Texas Pain
PARTNERS

Medical Forms Guide

Table of Contents

Texas Pain Partners PLLC
45 NE Loop 410 Suite 850, San Antonio, TX 78216
Phone: 210-805-9800 | Fax: 210-805-8770 | www.txpainpartners.com

Welcome to Texas Pain Partners

Dear Patient,

Welcome to Texas Pain Partners (TPP). We are honored that you have chosen us to provide your pain management care. Our dedicated team of healthcare professionals is committed to providing you with the highest quality of care in a compassionate and respectful environment.

You may have previously received care through our parent company, Consultants in Pain Medicine (CIPM). As part of a strategic transition, all patient services are now being provided by Texas Pain Partners. This change will not affect the continuity or quality of your care, and your current provider will continue to be involved in your treatment under the new organization.

At Texas Pain Partners, your comfort, safety, and well-being are our top priorities. We will continue to offer a full spectrum of pain management solutions tailored to your specific needs, including interventional procedures, medication management, and coordinated care planning.

To facilitate a smooth transition, we kindly ask that you complete the enclosed forms and authorizations. These will allow us to access your previous medical records from CIPM and ensure a seamless transfer of your care.

If you have any questions about this transition or your care, please do not hesitate to contact our office at 210-805-9800 or email us at info@txpainpartners.com.

Thank you for continuing to trust us with your care at Texas Pain Partners. We look forward to working with you toward better pain management and improved quality of life.

Warm regards,

Texas Pain Partners Leadership Team

Texas Pain Partners PLLC
45 NE Loop 410 Suite 850, San Antonio, TX 78216
Phone: 210-805-9800 | Fax: 210-805-8770 | www.txpainpartners.com

New Patient Registration Form

Please complete all sections below. All information is confidential.

Patient Information

First Name: _____ Last Name: _____

Date of Birth: _____ Social Security Number: _____

Gender: ☐ Male ☐ Female ☐ Other Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Race: ☐ Decline ☐ White ☐ Asian ☐ Black or African American ☐ Other_____

Ethnic Group: ☐ Decline ☐ Hispanic ☐ Not Hispanic or Latino ☐ Other_____

Driver's License: _____ State: _____ Expiration Date: _____

Address Line 1: _____

Address Line 2: _____

City: _____ State:_____ Zip Code: _____

Home Phone: _____ Cell Phone:_____ Work Phone: _____

Email Address: _____ Interpreter Needed: ☐Yes ☐No

Preferred Language: ☐ English ☐Spanish ☐Other:_____

Emergency Contact

First Name: _____ Last Name:_____

Relationship: ☐ Spouse ☐ Relative ☐ Son ☐ Daughter ☐ Partner ☐ Other:_____

Home Phone: _____ Cell Phone:_____ Work Phone: _____

Preferred Reminder Method:

☐Mail ☐Home Phone ☐Cell Phone ☐Email ☐Patient Portal **(Must sign a consent form)**

Previous Pain Doctor: ☐ No ☐ Yes Diagnosis:_____

If selected Yes: Physician Name_____ Phone_____

Address_____

MRI's: ☐ Yes ☐ No CT's: ☐ Yes ☐ No X-ray's: ☐ Yes ☐ No

Are you seeking treatment for an injury related to: ☐ Work ☐ Motor Vehicle Accident ☐ Other

Insurance Information

Primary Insurance: ☐ Yes ☐ No

Primary Insurance Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Policy #: _____ Group #: _____

Policyholder Name: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Guardian

Secondary Insurance: ☐ Yes ☐ No

Secondary Insurance Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Policy #: _____ Group #: _____

Policyholder Name: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Guardian

Preferred Pharmacy: _____ **Phone:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Responsible Party (If different from patient)

First Name: _____ Last Name: _____

Relationship: ☐ Spouse ☐ Relative ☐ Son ☐ Daughter ☐ Partner ☐ Other

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address _____

City: _____ State: _____ Zip Code: _____

Patient Signature: _____ Date: _____

Signing Authority (if not patient): _____ Date: _____

Relationship: ☐ Spouse ☐ Relative ☐ Son ☐ Daughter ☐ Partner ☐ Other: _____

CPM Consultants in Pain Medicine

Authorization to Release Medical Records

Patient Name: _____ **Date of Birth:** _____

Address:_____ **City:**_____ **State:**___ **Zip:** _____

Phone Number: _____ **Email (optional):** _____

I hereby authorize the release of my medical records as follows:

