PATIENT REGISTRATION

Please complete this form as fully as possible to assist us in your evaluation and treatment. Please read each question carefully and answer to the best of your ability. This information is part of your medical record and is governed by our Privacy Practice Policy.

Personal Information

Last Name: _____ First Name: _____

Middle Initial: _____ Sex: Male: ___ Female: ____ Date of Birth: _____

Social Security#: _____ Height: _____ Weight: _____ Race: _____

Driver's License #: _____ State: _____ email:_____

Marital Status:
Married___ Single ____ Divorced____ Widowed_____ Separated ____ Domestic Partner ____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone #: _____

Cell Phone: _____ Work Phone_____

May we leave messages on your answering machine? Yes____ No___

May we send text reminders to your cell phone? Yes____ No____

Employer: _____ Phone: _____
Occupation: _____ Address: _____ City: _____ State: _____ Zip: _____
Insurance Carrier: _____ Member Id_____
Group #_____
Card Holder Name: _____ DOB: _____
Secondary Insurance Carrier: _____ Member Id_____
Group #_____
Card Holder Name: _____ DOB: _____
Primary Care Physician_____Phone_____
Referring Physician_____ Phone_____
Emergency Contact Name: _____Relationship:_____
Home Phone #: _____ Cell Phone: _____
Work Phone_____

Patient Signature: _____

Date: _____

WILLIAMSON
PAIN INSTITUTE

PAYMENT AND CONSENT

You are financially responsible for the medical services you receive. Please review our policies below and provide your signature to indicate your agreement to these terms.

PRIVACY PRACTICES:

I acknowledge that I have been given a copy of the Williamson Pain Institute Notice of Privacy Practice and have read it. I understand that I should ask questions if I need any clarification about anything written in the policy.

Payments:
We accept payment by cash, check, visa, Mastercard, discover and American express.
I understand that I am financially responsible for all charges and that I am fully responsible for obtaining any referral required by my insurance carrier. I request that my medical insurance carrier make any payment directly to Williamson Pain Institute for serves rendered to me. As a courtesy, my charges will be filed with my insurance carrier, however, I will be billed if the claim is denied or is not paid in a timely manner. These services involve medication monitoring, including lab testing, urine immunoassay and urine drug testing, injection, imaging ultrasound, and office visits.

Copay/ Coinsurance:
All copay/coinsurance amount, plus any deductible is due when services are rendered, there is a $30 charge for all returned checks in addition to the amount of the check.

No Show/ Cancellation:
If a patient cannot adhere to their scheduled appointment time, they must call the office within the 24 hours of the scheduled appointment time. Williamson Pain Institute reserves the right to charge the patient $25 cancellation/ no show fee. Procedure cancellation/ no show will be charged $50.

Contact Permission:
In the event Williamson Pain Institute need to contact you (patient) regarding an appointment, lab results, medication, or any reason, it is permissible to. (Check that apply)

__ Leave a message on the answering machine

__ Speak with Name: _____ Relationship_____

Treatment
I consent to the performance of all treatments, administration of intra-articular and/or muscular injection with medication including to but not limited to steroid, anesthetic, normal saline, hyaluronan-based/viscosupplement production deemed medically necessary by the physician or the assigned designee. Performance of venipuncture/diagnostic procedures, imaging, ultrasound may be considered medically necessary or advisable of the judgment of the attending physician or their assigned designee.
I fully understand that this is given in advance of any specific diagnosis or treatment. I intend to consent to be continuing in nature, even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.
I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

_____ _____ _____ Patient (or responsible party signature) D.O.B. Date

WILLIAMSON
PAIN INSTITUTE

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

1603 MEDICAL PARKWAY
BLDG. 3, SUITE 330
CEDAR PARK, TX 78613

(512) 244-4383 OFFICE
(844) 938-4727 FAX

Patient Name:_____Date of Birth_____

Address:_____City/State/Zip:_____

Phone: Cell)_____

ABOVE LISTED PATIENT AUTHORIZES THE FOLLOWING HEALTHCARE FACILITY TO MAKE RECORD DISCLOSURE:

