I agree that Precision Pain Consultants may do the following unless I specifically give direction prohibiting such activity:

- Send visit reminders and test results to the address I have provided.
- Send routine correspondence, such as billing statements, to the address I have provided.
- Leave messages on an answering machine or voicemail associated with the telephone numbers I have provided to either confirm appointments or to request that I call the Practice on medical or billing matters.

Patient's Signature of Signature of Personal Representative

Date



I. PATIENT PROFILE:

Your first visit & medical history

Today Date: ___ / ___ / ___ Patient Name: _____

Your Birth Date: ___ / ___ / ___ Age: _____

Height: _____ Weight: _____

Sex: M F Marital Status: S M D W

II. CHIEF COMPLAINT:

Indicate your primary complaint: (neck, back, extremity, etc.)

III. HISTORY:

A. PRESENT ILLNESS:

When did this pain begin? _____

What were the circumstances that started the pain that you are being seen for today?

Is your pain the result of a ...

___ Fall ___ Auto Accident ___ Injury on the Job ___ Other

Have you had previous diagnostic tests?

Radiological Tests

When and where did you have the exam?

- ___ CT Scans
- ___ MRI
- ___ Myelogram
- ___ Discogram
- ___ EMG/NCS
- ___ Other, Explain: _____

Patient: _____

OFFICE USE ONLY (DO NOT WRITE IN THIS SPACE)

B. COMPLAINTS:

Dominant Pain:

Site:

Character:

Aggravating factors:

Alleviating factors:

Secondary Pain:

Site:

Character:

Aggravating factors:

Alleviating factors:

C. PAIN/PAIN BEHAVIOR:

1. VAS scale: Now _____ Range _____

2. NPDS / Roland Morris: _____

3. MSPQ: _____

4. Zung: _____

5. DRAM: _____

6. DAST: _____

7. Opioid Risk: _____

8. Pain drawing (noted as a reminder for Dr.)

9. Pain medication



Patient: _____

D. PAST MEDICAL HISTORY:

1. List any **ALLERGIES** you have to medications, foods, etc.

Have you ever had a reaction to?

- _____ Iodine / Seafood/ IV Contrast
- _____ Marcaine / Lidocaine
- _____ Steroids
- _____ Versed
- _____ Other

2. Medical Illnesses:

a. Current illnesses: In the last month have you...

- Been on antibiotics _____ No _____ Yes
- Had any invasive procedures _____ No _____ Yes
- Had a GI infection _____ No _____ Yes
- Had a lung infection _____ No _____ Yes

b. Chronic illnesses: Do you have a **CHRONIC ILLNESS**?

Describe. _____

c. Do you have any of the following medical conditions?

- AIDS/HIV _____ No _____ Yes
- Arthritis or joint pain _____ No _____ Yes
- Bleeding disorders _____ No _____ Yes
- Cancer _____ No _____ Yes
- Diabetes _____ No _____ Yes
- Epilepsy _____ No _____ Yes
- Heart problems _____ No _____ Yes
- Hepatitis _____ No _____ Yes
- High Blood Pressure _____ No _____ Yes
- Migraines or Headaches _____ No _____ Yes
- Muscle diseases _____ No _____ Yes
- Psychiatric problems _____ No _____ Yes
- Stomach problems _____ No _____ Yes
- Thyroid problems _____ No _____ Yes

3. Surgeries (non-spinal)

List any other surgeries (give dates)



Patient: _____

E. REVIEW OF SYSTEMS

Recently, have you had?

- Change in sleeping pattern ___ No ___ Yes
- Constitutional Symptoms ___ No ___ Yes
- Eye Problems ___ No ___ Yes
- Ears/Nose/Mouth/Throat Problems ___ No ___ Yes
- Cardiovascular (chest pain) ___ No ___ Yes
- Respiratory (shortness of breath) ___ No ___ Yes
- Gastrointestinal (nausea/vomiting) ___ No ___ Yes
- Genitourinary ___ No ___ Yes
- Musculoskeletal ___ No ___ Yes
- Skin ___ No ___ Yes
- Neurologic ___ No ___ Yes
- Psychiatric ___ No ___ Yes
- Hematologic/Lymphatic ___ No ___ Yes

F. SOCIAL HISTORY:

1. Do you smoke? ___ No ___ Yes ...how many packs a day? _____
2. Do you drink alcohol? ___ No ___ Yes ...how many days a week? _____
3. Marital Status:
4. Employment:

G. FAMILY HISTORY:

Do you have a family history of spine disease? Describe _____

VITALS:

- Blood Pressure
- Pulse
- Resp.
- Temp
- Weight
- Height



Patient Name: _____ DOB: _____

Medication Chart

Precision Pain Consultants is dedicated to offering the best possible treatment for each patient. Help us care for you better by telling us what prescriptions and over-the-counter medications you take. Please update this record every time you visit.