FROM: **Consultants in Pain Medicine, PLLC** *(or its custodian, Texas Pain Partners, PLLC)*
Address: 45 NE Loop 410, Ste. 850, San Antonio, TX 78216
Phone: 210-805-9800
Fax: 210-805-8770

TO: **Texas Pain Partners, PLLC**
Address: 45 NE Loop 410, Ste. 850, San Antonio, TX 78216
Phone: 210-805-9800
Fax: 210-805-8770

Purpose of Disclosure (Check one):

✓ Continuity of Care ☐ Transfer of Care to New Provider ☐ Personal Use
☐ Insurance ☐ Other: _____

Information to be Released:

✓ All medical records; **OR** (check those requested below):

☐ Progress notes ☐ Procedure/Operative reports ☐ Medication history ☐ Lab reports
☐ Imaging/Radiology ☐ Other: _____

Delivery Method:

✓ Electronic Medical Record Transfer ☐ Encrypted Email
☐ Fax ☐ Paper Copy (Mail or Pick-Up)

Authorization & Acknowledgment:

I understand that:

- This authorization is voluntary and may be revoked at any time by submitting a written request to the releasing party, except to the extent that action has already been taken based on this authorization.
- Once information is released, it may no longer be protected by HIPAA.
- I may be responsible for any applicable fees allowed under Texas law for the processing and copying of medical records, postage and other delivery expenses.
- This authorization will expire two **years** from the date signed unless otherwise specified below:

Signature of Patient: _____ **Date:** _____

- If signed by a personal representative (*e.g.,* legal guardian, medical POA), complete:
  Print Name:_____Relationship:_____
  AND attach documentation of legal authority.

Texas Pain Partners PLLC
45 NE Loop 410 Suite 850, San Antonio, TX 78216
Phone: 210-805-9800 | Fax: 210-805-8770 | www.txpainpartners.com

Consent and Authorization Forms

Consent to Treatment

I voluntarily consent to evaluation and treatment by the healthcare providers at Texas Pain Partners PLLC. I understand that my treatment may involve diagnostic procedures, physical examinations, and other medical treatments deemed necessary by my provider.

I understand that I have the right to ask questions and receive explanations about my treatment before procedures are performed. I also understand that I may withdraw this consent at any time by notifying Texas Pain Partners in writing.

Patient Signature:_____ Date:_____

Signing Authority (if not patient):_____ Date:_____

Relationship: ☐ Spouse ☐ Relative ☐ Son ☐ Daughter ☐ Partner ☐ Other:_____

Acknowledgment of Receipt of HIPPA Notice of Privacy Practices Form

I acknowledge that I have received a copy of the Texas Pain Partners PLLC Notice of Privacy Practices. I understand that this Notice describes how my medical information may be used and disclosed, and how I can access this information.

I understand that Texas Pain Partners may revise its Notice of Privacy Practices at any time and that I may obtain a revised copy by contacting the office or visiting the website at www.txpainpartners.com.

Patient Signature:_____ Date:_____

Signing Authority (if not patient):_____ Date:_____

Relationship: ☐ Spouse ☐ Relative ☐ Son ☐ Daughter ☐ Partner ☐ Other:_____

Photograph

I hereby authorize Texas Pain Partners PLLC, Inc., to take my photograph for inclusion in my medical chart retained by the clinic. I understand this photograph is solely for the purpose of identification and familiarization by the office staff and clinic physician(s).

Patient Signature:_____ Date:_____

Signing Authority (if not patient):_____ Date:_____

Relationship: ☐ Spouse ☐ Relative ☐ Son ☐ Daughter ☐ Partner ☐ Other:_____

Private Insurance Authorization for Assignment of Benefits and Information Release:

I, _____, the undersigned, authorize payment of medical benefits of Texas Pain Partners PLLC for any services furnished to me by the physician. I understand I am financially responsible for any amount no covered by my insurance policy. I understand I am financially responsible for any and all medical charges. I also authorize Texas Pain Partners PLLC to release to my insurance company, referring physician and other consultants on my case information concerning health care, advice, treatment or supplied provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Patient Signature:_____ Date:_____

Signing Authority (if not patient):_____ Date:_____

Relationship: ☐ Spouse ☐ Relative ☐ Son ☐ Daughter ☐ Partner ☐ Other:_____

Medicare Lifetime Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to Texas Pain Partners PLLC for any services furnished to me by the physician. I authorize 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 Signature:_____ Date:_____

Signing Authority (if not patient):_____ Date:_____

Relationship: ☐ Spouse ☐ Relative ☐ Son ☐ Daughter ☐ Partner ☐ Other:_____

Medication History Consent Form

Texas Pain Partners PLLC, P.A has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your "medication history." A medication history is a list of all prescription medicines that we or other doctors have prescribed for you. This list is collected from a variety of sources including: your pharmacy, your health insurer and other healthcare providers. An accurate medication history is very important in helping us treat you properly and avoiding potentially dangerous drug interactions.

