Texas Pain Partners

Dr. Shaun Jackson

(Please fill out this form. Please sign and date the bottom of the form.)

Patient First Name:_____ Patient DOB:_____

Patient Last Name:_____

Patient Primary Address:_____

City:_____ State:_____ Zip code:_____

Preferred Reminder Method: ___ mail ___home ___ phone ___ cell phone ___ patient portal (must sign consent form)

Gender: __male __ female Marital Status: ____Single ___Married ___ Widowed ___ Divorced

Race: ____Declined ____White ___Black or African ___Asian ____Other:_____

Ethnic Group: ___Declined ___ Hispanic ___Not Hispanic or Latino ___Other: _____

Emergency Contact: _____

Phone# (_____)_____ Relationship: _____

Do you give permission to release medical information to this person? _____YES _____ NO

Pharmacy

Name: _____

Address: _____

Phone #: _____

Primary Care Physician

Name: _____

Address: _____

Phone #: _____

I certify that the above demographic information is correct.

Signature: _____ Date:_____

Information Form Date: _____

Name: _____ Date of birth: _____

Employer: _____ Occupation: _____

Do you work now? Yes No Part-time What does your work involved?_____

Name of Doctor who referred you: _____

List of other Doctors you have seen for this pain problem:_____

_____

_____

Give details of injury or circumstances causing your pain:_____

_____

_____

Were you injured on the job? Yes No

How and when were you treated for this problem? _____

_____

_____

Have you had surgery for this problem? Yes No

If YES give: Date Hospital Name of surgeon

_____ _____ _____

_____ _____ _____

_____ _____ _____

Test performed: X ray's MRI CT scan EMG Bone Density test

Lab work Other test

Where and When: _____

What is your pain status now? Worst Better Same Has it changed and how?_____

_____

What other treatment have you received: (i.e bedrest, physical therapy, chiropractic therapy)

_____

_____

Medications

Drug Allergies/ Food allergies: _____

_____

Please list medication you have previously taken for pain:

Medication and dosage	Was it helpful? Yes or no	Reason for stopping
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list medications you are currently taking for Pain:

Medication and dosage	Is it helpful?	Prescribing Doctor
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list other medications you are CURRENTLY TAKING (include vitamin and supplements etc.)

Medication and dosage	Prescribing Doctor
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please circle on a scale of 0 to 10: (0 is no pain……10 is the worst imaginable)

At its best 0 1 2 3 4 5 6 7 8 9 10

Most of the time 0 1 2 3 4 5 6 7 8 9 10

At its worst 0 1 2 3 4 5 6 7 8 9 10

For the following descriptions, place a SINGLE number for each word that describes your pain:

None= 0	Mild=1	Moderate=2	Severe= 3
Throbbing _____	Gnawing _____		Splitting _____
Shooting _____	Hot/ Burning _____		Tiring_____
Stabbing/Sharp_____	Aching _____		Sickening _____
Tender _____	Fearful _____		Heavy _____
Cruel _____	Cramping _____		

Married? Yes No
How many children's do you have? _____
Level of education? _____
What type of work do you do? _____
Have you lost or gained weight in the last six months? Yes No
How many pounds? _____ please check: _____ lost _____ gained
Do you: Drink alcoholic beverage? _____ Yes (amount) _____
Do you smoke? _____ Yes (how much)_____
Have you ever been treated for addiction? Yes No

Family history (circle all that applies TO YOUR FAMILY)

Asthma	Genetic Disorder	Kidney Problems
Arthritis	Headaches	Lung Problems
Cancer	Heart Problems	Seizures
Diabetes	Hypertension	Tuberculosis

Others: _____

Past Medical History Please circle any of the following that **APPLY TO YOU**

Anxiety	Constipation	GI bleed	Heart problems	Kidney problems
Tuberculosis	Arthritis	Depression	Glaucoma	HIV
Lung problems	Asthma	Diabetes	Hepatitis	Hypertension
Stomach Ulcer	Cancer	Genetic Disorder	Headaches	Impotence
Seizures				

