COMPREHENSIVE PAIN MANAGEMENT CENTER
MOHAMMAD TARIQ, M.D.
NORIN UKANI, FNP-C

PERSONAL INFORMATION

NAME: ______________________________ DOB: ______________

HOME PHONE: ____________ CELL: ____________ WORK: __________

ADDRESS: ____

CITY: __________________ STATE: ________ ZIP: ____________

EMAIL ADDRESS: ____

SEX: M F MARITAL STATUS: S M W D

SOCIAL SECURITY#: __________________ EMPLOYER: ____________

REFERRING PHYSICIAN: __________________ PHONE: ____________

PRIMARY CARE PHYSICIAN: __________________ PHONE: ____________

EMERGENCY CONTACT

NAME: ______________ RELATIONSHIP: ________ PHONE: ____________

INSURANCE INFORMATION

PRIMARY: __________________ POLICY HOLDER: ______________

SSN: ______________ DOB: __________ RELATIONSHIP: ____________

MEMBER ID #: ________________ GROUP #: __________ COPAY: ________

SECONDARY: __________________ POLICY HOLDER: ______________

SSN: ______________ DOB: __________ RELATIONSHIP: ____________

POLICY #: ________________ GROUP# ____________ COPAY: ________

PLEASE SIGN AND RETURN TO RECEPTIONIST (PLEASE READ CAREFULLY BEFORE SIGNING)
I, THE UNDESIGNED, ACKNOWLEDGE RECEIPT OF MEDICAL SERVICES AND AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM FOR HEALTH CARE PAYMENT ONLY. I AUTHORIZE PAYMENT TO THE PROVIDER. I ALSO UNDERSTAND THAT I SHOULD VERIFY COVERAGE WITH MY INSURANCE COMPANY AS WELL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE. **I WILL ALSO NOTIFY COMPREHENSIVE PAIN MGMT CENTER STAFF OF ANY CHANGES TO MY INSURANCE AND MY ADDRESS/PHONE.** We will bill your insurance company as a courtesy; however, any balance due is your responsibility. Payment will requested from you if reimbursement from your insurance company is not received within 60 days.

SIGNATURE ______________________________ DATE: ____________

PLEASE **CIRCLE** THE FOLLOWING THAT APPLIES TO YOU

Patient Name: ______________________________ DOB: ____________________

Diabetes
Seizures
Cancer
Hernia
Psoriasis
Jaundice/Hepatitis
Tuberculosis
Eczema
Herpes
Rheumatic Fever
Phobias
Scarlet Fever
Hives
Polio
Mumps
Chicken Pox
Measles
German measles
Crohn's Colitis
Diverticulosis
Heartburn
Mental Illness
Memory Loss
Excess Moodiness
Neverousness
Depression
Rashes

Varicose Veins/Phlebitis
Hemorrhoids
Constipation
Diarrhea
Change in Bowel habits
Bloodily or tarry stools
Abdominal pain
Gall Bladder trouble
Gout
Asthma/Wheezing
Shortness of Breath (on exertion)
Stroke
Bronchitis
Chronic Cough
Pneumonia/Pleurisy
Dizzy Spells
Fainting Spells
Chest Pain
Heart Murmur
Palpitations
Irregular Pulse
Chronic Fatigue
Col Numb Feet
High Blood Pressure
Bone FX/Joint Injury

Alcohol __oz per week
Smoking __#years
__#per day
Coffee/Tea __#cups per day
Muscle Weakness
Arthritis
Osteoporosis
Rheumatism
Recurrent Back pain
Leg pain when walking
Numbness
Tingling Sensations
Foot Pain
Swollen Ankles
Tremor/Hands Shaking
Frequent Headaches
Kidney Stones
Urethral Discharge
Blood in Urine
Frequent Urine Infections
Decreased Hearing
Frequent Ear Infections
Ringing in Ears
Hepatitis
Venereal Disease
Bruise Easily

Eye Pain
failing Vision
Double or Blurred Vision
Sleeping Difficulty
Anemia
Thyroid Disease
Recent Weight loss
Recent Loss of Appetite
Peptic Ulcer
Difficulty Swallowing
Frequent Sore Throat
Prolonged Hoarseness
Nausea/Vomiting
Allergies
Hay Fever
Persistent Sinus Trouble
Recurrent Nose Bleeds
Menstrual Flow
( )Reg. ( )Irreg
Pain/Cramps
Length of Cycle____
Date of last period______
Decrease on force/flow
Pain/Bleeding during sex
Pain/Bleeding after sex

Are you ALLERGIC to any medications? ( ) Yes ( ) No
If yes, please list medications you are **allergic** to

____
____
____
____

List any/all current medications and dosage you are presently taking and how you are taken them:

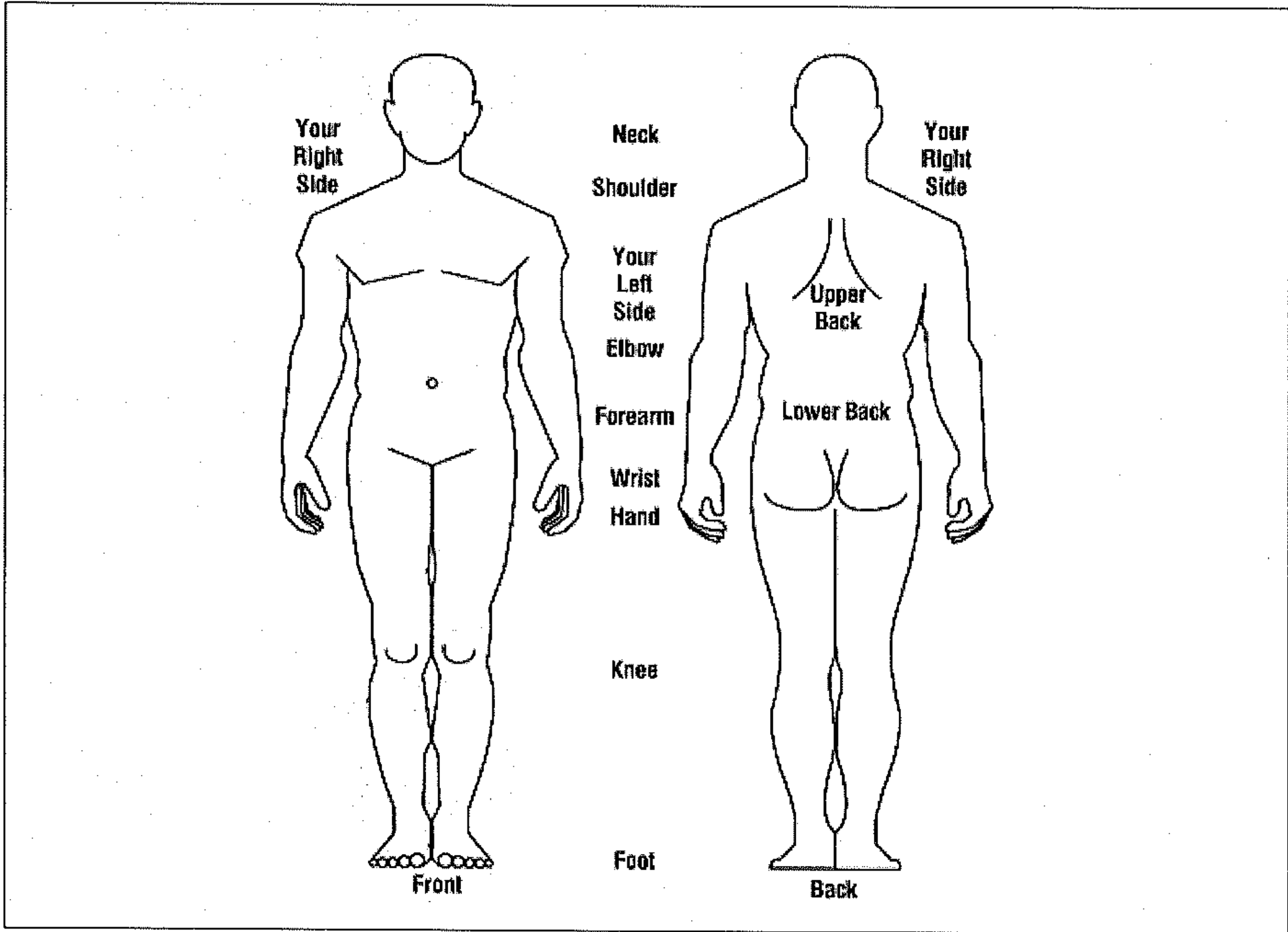
1.____
2.____
3.____
4.____
5.____

Please list the names, addresses, and phone numbers for all physicians you have seen for your pain.

1.____
2.____
3.____
4.____

BODY MARKS

Write an X or X's on the figure below to indicate your main pain area. If your pain sensations spread, use arrows where it spreads.



SIGN: ______________________________ DOB: ____________________

DATE: ____________________

PATIENT AUTHORIZATION FORM

I, ______________________________, hereby authorize you to release specific information regarding

- Treatment
- Medications
- Procedure Results
- Billing Matters

To the following listed family members. I understand if they are not listed, this office is obligated by law to refuse to disclose any information.

Family Member Name & Relation:	**Phone Number:**
____	________________________
____	________________________
____	________________________
____	________________________
____	________________________

I, ______________________________, hereby;

- Authorize our office staff to you leave messages at Home, Cell or Work on Voicemail.
- Do Not Authorize our office staff to leave messages at Home, Cell or Work on Voicemail.

Regarding billing, and/ or any scheduled appointments.

____ ________________________

Patient/Guardian Signature Date

I, ____________________________________, undersigned that if I wish to revoke any or all of this authorization that it will be my responsibility to provide it in writing to this office. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPPA.