By signing this consent form you give us permission to collect, give your pharmacy and your health plan permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions such as depression. This information will become part of your medical record.

This medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make medication histories available to us and the medication history from your health plan might not include medication that you purchased without using your health insurance. Your medication history might not include over the counter medicine, supplements or herbal remedies. It is still very important for us to take the time to discuss everything you are taking and for you to point out and report any errors in your medication history to our staff.

PATIENT ACKNOWLEDGEMENT

By signing below, I, _____, DOB: _____, give permission for Texas Pain Partners PLLC, Inc., to obtain my medication history from my pharmacy, my health plans and other healthcare providers.

Patient Signature:_____ Date:_____

Signing Authority (if not patient):_____ Date:_____

Relationship: ☐ Spouse ☐ Relative ☐ Son ☐ Daughter ☐ Partner ☐ Other:_____

Texas Pain Partners PLLC
45 NE Loop 410 Suite 850, San Antonio, TX 78216
Phone: 210-805-9800 | Fax: 210-805-8770 | www.txpainpartners.com

Medical History and Medication List

Please provide complete and accurate information. This helps us understand your medical background and deliver appropriate care.

Primary Care Provider: _____ Phone: _____

Address: _____

Medical History

Please check any of the following conditions you currently have or have had in the past:

☐ Anxiety	☐ Arthritis	☐ Asthma	☐ COPD
☐ Depression	☐ Diabetes	☐ Heart Disease	☐ Hepatitis
☐ HIV/AIDS	☐ High Blood Pressure	☐ Kidney Disease	☐ Liver Disease
☐ Osteoporosis	☐ Seizures	☐ Sleep Apnea	☐ Stroke

☐ Other not listed:_____

☐ Cancer, please write in type:_____

☐ Pain pump or Stimulator: (Who implanted, company, functioning)

_____

☐ Consume alcohol? If checked, how many drinks per day/week?_____Day/_____Week

☐ Currently a smoker? If checked, how many per day/week?_____Day/_____Week

Surgical History

List any previous surgeries and the year they occurred:

Surgery:_____ Year:_____

Surgery:_____ Year:_____

Surgery:_____ Year:_____

Allergies

List all known allergies:

Medications:_____

Food:_____

Environmental Factors:_____

Current Medications

List all medications you are currently taking, including over-the-counter, vitamins, or supplements:

	Medication Name	Dosage	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Risk Assessment

Please mark each box that applies:

	Yes	No
Family History of Abuse:		
Alcohol		
Illegal Drugs		
Prescription Drugs		
Personal History of Substance Abuse:		
Smoking		
Alcohol		
Illegal Drugs		
Prescription Drugs		
Age Between 16-25 Years		
Psychological Disease		
ADD, OCD, Bipolar, Schizophrenia		
Depression		
Score Total (To be calculated by medical provider)		

I certify that the above information is accurate and complete to the best of my knowledge.