Facility Name:_____Facility Phone:_____

Facility Address:_____Facility Fax:_____

City/State/Zip:_____

THE PURPOSE OF DISCLOSURE IS: __Change of Insurance/Physician __Continuation of Care __Treatment __Referral __Other_____

THIS REQUEST AND AUTHORIZATION APPLIES TO: (check all that apply)
__Clinical Notes __Progress Notes __History/Physical __Discharge notes __Radiology reports
__Lab Reports __Urgent care __Pathology Reports __Operative reports __Physician Orders
__Other_____

THIS INFORMATION MAY BE DISCLOSED AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION:
Release to:
WILLIAMSON PAIN INSTITUTE
1603 Medical Parkway Bldg. 3, Suite 330
Cedar Park, TX 78613
FAX: 844-938-4727 PHONE: 512-244-4383

I understand that the authorization for disclosure of records as detailed above, unless specifically limited by me in writing, will extend to all aspects of treatment provided. These records may include testing for all sexual transmitted diseases, AIDS, and hepatitis, as well as drug, alcohol and/or psychiatric information. Williamson Pain Institute is hereby released from all legal responsibility of liability for the release of the above disclosure of information. I have the right to withdraw this authorization at any time and that such revocation must be in writing.

Patient Signature_____Date:_____

Print patient name:_____

THIS AUTHORIZATION EXPIRES 365 DAYS AFTER IT IS SIGNED

PATIENT QUESTIONAIRE

Name: _____

DOB: _____

PAIN HISTORY

Reason for your visit Briefly describe your pain: _____

_____

Duration When did your current pain problem begin (date)? _____

Onset Under what circumstances did your pain first begin?

___ Accident at work on (date) _____

___ Accident at home

___ Auto accident

___ Unknown

___Following surgery

___ Following an illness

___ Sports injury

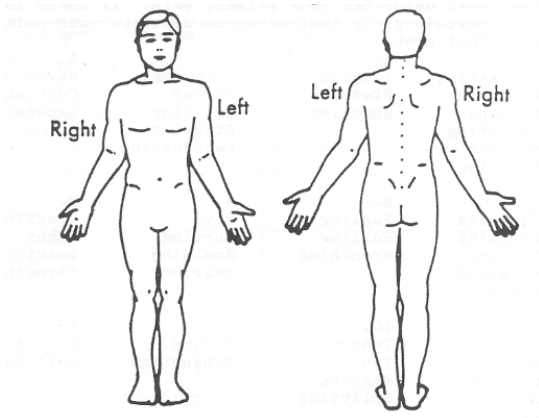
___ Other

Describe the speed of onset of pain ___ Sudden ___ Abrupt ___ Gradual ___ Other

Severity On a scale of 1 - 10, grade your pain. ___ At it's worst ___ At it's best ___ At this moment

(0= No Hurt | 1-2= Hurts a little bit | 3-4= Hurts a little more | 5-6= Hurts even more | 7-8= Hurts a whole lot 9-10= Hurts the worst)

Location Mark on the drawings the areas where you feel pain:



Frequency

How often do you have this pain?

___ Occasionally ___ Constantly ___ Daily ___ Weekly ___ Monthly

What time of day is your pain worst?

___ Morning ___ Afternoon ___ Evening ___ Night

What time of day is your pain the least?