PRESCRIPTIONS			PRESCRIPTIONS		
Name of Medication	Dose	How many times per day?	Name of Medication	Dose	How many times per day?
1)			9)		
2)			10)		
3)			11)		
4)			12)		
5)			13)		
6)			14)		
7)			15)		
8)			16)		

Allergies _____

Main Reason for today's visit:

Other Concerns I would like to discuss if there is time:

Please check all that apply:

I have prescriptions that need to be refilled I need a school or work excuse

I need a referral for my insurance company I need the attached forms filled out

Pharmacy I will use for my prescriptions _____ Phone _____



Medication Agreement and Instruction

You are expected to use your medication appropriately. Do not share, sell or otherwise permit others access to your medication. Take your medication only as directed on the bottle or explained to you by the physicians or physician assistants. Store your medication in a safe place. Count your medication at the pharmacy when receiving it.

Only one provider (physician/physician assistant) should prescribe and maintain your medication.

If you find your medication is not effective, do not increase your medication dosages yourself. Please email info@austinppc.com or call 512.892.0490 to speak with a medical assistant. While we try to answer everybody promptly, you must allow at most 48 hours for response to your email or call. We may schedule a follow-up appointment to discuss some issues.

Please do not contact our office for refills. Please request your prescription refills at least 48 hours prior to medications running out, not counting Saturdays, Sundays, or holidays. This allows for proper review of your history or time for prior authorization required by insurance companies.

In case of lost, stolen, self-increased medication or any other unexplained discrepancies, early refills will not be provided. Non-opioid medication or withdrawal medication may be offered.

Maintain a primary care physician that you see for general or other medical care, lab testing for other acute or chronic health conditions that may require annual or routine monitoring and care.

Provide a list of other medical conditions, medications, and other physicians and notify our office of any changes that may occur.

Allow periodic medication monitoring by urine drug screens (UDS) and other lab testing if necessary as part of your treatment plan. In case of inconsistencies on your UDS, you will be dismissed from our care and offered one month's worth of medication and instructions on how to taper it. Do not use alcohol or take any other mind altering substances while using pain medications. Chronic opioid analgesic therapy may cause dependence, addiction or re-addiction, and tolerance.

Please initial and sign:

_____ I have read and had the opportunity to discuss the information in this MEDICATION AGREEMENT between myself, my physician or physician assistant and Precision Pain Consultants.

_____ I understand that for my safety, failure to follow the instructions detailed in this agreement may result in non- narcotic pain management treatments only, and possible dismissal from services through Precision Pain Consultants.

Patient Name (Printed)

Date

Patient Signature

Witness



Patient Name: _____ Date: _____

Modified Somatic Perception Questionnaire

Please describe how you have felt during the Past Week by making a check in the appropriate box. Please answer all questions. Do NOT think before answering.

	Not at all	A little, slightly	A great deal, quite a bit	Extremely could not have been worse
1. Heart Rate increases				
2. Feeling hot all over	0	1	2	
3. Sweating all over	0	1	2	3
4. Sweating in a particular part of the body				
5. Pulse in the neck				
6. Pounding in head				
7. Dizziness	0	1	2	3
8. Blurring of vision	0	1	2	3
9. Feeling faint	0	1	2	3
10. Everything appearing normal				
11. Nausea	0	1	2	3
12. Butterflies				
13. Pain or ache in stomach	0	1	2	3
14. Stomach churning	0	1	2	3
15. Desire to pass water				
16. Mouth becoming dry	0	1	2	3
17. Difficulty swallowing				
18. Muscles in neck aching	0	1	2	3
19. Legs feeling weak	0	1	2	3
20. Muscles twitching or jumping	0	1	2	3
21. Tense feeling across forehead	0	1	2	3
22. Tense feeling in jaw muscles				



Patient name: _____ Date: _____

Modified ZUNG Depression Index

Please indicate for each of these questions which answers best describe how you have been feeling recently.

	Rarely or none of the time (less than 1 day per week)	Some or little of the time (1-2 days per week)	A moderate amount of time (3-4 days per week)	Most of the time (5-7 days per week)
1. I feel downhearted and sad.	0	1	2	3
2. Morning is when I feel best.	3	2	1	0
3. I have crying spells or feel like it	0	1	2	3
4. I have trouble getting to sleep at night.	0	1	2	3
5. I feel that nobody cares.	0	1	2	3
6. I eat as much as I used to.	3	2	1	0
7. I still enjoy sex.	3	2	1	0
8. I noticed I am losing weight.	0	1	2	3
9. I have trouble with constipation.	0	1	2	3
10. My heart beats faster than usual.	0	1	2	3
11. I get tired for no reason>	0	1	2	3
12. My mind is as clear as it used to be.	3	2	1	0
13. I tend to wake up too early.	0	1	2	3
14. I find it easy to do the things I used to.	3	2	1	0
15. I am restless and can't keep still.	0	1	2	3
16. I feel hopeful about the future.	3	2	1	0
17. I am more irritable than usual.	0	1	2	3
18. I find it easy to make a decision.	3			
19. I feel quite guilty.	0	1	2	3
20. I feel I am useful and needed.	3	2	1	0
21. My life is pretty full.	3	2	1	0
22. I feel the others would be better off if I were dead.	0	1	2	3
23. I am still able to enjoy the things I used to.	3	2	1	0



NECK PAIN and DISABILITY SCALE

Please indicate an X on the grid indicating where your pain is:

How bad is your pain today?