Patient Signature:_____ Date:_____

Signing Authority (if not patient):_____ Date:_____

Relationship: ☐ Spouse ☐ Relative ☐ Son ☐ Daughter ☐ Partner ☐ Other:_____

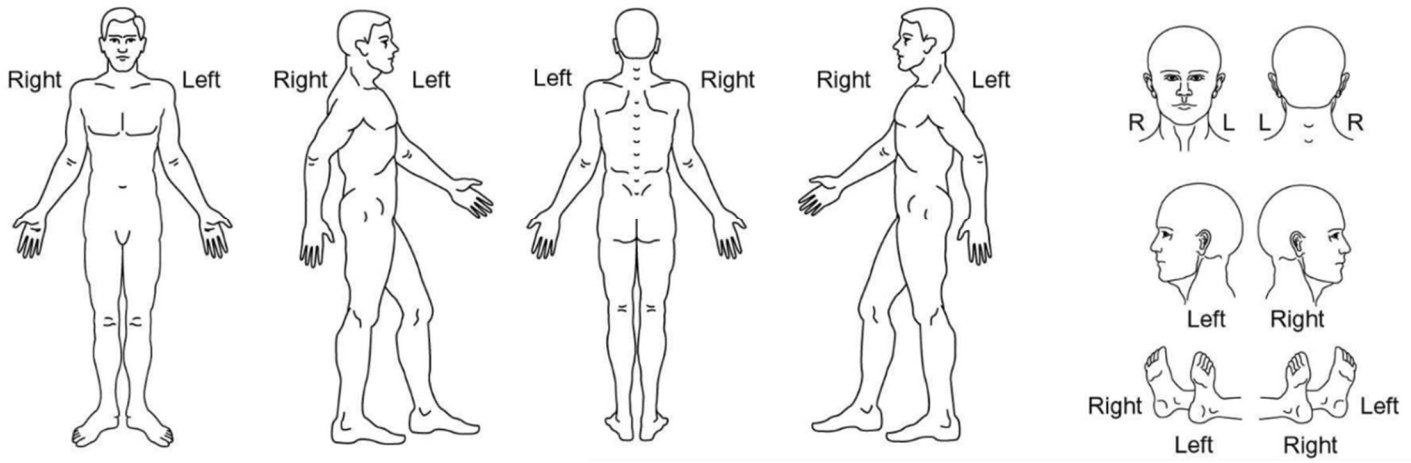
Texas Pain Partners PLLC
45 NE Loop 410 Suite 850, San Antonio, TX 78216
Phone: 210-805-9800 | Fax: 210-805-8770 | www.txpainpartners.com

Initial Patient Assessment Tool

Date:_____

Patient's Name:_____ Age:_____

1. Location: Patient or Nurse mark drawing. (Pink= Pain Blue= Numbness)



2. Intensity: Patient rates the pain.

Scale
On a scale of 1 to 10, 1 being the lowest and 10 being the highest

Present pain:	Worst pain gets:	Best pain gets:	Acceptable level of pain:

3. Is this pain constant? ☐ Yes ☐ No If no, how often does it occur?_____

4 Quality: (For example: ache, deep, sharp, sensitive, itchy, hot, cold) _____

5. Onset, Duration, Variations, Rhythms:_____

6. Manner of expressing pain:_____

7. What relives pain?_____

8. What causes or increases the pain?_____

9. Effects of pain:

Accompanying Symptoms:	Appetite:
Concentration:	Emotions:
Physical activity:	Sleep:
Other:	Urinary Incontinence:

Patient Signature:_____ Date:_____

Signing Authority (if not patient):_____ Date:_____

Relationship: ☐ Spouse ☐ Relative ☐ Son ☐ Daughter ☐ Partner ☐ Other:_____

Texas Pain Partners PLLC
45 NE Loop 410 Suite 850, San Antonio, TX 78216
Phone: 210-805-9800 | Fax: 210-805-8770 | www.txpainpartners.com

Zero Tolerance Policy Acknowledgment

Texas Pain Partners PLLC enforces a Zero Tolerance Policy to maintain a safe and respectful environment.

Purpose:
To emphasize our commitment to providing a safe, respectful, and supporting environment for our patients and their visitors within the Texas Pain Partners PLLC, we have created standards of expected behavior.

We expect everyone to:

- Treat all TPP staff, doctors, other patients, and visitors with courtesy and respect.
- Communicate in a calm and cooperative manner.
- Maintain an alcohol, illegal substance, and weapon free premises.
- Refrain from using abusive, threatening or violent language or behavior.

We have a **zero-tolerance approach** to any form of:

1. **Abusive Language:** Including yelling, swearing or discriminatory remarks.
2. **Threatening Behavior:** Such as intimidation, bullying or verbal threats.
3. **Violence:** Any physical aggression, including throwing objects or assault.
4. **Harassment:** Sexual, racial, or any other form of harassment.
5. **Damage or theft to Property:** Intentional damage to practice property or personal belongings of others.
6. **Smoking, drinking alcohol, vaping, or substance abuse on the premises**
7. **Weapons-possession on the premises is strictly prohibited.**
8. **Discussing medical practice staff, reception staff, management and/or contracting doctors on social media platforms**
9. **Taking videos or photos of medical practice staff, reception staff, management and/or contracting doctors or the practice setting without permission from the practice**

Expected Behavior
Patients and visitors are expected to:

- Cooperate with medical practice staff, reception staff, management and/or contracting doctors and follow reasonable instructions.
- Respect the privacy, dignity and diversity of others.
- Avoid disrupting the care or comfort of other patients.
- Refrain from bringing prohibited items (e.g., weapons, drugs, or alcohol) onto the premises.

I acknowledge and understand the Zero Tolerance Policy as stated above.