___ Morning ___ Afternoon ___ Evening ___ Night

WILLIAMSON
PAIN INSTITUTE

PATIENT QUESTIONAIRE

Name: _____

DOB: _____

Past Medical History

Check any of the following medical conditions you have had or current:

___ COPD ___ Arthritis ___ Hernia ___ Diabetes ___ Asthma ___ High cholesterol ___ Cancer

___ GERD (reflux) ___ High blood pressure ___ Hepatitis ___Depression ___ Kidney disease

___ Addiction/substance abuse ___ Migraines ___ Mental illness ___ Anxiety ___ Heart disease

___ Renal disease ___ Memory loss ___ Thyroid disease ___ Other: _____

_____

Family Medical History

Circle any of the following medical conditions that any of your BLOOD relatives have had or presently have an indicate relationship

Diagnosis **Relationship to you**

COPD _____

Diabetes_____

Addiction/Substance Abuse_____

Arthritis_____

Asthma_____

Bleeding disorder_____

Cancer_____

Chronic pain_____

Depression/ Mental illness _____

Heart disease_____

High Blood Pressure_____

Kidney Disease_____

Stroke_____

Thyroid Disease_____

Other _____

Past Surgical History (Date and Procedure):

_____

_____

_____

_____

_____

WILLIAMSON
PAIN INSTITUTE

PATIENT QUESTIONAIRE

Name: _____

DOB: _____

Medications

Pharmacy name and location:_____

Phone: _____

Are you currently taking any PRESCRIPTION MEDICATIONS? ____ Yes ____ No

If yes, list ALL prescription medications, over-the-counter, vitamins/herb supplements:

_____

_____

_____

_____

_____

Are you currently taking BLOOD THINNERS (i.e. Plavix, Coumadin, Warfarin, Heparin, or Asprin?

____ Yes ____ No

If yes, please list: _____

Please list cardiologist name and facility:_____

Allergies:

Please list all MEDICATIONS you are allergic to and reaction:

_____

_____

_____

_____

_____

WILLIAMSON

PAIN INSTITUTE

PATIENT QUESTIONAIRE

Name: _____

DOB: _____

Systems Review:

Please circle below if you are experiencing or have recently experienced any of the following:

Constitutional:
Weight gain (___lbs)
Weight loss (___lbs)
Exercise intolerance
Unsafe relationship
Chills
Fever
Night Sweats

Eyes/Ears/Nose:
Dry eyes
irritation
Vision change
Difficulty hearing
Frequent nosebleeds
Sinus pressure/drainage

Mouth/throat:
Teeth abnormalities
Bleeding gums
Mouth ulcer
Dry mouth
Mouth bleeding
Snoring
Oral abnormalities
Sore throat

Cardiovascular:
Chest pain or exertion
Arm pain on exertion
Palpitations
Known heart murmur
Light-headed on standing

Respiratory:
Cough
Coughing up blood
Wheezing
Shortness of breath/walking
Shortness of breath/lying
Sleep apnea

Gastrointestinal:
Change in appetite
Abdominal pain
Nausea/vomiting
Vomiting blood
Diarrhea
Black/bloody stools

Genitourinary:
Difficulty urinating
Increased urinary frequency
Urinary loss of control
Blood in urine

Musculoskeletal:
Muscle aches
Muscle weakness
Joint pain
Back pain
Swelling in the extremities

Integumentary (skin/breast):
Dry skin
Itching
Rash
Jaundice
Abnormal mole
Growths/lesions

Neurological:
Frequent or severe headaches
Migraines
Numbness
Weakness
Dizziness
Seizures
Loss of consciousness
Restless

Psychiatric:
Sleep disturbances
Restless sleep
Feeling depressed
Feeling confused
Alcohol abuse

Endocrine
Fatigue
Increased thirst
Cold intolerance
Hair loss
Increased hair growth

Hematologic:
Swollen glands
Easy bruising
Excessive bleeding

Allergic/Immunologic:
Runny nose
Sinus pressure
Itching
Hives
Frequent sneezing

_____

Patient Signature Date

WILLIAMSON
PAIN INSTITUTE

OPIOID RISK TOOL (ORT)

Patient Name:_____ DOB:_____

Instructions: Please read the following questions and circle the true answer "yes" or "no."