Other:_____

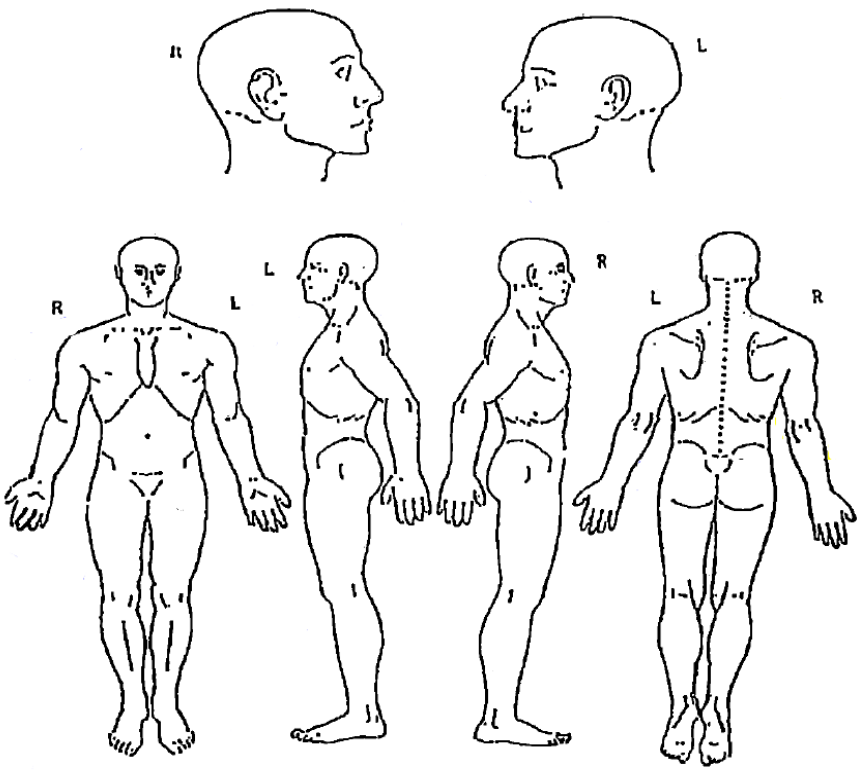
Surgical history:

Date:	Name of surgery:	Name of provider:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please mark the diagrams where you feel the symptoms described. You may have more that cone body area affected by these symptoms and you may have more than one symptoms in one specific area. **Mark each area with each symptom you feel in each location.**

As an example, if the symptoms is described as burning: mark for burning is **XXX,** put the **XXX** in the area where you feel a burning sensation. You may also experience **perspiration** in a specific area, but nowhere else. The symbol to mark in that area on the diagram is PPP. In addition, you may feel numbness in your fingers, but **dull/aching** pain in your shoulders. Mark these body area with the corresponding symbols +++ and **NNN**.

Burning = XXX	Dull/Aching = DDD	Numbness = NNN
Spasm/Cramps = SSS	Perspiration = PPP	Stabbing/sharp = !!!
Pins & Needles = ///	Sensitive to tough = ###	Swelling = ***



Texas Pain Partners, PLLC.
423 Treeline Park, Suite 325
San Antonio, Tx 78209
Phone# (210) 546-1460 Fax# (210) 447- 6351

I hereby authorized Texas Pain Partners, Inc to take my photograph for inclusion I my medical chart retained by the clinic. I understand this photograph is solely for the purpose for identification and familiarization by the office staff and the clinic physician.

_____
Patient signature

Please fill out and sign the following release form so we can obtain copies of any medical records that may be needed in order to assess your condition more thoroughly.

Date: _____

I, _____ hereby authorize the release of my medical records to Texas Pain Partners.

_____ _____
Patient signature Date

_____ _____
Witness Date

Primary Care Physician: _____

Address: _____

Phone and Fax#: _____

Texas Pain Partners, PLLC.

423 Treeline Park, Suite 325
San Antonio, Tx 78209
Phone: (210)546-1460
Fax: (210)546-1459

Shaun Jackson M.D.
Christopher McAllister M.D.
Whitney Jackson D.N.P, A.P.R.N, F.N.P-C

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient name: _____ DOB: _____

SSN:_____

I hereby authorize the release of any medical records to:

Texas Pain Partners, PLLC.
Dr. Shaun C. Jackson M.D.
423 Treeline Park, Suite 325
San Antonio, Tx 78209
Phone: (210)546-1460

Request medical records from: _____

_____

_____

Please check all that apply:

___ Labs
___Imaging
___Others_____

___ Progress notes
___ All medical records

Patient signature:_____ Date:_____/_____/_____

This authorization will automatically expire two (2) years from the date signed

In order to comply with regulation for Health Insurance Portability and Accountability Act HIPAA governing the confidentiality of patient information a completed HIPAA compliant. Authorization to Release Medical Records must accompany each request for medical records even though you may have already obtained a signed consent from the patient.

We are sorry for any inconvenience this may cause**,** but the law were enacted to protect the confidentiality of medical information. Physician must comply with HIPAA privacy standards by requiring a fully completed form with all required information before releasing patient information. Thank you for your corporation.

Request with incomplete addresses will not be processed

Texas Pain Partners, PLLC.