Patient Signature:_____ Date:_____

Signing Authority (if not patient):_____ Date:_____

Relationship: ☐ Spouse ☐ Relative ☐ Son ☐ Daughter ☐ Partner ☐ Other:_____

Texas Pain Partners PLLC
45 NE Loop 410 Suite 850, San Antonio, TX 78216
Phone: 210-805-9800 | Fax: 210-805-8770 | www.txpainpartners.com

Informed Consent, Prescription Policy, and Opioid Agreement

This agreement is made between you, the patient, and Texas Pain Partners to ensure safe, responsible, and effective use of controlled substances, including opioids, as part of a comprehensive pain management program. The goal is to improve function and quality of life while minimizing the risk of medication(s) misuse, diversion, and addiction. Failure to comply may result in termination of the patient-provider relationship through Texas Pain Partners and possible notification to Federal, State, or Local Law Enforcement authorities if a crime is believed to have been committed.

Consent to Treatment and/or Drug Therapy: By initialing, I am certifying that I understand and agree:

_____ There is a risk that opiate addiction, and physical dependence, may occur. This means that I may become psychologically dependent on the medication(s). If this occurs, the medication(s) will be stopped and I will be referred to appropriate substance abuse treatment.

_____ Long term use of opioid pain medication(s) will render it less effective over time, which is why it is recommended that the least amount of opioid medication(s) is used for adequate relief.

_____ Texas Pain Partners' goal is to minimize opioid medication usage while controlling my condition with interventional or therapeutic methods.

_____ Opiate medication(s) offer no disease-modifying components and only treat the symptoms of your condition in the short term.

_____ I agree to minimize, safely wean, or discontinue the use of Benzodiazepines if prescribed opiates by Texas Pain Partners due to increased risk of accidental overdose. Benzodiazepines will not be prescribed by Texas Pain Partners.

_____ The risks and side effects of opiate medication(s) include, but are not limited to the following: sedation, drowsiness, feeling sleepy, confusion, change of ability to think clear, difficulty with balance, constipation, nausea, vomiting, decrease in respiration or breathing, low testosterone levels in males, extreme risk of accidental overdose when taken with a benzodiazepine-Such as Ativan, Lorazepam, Xanax, Valium, Diazepam.

_____ Opioid medication(s) use while pregnant are not advised due to the risk of withdrawal for the baby at birth.

_____ The use of more than one opioid medication increases the risk of adverse drug effects. I understand and agree to notify my provider immediately of any adverse effects from the medication(s) so the treatment plan may be modified.

Prescription Policy and Opioid Agreement: By initialing, I am certifying that I understand and agree:

_____ Opioid medication(s) prescribed by Texas Pain Partners is for my use only. I have not, and will not, share, sell, or trade my medication(s) with any other person(s) and understand that doing so is illegal and grounds for immediate discharge.

_____ I will take my medication(s) exactly as directed by the prescribing provider.

_____ I will inform my provider and the clinical team at Texas Pain Partners of all medications I am currently taking at each visit.

_____ I cannot use unauthorized substance(s)/medication(s), illegal drugs, alcoholic beverages, or another person's prescribed medication(s) while I am a patient with Texas Pain Partners.

_____ Under no circumstance may I obtain an opioid medication from any other physician or take old or expired opiate medication(s).

_____ I understand that in the event of an emergency after hours, I will seek care at the nearest emergency treatment facility. Texas Pain Partners should be contacted as soon as reasonably possible after seeking emergency medical care. Controlled medication(s) professionally administered inside a hospital setting do need to be reported to Texas Pain Partners at your earliest convenience.

_____ All of my controlled substance prescription(s) must be obtained at ONE Pharmacy of Record, which I designate:

Pharmacy of Record Name: _____

Phone Number: _____

Location: _____

_____ I will not dispose of my opioid medication(s) without prior permission from my prescribing physician. Disposal of medication(s) can only be done by a medical representative at our facility or at a facility approved by this practice.

_____ I will safeguard my medication(s) from theft by using a lockbox at my home to protect myself and others around me. Stolen or lost medication(s) will not be replaced.

_____ Texas Pain Partners ONLY fills 30-day prescriptions. Out of town travel should be planned accordingly. Texas Pain Partners will not allow early refills.

_____ It is my responsibility to schedule and attend my monthly medication refill appointments. Texas Pain Partners will not call me to make this appointment.

_____ If I fail to schedule or miss my medication refill appointment, Texas Pain Partners will only be able to offer their first available appointment. I understand I may be without medication(s) until then.

_____ Texas Pain Partners may issue me a prescription for a Naloxone product. I agree to fill the prescription and keep it readily at hand in case of an accidental medication overdose.

_____ I am subject to routine and random drug screen tests and/or pill counts at my physician's request in compliance with Texas Medical Board Rule §170.3 and federal guidance regarding pain management protocol.