1. Family History
   - Is there a history of alcohol abuse in your family? Yes | No
   - Is there a history of illegal drug abuse in your family? Yes | No
   - Is there a history to prescription drug abuse in your family? Yes | No

2. Personal History
   - Do you have a history of alcohol abuse? Yes | No
   - Do you have a history of drug abuse? Yes | No
   - Do you have a history of prescription drug abuse? Yes | No

3. Age
   - Are you between the ages of 16 and 45? Yes | No

4. Sexual Abuse
   - Do you have a history of preadolescent (childhood) sexual abuse? Yes | No

5. Psychological disease
   - Do you have a history of Attention Deficit Disorder (ADD), Obsessive Compulsive Disorder (OCD), Bipolar Disorder, or Schizophrenia? Yes | No
   - Do you have a history of depression? Yes | No

I acknowledge that I have provided you with the most accurate and complete information about my medical history to the best of my ability.

Patient Signature:_____

Date:_____

WILLIAMSON
PAIN INSTITUTE

Medication Agreement: After a thorough review of your medical history, failure of conservative, medical, and surgical management, it may be determined that you require narcotic medication for your chronic pain condition. The risks, complications, and side effects of the medication have been explained to you prior to proceeding with opioid therapy. This agreement applies to all Medications: Narcotic and Non-Narcotic, prescribed by Asad Nawaz, M.D. By signing below, you agree to the following terms. Failure to comply with any of these terms may result in discontinuation of therapy and termination of treatment at Williamson Pain Institute.

This is a legal binding agreement.

- Patient will obtain ALL narcotic prescriptions only from Asad Nawaz, M.D.
- Patient has never been involved in the sale, diversion, illegal possession or transportation of controlled substance including: narcotics, sleeping pills, nerve pills, and/or painkillers.
- Patient does not have a current problem of illegal substance abuse or dependence.
- Patient will take medication only as prescribed and
- under no circumstance allow any other individual to take these medications.
- Patient will follow the advice of Asad Nawaz, M.D. In regard to stopping controlled substances if it is considered necessary.
- Patient consents to unannounced blood/urine drug screenings test to properly assess the effect of narcotics and patient compliance.
- Patient will consent to unannounced pill counts of their medications.
- Patient understands it is their responsibility to make sure that the office has the correct contact information on file (ie; home/cell number, home address).
- If the patient is female of child bearing age, the patient certifies that she is not pregnant and will take appropriate measures to prevent pregnancy during treatment. If patient becomes pregnant, she will notify Dr. Nawaz immediately.
- Patient agrees to referral to other services including professionals from chemical dependency, psychiatry, and behavioral services prior to and during drug treatment.
- Patient agrees to comply with the total treatment plan including other modalities of treatment (ie; Nerve blocks, physical therapy, psychological counseling, etc.) as deemed necessary.
- Patient will keep all appointment as scheduled with Williamson Pain
- Patient understands that medication is to be taken as prescribed ONLY. Patient will not deviate from treatment plan.
- Patient understands medications will not be refilled early. Patient will not call the physician after office hours to get medication refilled.
- If patient ever test positive for ANY illegal drugs the patient's narcotic medication can be stopped.
- If patient is ever found to have received narcotic medication from another provider the patient narcotic medication can be stopped.
- Patient understand that no allowance will be made for LOST, SPILLED, or STOLEN medications.
- If patient goes to an emergency room, urgent care facility or hospital, the patient is required to inform the treating medical staff of the existence of the opioid contract. Patient will notify the office within 1 (one) business day if given any medications.
- If the patient feels that they require more opioid (narcotics) medication than has been prescribed; they must contact Asad Nawaz, M.D. Prior to increasing the dose.
- Patient will allow Asad Nawaz, M.D. And/or staff to communicate with the referring physicians and pharmacists regarding the use of narcotics.