423 Treeline Park, Suite 325
San Antonio, Tx 78209
Phone: (210)546-1460
Fax: (210)546-1459

Shaun Jackson M.D.
Christopher McAllister M.D.
Whitney Jackson D.N.P, A.P.R.N, F.N.P-C

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient name: _____ DOB: _____

SSN:_____

I hereby authorized the release of records to:
Name:_____

_____

_____

Records requested: _____

_____

For the purpose of: _____

_____

_____

Patient signature:_____ Date:_____/_____/_____

This authorization will automatically expire two (2) years from the date signed

In order to comply with regulation for Health Insurance Portability and Accountability Act HIPAA governing the confidentiality of patient information a completed HIPAA compliant. Authorization to Release Medical Records must accompany each request for medical records even though you may have already obtained a signed consent from the patient.

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ASSIGNMENT OF BENEFITS

Private insurance authorization for assignment of benefits and information release:

I, the undersigned, authorize payment of medical benefits to Texas Pain Partners for any services furnished to me by the physician. I understand I am financially responsible for any amount not covered by my insurance policy. I also authorized Texas Pain Partners to release to my insurance company, referring physician and other consultants on my case information concerning healthcare, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating the administering claims of benefits.

Patient sign:_____ Date: _____

MEDICARE LIFTTIME SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made on my behalf to Texas Pain Partners for any services furnished to me by the physician. I authorized any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Patient sign:_____ Date:_____

Certification

Texas Pain Partners, PLLC is pleased to offer you treatment for your injury or suffering. However, you are advised that according to most commercial insurance policies and generally accepted practice, treatment for work related chronic injuries must first be filed under Texas Workman's Compensation. We will be happy to assist you this process. Also if this is a litigation case, our office needs to be informed before services are rendered.

I _____ hereby certify that I am/ I am not treatment for ***an illness or injury that resulted from an incident/accident at my place of work or from a motor vehicle accident.***

MVA/Date of Incident: _____

If applicable, Attorney's Name _____ Phone: _____

Patient Print Name: _____ Date: _____

Patient Signature: _____

Health Insurance Portability and Accountability Act

By signing this document, I Acknowledge that I have been given the opportunity to read the Notice of Privacy Practices of Texas Pain Partners, PLLC.

_____ _____

Patient Print and Signature Date

NO-SHOW/LATE CANCELLATION POLICY

- Texas Pain Partners, PLLC. cultivates a doctor-patient relationship that is based on trust, focusing on patient as individuals. Our physician and excellent support staff strive to be fair and courteous in all of our dealings.
- The following policy has been established to help us serve you better. It is necessary for us to make appointments in order to see our patient as efficiently as possible. No-shows and late cancellations cause problems that go beyond any financial impact to our practice. When appointments is made, it takes an available time slot away from another patient in need of medical care. No cancelling and appointment is a timely fashion is unfair to other patient, some of whom may be quite ill and may unnecessarily delay of delivery of health care. For their reasons we have developed the following No-show/Late Cancellation policy.
- A no-show is defined as missing a scheduled appointment without calling us in advanced to cancel the appointment. A late cancellation is defined as failing to cancel or rescheduled a scheduled appointment by 3 p.m. the day before your scheduled appointment. We request that if your need to cancel or rescheduled your appointment, you must contact our office no later than 3 p.m. the day before your scheduled appointment so that we may office the appointment time to another patient who is in need of medical attention.
- We understand that everyone might have unforeseen events in which you cannot make our appointment with us so we have allotted you one grace appointment each calendar year in which you will not be charged a fee, as described below, for that sudden emergency.
- For each subsequent no-show or late cancellation during the same calendar year, we are charging the normal fee of $50 for office visits and $100 for procedures to cover for the staff that is on hand to provide your needs, this charge will apply to change to your insurance carrier or Medicare, as applicable. These fees are your financial responsibility and they must be paid prior to making any new appointment. A patient who ho-shows there times within a twelve month period, regardless of whether it is in the same calendar year, is subject to dismissal from the practice.
- Finally, we understand that the circumstances beyond your control may arise, where adequate notice is not possible. These limited situations will be considered on a case by case basis.
- Please understand that the intent of this policy is to aid us in offering a high standard of care to our patient and that this policy is in place to help us achieve that goal. We pledge to do out part to keep our schedule mobbing as efficiently as we possibly can. We value you as a patient and appreciate your understanding and cooperation.

I acknowledge that I have read and understand this No-show/Late Cancellation Policy I further understand that I will incur fees in the event I fail to notify this office before 3 p.m. the day before my scheduled appointment or if I fail to show up for my scheduled appointment. Any fees uncured are my responsibility to pay and in the event I incur a fee shall be pain prior to making any new appointment.

Patient Name:_____

Patient Signature:_____ Date:_____