_____ I MUST comply within 72 hours of receiving the request in order to obtain my monthly prescription and/or continue care at Texas Pain Partners.

_____ I understand that the results of any drug screen will be documented in my medical record and may be shared with referring providers, pharmacies, or legal entities as permitted or required by law.

I understand that my opioid medication(s) may be discontinued if...

_____ I refuse to submit to testing, tamper with samples, or do not comply with the treatment suggested by my provider
_____ I test positive for an illegal substance on a urine drug screen test
_____ I test negative for any prescribed medication(s) on a urine drug test
_____ I test positive for a medication that is not currently prescribed to me
_____ I do not show up and/or do not have the correct medication(s) count at mandatory pill count appointments
_____ I NO SHOW or continually cancel office visit appointments or scheduled interventional procedures
_____ I do not take my medications exactly as directed by my physician.

I agree that I have had ample opportunity to ask any questions regarding informed consent, prescription policy and my opioid contract with my Texas Pain Partners provider to my satisfaction. I have read and understand the Informed Consent, Prescription Policy, and Opioid Agreement. I agree to the terms and conditions stated above and I authorize:

Texas Pain Partners and its medical staff to collect and test urine and/or other biological samples to monitor my medication usage.

My Pharmacy of Record to release any and all patient information to Texas Pain Partners staff for the purpose of medication(s) compliance and my continued patient care.

Any past, present, or future medical treatment providers to release my personal medical information and patient medical records, at the request of Texas Pain Partners. I further authorize the medical treatment provider to discuss my medical treatment and/or medical care with Texas Pain Partners upon their request.

I have read and understand this Controlled Substance Agreement. I agree to the terms and conditions stated above.

Patient Name:_____ Date:_____

Patient Signature:_____

Texas Pain Partners' Staff Witness Signature:_____Date:_____

Texas Pain Partners PLLC
45 NE Loop 410 Suite 850, San Antonio, TX 78216
Phone: 210-805-9800 | Fax: 210-805-8770 | www.txpainpartners.com

Drug Screening Authorization Form

Purpose:

To ensure safe, effective, and compliant management of medications—particularly controlled substances Texas Pain Partners PLLC requires all patients prescribed such medications to participate in routine drug screening. This authorization complies with Texas Medical Board Rule §170.3 and federal guidance regarding pain management protocols.

Authorization and Consent:

I hereby authorize Texas Pain Partners PLLC and its medical staff to collect and test urine and/or other biological samples to monitor my medication usage. I understand that these screenings are required to:

- Ensure compliance with prescribed therapy
- Identify potential misuse, diversion, or abuse of substances
- Comply with state and federal guidelines for controlled substances

Frequency and Conditions:

I acknowledge that drug screening is required as a condition of treatment if I am prescribed controlled substances. I agree to submit to the following without prior notice:

- Initial drug screen at the time of first narcotic prescription
- Random or scheduled screenings every three (3) months thereafter
- Additional tests if misuse or diversion is suspected

Results and Confidentiality:

I understand that the results of any drug screen will be documented in my medical record and may be shared with referring providers, pharmacies, or legal entities as permitted or required by law. I understand that refusal to submit to testing, tampering with samples, or non-compliance may result in modification or discontinuation of treatment, or dismissal from the practice.

Patient Acknowledgment and Signature:
I have read and understand the above information. I have had the opportunity to ask questions, and all my questions have been answered. I voluntarily agree to comply with the drug screening policy of Texas Pain Partners PLLC.

Patient Signature:_____ Date:_____

Signing Authority (if not patient):_____ Date:_____

Relationship: ☐ Spouse ☐ Relative ☐ Son ☐ Daughter ☐ Partner ☐ Other:_____

Provider/Witness Name: _____ Date:_____

Provider/Witness Signature: _____

Texas Pain Partners PLLC
45 NE Loop 410 Suite 850, San Antonio, TX 78216
Phone: 210-805-9800 | Fax: 210-805-8770 | www.txpainpartners.com

Request for Medical Records

Date: _____ Fax: _____

To: _____ From: _____

Patient Name: _____ D.O.B. _____

Patient will see (Write in Dr. Name): _____

Please send:

☐ Last 3 Office Visit Notes ☐ Last X-ray Report ☐ Last MRI Report

☐ Medication List (if available) ☐ Insurance Information ☐ Demographics

☐ Other: _____

Comments:

_____

_____

_____

If you have any question, please call (210) 805-9800.

Thank you for your cooperation.