- Patient WILL NOT dispose of medications without discussing with Dr. Nawaz. If it is determined the medications need to be disposed of, the medications will be brought to the office, so they can be destroyed of properly.
- Patient WILL NOT use any illegal drugs or mix alcohol with any of the prescribed medications.
- Patient understands that if I am verbally or physically abusive to any staff member or engage in any illegal activity such as altering a prescription, that the incident may be reported to other physicians, local medical facilities, pharmacies and other authorities such as the local police department, drug enforcement agency, etc. as deemed appropriate for the institution.
- Prescription Source: All medications prescribed to you must be obtained from Williamson Pain or another licensed provider within the state of Texas.
- Prohibited Sources: You agree not to obtain medications from any sources outside of the United States, including but not limited to overseas pharmacies or providers in Mexico and Canada.
-

I have read this document, understand it and have had all my questions answered to my satisfaction. I consent to the use of opioids (narcotics) to help control my pain and understand that the treatment will be conducted in accordance with the conditions stated above.

_____ _____

Print Patient Name **Date of Birth**

_____ _____

Patient Signature **Date**

_____ _____

Asad Nawaz, M.D. **Date**

_____ _____

Witness Signature **Date**

WILLIAMSON
PAIN INSTITUTE

TELEMED CONSENT

TO BETTER SERVE THE NEEDS OF THE COMMUNITY, ESPECIALLY CONSIDERING THE CORONAVIRUS PANDEMIC, HEALTH CARE SERVICES ARE NOW AVAILABLE USING TELECOMMUNICATIONS OR INFORMATION TECHNOLOGY ("TELEMEDICINE"). TELEMEDICINE INVOLVES THE USE OF REAL-TIME EVALUATION, DIAGNOSIS, CONSULTATION, AND TREATMENT OF HEALTH CONDITIONS USING INTERACTIVE TELECOMMUNICATIONS TECHNOLOGY.

1. I UNDERSTAND THAT THE SAME STANDARD OF CARE APPLIES TO A TELEMEDICINE VISIT AS APPLIES TO AN IN-PERSON VISIT.
2. I UNDERSTAND THAT I WILL NOT BE PHYSICALLY IN THE SAME ROOM AS MY HEALTH CARE PROVIDER. I WILL BE NOTIFIED OF, AND MY CONSENT OBTAINED FOR ANYONE OTHER THAN MY HEALTHCARE PROVIDER PRESENTS IN THE ROOM.
3. I UNDERSTAND THAT THERE ARE POTENTIAL RISKS TO USING TECHNOLOGY, INCLUDING SERVICE INTERRUPTIONS, INTERCEPTION, AND TECHNICAL DIFFICULTIES.

A. IF IT IS DETERMINED THAT THE VIDEOCONFERENCING EQUIPMENT AND/OR CONNECTION IS NOT ADEQUATE, I UNDERSTAND THAT MY HEALTH CARE PROVIDER OR I MAY DISCONTINUE THE TELEMEDICINE VISIT AND MAKE OTHER ARRANGEMENTS TO CONTINUE THE VISIT.

4. I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO PARTICIPATE OR DECIDE TO STOP PARTICIPATING IN A TELEMEDICINE VISIT, AND THAT MY REFUSAL WILL BE DOCUMENTED IN MY MEDICAL RECORD. I ALSO UNDERSTAND THAT MY REFUSAL WILL NOT AFFECT MY RIGHT TO FUTURE CARE OR TREATMENT.

A. I MAY REVOKE MY RIGHT AT ANY TIME BY CONTACTING WILLIAMSON PAIN INSTITUTE AT 512-244-4383.

5. I UNDERSTAND THAT THE LAWS THAT PROTECT PRIVACY AND THE CONFIDENTIALITY OF HEALTH CARE INFORMATION APPLY TO TELEMEDICINE SERVICES.
6. I UNDERSTAND THAT MY HEALTH CARE INFORMATION MAY BE SHARED WITH OTHER INDIVIDUALS FOR SCHEDULING AND BILLING PURPOSES.