--	--	--	--	--	--	--	--	--	--

(0) NO PAIN

Most Severe Pain(5)

SCORE _____

How bad is your pain on the average?

--	--	--	--	--	--	--	--	--	--

(0) NO PAIN

Most Severe Pain(5)

SCORE _____

How bad is your pain at its worst?

--	--	--	--	--	--	--	--	--	--

(0) NO PAIN

Most Severe Pain(5)

SCORE _____

Does your pain interfere with your sleep?

--	--	--	--	--	--	--	--	--	--

(0) NO PAIN

Most Severe Pain(5)

SCORE _____

How bad is your pain with standing?

--	--	--	--	--	--	--	--	--	--

(0) NO PAIN

Most Severe Pain(5)

SCORE _____

How bad is your pain with walking?

--	--	--	--	--	--	--	--	--	--

(0) NO PAIN

Most Severe Pain(5)

SCORE _____

Does your pain interfere with driving or riding in a car?

--	--	--	--	--	--	--	--	--	--

(0) NO PAIN

Most Severe Pain(5)

SCORE _____

Does your pain interfere with social activities?

--	--	--	--	--	--	--	--	--	--

(0) NO PAIN

Most Severe Pain(5)

SCORE _____

Does your pain interfere with recreational activities?

--	--	--	--	--	--	--	--	--	--

(0) NO PAIN

Most Severe Pain(5)

SCORE _____

NECK PAIN and DISABILITY SCALE

Does your pain interfere with work activities?

--	--	--	--	--	--	--	--	--	--

(0)NO PAIN

Most Severe Pain(5)

SCORE _____

Does your pain interfere with your personal care (eating, dressing, bathing, etc)?

--	--	--	--	--	--	--	--	--	--

(0)NO PAIN

Most Severe Pain(5)

SCORE _____

How has your pain changed your outlook on life and the future (depression, hopelessness, etc.)?

--	--	--	--	--	--	--	--	--	--

(0)NO PAIN

Most Severe Pain(5)

SCORE _____

Does pain affect your emotions?

--	--	--	--	--	--	--	--	--	--

(0)NO PAIN

Most Severe Pain(5)

SCORE _____

Does your pain affect your ability to think or concentrate?

--	--	--	--	--	--	--	--	--	--

(0)NO PAIN

Most Severe Pain(5)

SCORE _____

How stiff is your neck?

--	--	--	--	--	--	--	--	--	--

(0)NO PAIN

Most Severe Pain(5)

SCORE _____

How much trouble do you have turning your neck?

--	--	--	--	--	--	--	--	--	--

(0)NO PAIN

Most Severe Pain(5)

SCORE _____

How much trouble do you have looking up or down?

--	--	--	--	--	--	--	--	--	--

(0)NO PAIN

Most Severe Pain(5)

SCORE _____

How much trouble do you have working overhead?

--	--	--	--	--	--	--	--	--	--

(0)NO PAIN

Most Severe Pain(5)

SCORE _____

How much do pain pills help?

--	--	--	--	--	--	--	--	--	--

(0)NO PAIN

Most Severe Pain(5)

SCORE _____



The Drug Abuse Screening Test (DAST)

Directions: The following questions concern information about your involvement with drugs. Drug abuse refers to (1) the use of prescribed or "over-the-counter" drugs in excess of the directions, and (2) any non-medical use of drugs. Consider the past year (12 months) and carefully read each statement. Then decide whether your answer is YES or NO and check the appropriate space. Please be sure to answer every question.

Table with 28 rows of screening questions and two columns for YES and NO answers.

Patient Signature _____ Date _____



OPIOID RISK TOOL

Patient Name: _____ Date: _____

mark each
box that applies

- 1. Family history of substance abuse
 - Alcohol []
 - Illegal Drugs []
 - Prescriptions Drugs []

- 2. Personal history of substance abuse
 - Alcohol []
 - Illegal Drugs []
 - Prescriptions Drugs []

- 3. Age (mark box if 16-45) []

- 4. History of preadolescent sexual abuse []

- 5. Psychological disease
 - Attention deficit Disorder []
 - Obsessive Compulsive Disorder
 - Bipolar
 - Schizophrenia

 - Depression []

Patient Signature: _____