Texas Pain Partners PLLC
45 NE Loop 410 Suite 850, San Antonio, TX 78216
Phone: 210-805-9800 | Fax: 210-805-8770 | www.txpainpartners.com

Authorization of Beneficiary

Patient Information

First Name: _____ Last Name: _____

Date of Birth: _____ Medical Record Number (if known): _____

Beneficiary Designation

First Name: _____ Last Name: _____

Relationship: ☐ Spouse ☐ Relative ☐ Son ☐ Daughter ☐ Partner ☐ Other:_____

Primary Phone: _____ Secondary Phone:_____ Email: _____

Scope of Authorization

This section authorizes Texas Pain Partners (TPP) to:

- ☐ Share appointment reminders, prescription notifications, and medication pick-up details with my beneficiary.
- ☐ Discuss my controlled substance treatment plan (e.g. medication name, dosage, pickup times).
- ☐ Provide updates on early refills, lost prescriptions, or treatment changes.

I understand that this authorization:

- Permits staff to communicate only non-sensitive information (e.g. medication reminders, basic treatment status).
- Does NOT allow release of full medical records, sensitive health details, or billing/insurance information.
- May be revoked at any time by submitting a written notice to Texas Pain Partners.

Effective Period:
This authorization is valid from: ____/____/____ Until: ____/____/____
☐Indefinitely ☐End of treatment ☐Other:_____

Acknowledgment & Signature
I affirm that I am the patient (or legal guardian) and authorize Texas Pain Partners to share the designated information with the named beneficiary, as outlined above.

Patient Signature:_____ Date:_____

Signing Authority (if not patient):_____ Date:_____

Relationship: ☐ Spouse ☐ Relative ☐ Son ☐ Daughter ☐ Partner ☐ Other:_____

Revocation of Authorization
To revoke this authorization, I must submit a written notice to Texas Pain Partners at the address or email on file. Revocation will not affect disclosures made before TPP received my revocation.

Beneficiary Signature Acknowledgment (optional): _____ Date: _____

TPP Staff (witness) Signature: _____ Date: _____

Texas Pain Partners PLLC
45 NE Loop 410 Suite 850, San Antonio, TX 78216
Phone: 210-805-9800 | Fax: 210-805-8770 | www.txpainpartners.com

Financial Agreement and Office Policies

This document outlines the financial and administrative policies of Texas Pain Partners PLLC (TPP). By signing below, you acknowledge that you have read, understand, and agree to the terms outlined.

Insurance & Billing

- I understand that it is my responsibility to provide accurate and current insurance information at the time of service.
- I authorize TPP to bill my insurance carrier directly for services provided.
- I am responsible for all co-pays, deductibles, coinsurance, and any services not covered by insurance.
- If my insurance company denies payment, I understand that I am responsible for the full amount.

Self-Pay Patients

- I understand that if I do not have insurance or choose not to use it, I am considered a self-pay patient.
- Payment is due in full at the time services are rendered unless a payment plan is arranged in advance.
- Payment plan options may vary and must be approved by the billing department.

Appointment Cancellation & No-Show Policy

- I agree to provide at least 24 hours' notice if I am unable to attend a scheduled appointment.
- I understand that failure to cancel or reschedule in advance may result in a no-show fee.
- The no-show fee is $100 for missed office visits and $200 for missed procedures.

Medical Records Requests

- Medical records are available upon request and may be subject to fees as outlined in the Texas Administrative Code.
- Records may take up to 15 business days to process.
- Authorization of electronic communication

I have read and understand the financial agreement and office policies described above. I agree to comply with these terms.

Patient Signature:_____ Date:_____

Signing Authority (if not patient):_____ Date:_____

Relationship: ☐ Spouse ☐ Relative ☐ Son ☐ Daughter ☐ Partner ☐ Other:_____

Texas Pain Partners PLLC
45 NE Loop 410 Suite 850, San Antonio, TX 78216
Phone: 210-805-9800 | Fax: 210-805-8770 | www.txpainpartners.com

Signature Authorization Page

By signing below, I acknowledge that I have read, understood, and agreed to the following Texas Pain Partners PLLC (TPP) documents as part of my patient onboarding:

☐ Consent to Treat

☐ Authorization to Release Medical Records from CIPM to TPP

☐ Acknowledgment of Receipt of HIPAA Notice of Privacy Practices

☐ Pain Management Contract (Opioid Agreement)

☐ Financial Agreement and Office Policies

☐ Patient Rights and Responsibilities

☐ Interpreter Services Acknowledgment

☐ Telemedicine Consent Form

I understand that these documents may be amended from time to time, and that I may request a current version from TPP at any time. I also understand that refusal to sign any of these forms may impact the services that can be provided to me.