A. I UNDERSTAND THAT MY INSURANCE CARRIER WILL HAVE ACCESS TO MY MEDICAL RECORDS FOR QUALITY REVIEW/AUDIT.

B. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY OUT-OF-POCKET COSTS SUCH AS COPAYMENTS OR COINSURANCES THAT APPLY TO MY TELEMEDICINE VISIT.

C. I UNDERSTAND THAT HEALTH PLAN PAYMENT POLICIES FOR TELEMEDICINE VISITS MAY BE DIFFERENT FROM POLICIES FOR IN-PERSON VISITS.

7. I UNDERSTAND THAT THIS DOCUMENT WILL BECOME A PART OF MY MEDICAL RECORD.

BY SIGNING THIS FORM, I ATTEST THAT I (1) HAVE PERSONALLY READ THIS FORM (OR HAD IT EXPLAINED TO ME) AND FULLY UNDERSTAND AND AGREE TO ITS CONTENTS; (2) HAVE HAD MY QUESTIONS ANSWERED TO MY SATISFACTION, AND THE RISKS, BENEFITS, AND ALTERNATIVES TO TELEMEDICINE VISITS SHARED WITH ME IN A LANGUAGE I UNDERSTAND.

_____ _____ _____

PATIENT/PARENT/GUARDIAN PRINTED NAME PATIENT/PARENT/GUARDIAN SIGNATURE DATE

_____ _____

WITNESS SIGNATURE DATE

WILLIAMSON
PAIN INSTITUTE

PHYSICIAN ASSISTANT
CONSENT FOR TREATMENT

THIS FACILITY HAS ON STAFF A PHYSICIAN ASSISTANT TO ASSIST IN THE DELIVERY OF MEDICAL (MAY INDICATE SPECIALTY) CARE.

A PHYSICIAN ASSISTANT IS NOT A DOCTOR. A PHYSICIAN ASSISTANT IS A GRADUATE OF A CERTIFIED TRAINING PROGRAM AND IS LICENSED BY THE STATE BOARD. UNDER THE SUPERVISION OF A PHYSICIAN, A PHYSICIAN ASSISTANT CAN DIAGNOSE, TREAT AND MONITOR COMMON ACUTE AND CHRONIC DISEASES AS WELL AS PROVIDE HEALTH MAINTENANCE CARE.

"SUPERVISION" DOES NOT REQUIRE THE CONSTANT PHYSICAL PRESENCE OF A SUPERVISING PHYSICIAN, BUT RATHER OVERSEEING THE ACTIVITIES OF AND ACCEPTING RESPONSIBILITY FOR THE MEDICAL SERVICES PROVIDED.

A PHYSICIAN ASSISTANT MAY PROVIDE SUCH MEDICAL SERVICES THAT ARE WITHIN HIS/HER EDUCATION, TRAINING AND EXPERIENCE. THESE SERVICES MAY INCLUDE:

· OBTAINING HISTORIES AND PERFORMING PHYSICAL EXAMS
· ORDERING AND/OR PERFORMING DIAGNOSTIC AND THERAPEUTIC PROCEDURES
· FORMULATION A WORKING DIAGNOSIS
· DEVELOPING AND IMPLEMENTING A TREATMENT PLAN
· MONITORING THE EFFECTIVENESS OF THERAPEUTIC INTERVENTIONS
· ASSISTING AT SURGERY
· OFFERING COUNSELING AND EDUCATION
· SUPPLYING SAMPLE MEDICATIONS AND WRITING PRESCRIPTIONS (WHERE ALLOWED BY LAW)
· MAKING APPROPRIATE REFERRALS

I HAVE READ THE ABOVE, AND HEREBY CONSENT TO THE SERVICES OF A PHYSICIAN ASSISTANT FOR MY HEALTH CARE NEEDS.

PRINT NAME:_____

SIGNATURE: _____ DATE:_____