Patient Signature:_____ Date:_____

Signing Authority (if not patient):_____ Date:_____

Relationship: ☐ Spouse ☐ Relative ☐ Son ☐ Daughter ☐ Partner ☐ Other:_____

Texas Pain Partners PLLC
45 NE Loop 410 Suite 850, San Antonio, TX 78216
Phone: 210-805-9800 | Fax: 210-805-8770 | www.txpainpartners.com

Telemedicine Consent Form

Texas Pain Partners PLLC (TPP) offers telemedicine services to provide convenient and timely access to medical care. Telemedicine involves the use of electronic communications to enable healthcare services at a distance, including video conferencing and secure messaging.

Telemedicine Services

By signing this form, I consent to engage in telemedicine with TPP. I understand that:

- Telemedicine allows me to consult with a provider remotely using video or audio technology.
- My medical information will be protected using secure, HIPAA-compliant technology.
- I may decline or withdraw consent at any time without affecting my right to future care or treatment.
- There are potential risks, including interruptions, unauthorized access, or technical failures, which may affect the quality of care.
- My provider may determine that an in-person visit is necessary for further evaluation or treatment.

Technology Requirements

I understand that I must have access to a device with a camera, microphone, and internet connection to participate in telemedicine visits.

I have read and understand the information provided above regarding telemedicine. I have had the opportunity to ask questions, and all my questions have been answered.

Patient Signature:_____ Date:_____

Signing Authority (if not patient):_____ Date:_____

Relationship: ☐ Spouse ☐ Relative ☐ Son ☐ Daughter ☐ Partner ☐ Other:_____

Texas Pain Partners PLLC
45 NE Loop 410 Suite 850, San Antonio, TX 78216
Phone: 210-805-9800 | Fax: 210-805-8770 | www.txpainpartners.com

Interpreter Services Acknowledgment

Texas Pain Partners PLLC (TPP) is committed to providing clear communication and quality care to all patients. Interpreter services are available at no cost to patients who prefer to communicate in a language other than English or who require sign language assistance.

Patient Acknowledgment

Please review and complete the section below to inform us of your communication preferences:

☐ I DO require interpreter services.

Preferred Language: _____

☐ I DO NOT require interpreter services and am comfortable communicating in English.

I understand that I have the right to receive interpreter services when needed. If I require services at any time during my care with Texas Pain Partners, I will inform the staff.

Patient Signature:_____ Date:_____

Signing Authority (if not patient):_____ Date:_____

Relationship: ☐ Spouse ☐ Relative ☐ Son ☐ Daughter ☐ Partner ☐ Other:_____

Texas Pain Partners PLLC
45 NE Loop 410 Suite 850, San Antonio, TX 78216
Phone: 210-805-9800 | Fax: 210-805-8770 | www.txpainpartners.com

Patient Rights and Responsibilities

At Texas Pain Partners PLLC (TPP), we are committed to treating our patients with dignity, respect, and compassion. We believe that informed patients who understand their rights and responsibilities can actively participate in their healthcare.

Patient Rights

• To receive considerate, respectful, and compassionate care regardless of race, ethnicity, age, gender, religion, sexual orientation, or disability.

• To be informed about your diagnosis, treatment, and prognosis in a way that you can understand.

• To ask questions and receive clear answers regarding your care.

• To accept or refuse treatment to the extent permitted by law and to be informed of the medical consequences.

• To privacy and confidentiality concerning your medical care.

• To review and obtain copies of your medical records, subject to legal and policy guidelines.

• To receive care in a safe environment free from all forms of abuse or harassment.

• To voice concerns or complaints without fear of retaliation and to have those concerns addressed promptly.

Patient Responsibilities

• To provide accurate and complete information about your health history and current condition.

• To follow the treatment plan recommended by your provider and to communicate if you do not understand or cannot follow the plan.

• To respect clinic staff, providers, other patients, and visitors.

• To arrive on time for scheduled appointments and provide advance notice for cancellations.

• To fulfill financial obligations related to your care in a timely manner.

• To inform us of any changes in your insurance, contact information, or health status.

I acknowledge that I have read and understand the Patient Rights and Responsibilities outlined above. I agree to uphold my responsibilities and understand my rights as a patient of Texas Pain Partners.

Patient Signature:_____ Date:_____

Signing Authority (if not patient):_____ Date:_____

Relationship: ☐ Spouse ☐ Relative ☐ Son ☐ Daughter ☐ Partner ☐ Other:_____