____ ________________________

Patient/Guardian Signature DOB Date

COMPREHENSIVE PAIN MANAGEMENT CENTER

MOHAMMAD TARIQ, M.D.
NORIN UKANI, FNP-C

Please initial each line below to indicate you have read and understand each tab.

Treatment Agreement

____ I promise full cooperation with my treating specialist whether by procedure or non-procedure means. I understand that if I do not follow my doctor's instructions concerning my care and treatment, including any necessary physical therapy or medications. The outcome of my care and treatment could be put into jeopardy and less than optimal results may occur.

Release of Information

____ For the purpose of payment, I allow Comprehensive Pain Management Center to release my Private Health Information to any and all of my insurance carriers, their third party payers and claim reviewers, until the claim is resolved. For the purpose of treatment, I also allow the above listed practices to release my information or contact any and all of my treating physicians.

Patient Financial Policy

____ You are responsible for all authorizations/referrals needed to seek treatment in this office. You must inform the office of all personal information (home address, phone numbers, etc...) and/or insurance changes and authorizations referral requirements. In the event our office is not informed, you will be responsible for any charges denied.

____ **Your portion of payment for office services is due at the time of service. We accept VISA, MasterCard, Discover, Check or Cash.**

____ We have made prior arrangements with insurers and other health plans to accept assignment of benefits. We will bill those plans with which we have and agreement and will require you to pay the co-pay at the time of service. If you are seeing our doctor on an "Out-of-Network" basis, you will be subject to those out of network rates.

____ Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you with an assignment of benefits. You are agreeing to have your insurance pay the doctor directly. **If your Insurance Company does not pay the practice within 60 days, the patient or guardian seeking care for a minor, will be responsible for payment of services. You are encouraged to contact our billing department @ 972-316-3344 ext 108 with any questions or concerns.**

____ Not all services are a covered benefit in all insurance policies; some plans even impose a waiting period before covering services. In the event your health plan determines a service to be "non-covered or pre-existing," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for any charges rendered. **For that reason we encourage you as the policy holder to get involved with your insurance prior to any procedures, for clarification of benefits prior to any services rendered.**

____ Clinic days are Monday and Friday in Lewisville and Tuesday and Wednesday in McKinney with limited appointments. Please honor our 24 hour reschedule notice, as there are other patients waiting to get an appointment. There is a $25 charge for office visit appointments and a $50 charge for procedure appointments without a 24 hour advanced notice. **Repetitive cancelled appointments and/or non-compliance may result in a transfer care to an alternative practice.**

____ We realize that temporary financial problems may affect timely payments of your account. If such problems so arise, we encourage you contact us promptly for assistance in the management of your account. Any payment exceptions will be agreed upon in writing with our billing department or office manager.

____ Past due accounts are subject to collection proceedings. All fees included, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due to this office.

____ **There is a service fee of $25 for all returned checks.** Upon an NSF or Closed Account occurrences, all future remittances will need to be in other forms of payment. Restitution of "Theft-by-Check" will be required from the District Attorney's Office.

____ Accounts no longer maintaining a financial "Good Faith" status will result in the termination of the Comprehensive Pain Management Center Doctor-Patient relationship.

I________________________________, request that payment of authorized insurance benefits, including Medicare, other government sponsored programs, private insurance and other health plans be made to Comprehensive Pain Management for the services rendered to me. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is to be financially responsible for all changes, whether or not paid by said insurance. I authorize any holder of medical or other information about me; to release any information needed to determine these benefits fir related services. I understand that I am responsible for any unpaid balance that my insurance does not pay.

Authorization of Payment

___ I hereby assign all Medical Benefits directly to Comprehensive Pain Management Center for the payment of any services rendered. I also authorize release of medical records necessary to process my health claims. I fully understand that in the event my insurance company does not pay for the services I received, I will be financially responsible for payment.

We are dedicated to providing the best possible care and service to you and regard your complete understanding of our policies as an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or the office manager.

______________________________ ______________________ __________
Print Patient's Name DOB Signature of Patient/Guardian Date

______________________________ ______________________ __________
Print Office Witness Name Signature of Office Witness Date

MOHOMMAD TARIQ, M.D.
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review carefully

UNDERSTANDING YOU HEALTH RECORD/INFORMATION:

The Health Insurance Portability & Accountability Act of 1996 is a federal program that requires that all medical records and other individually identifiable health information, or protected health information ("PHI") used to disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. The Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

YOUR HEALTH INFORMATION RIGHTS:

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to request, inspect, and obtain a copy of your health record, obtain an accounting of disclosures of your health information, request communication of your health information by alternative means or at alternative locations, revoke your authorization to use or disclose health information except to the extent that action has already been taken. Your ability to restrict disclosures also relates to prohibitions and permissions set in place by you regarding our ability to disclose of your PHI to your family members, other relatives, close personal friends, or any other identified by you. We are not, however required to agree to a requested restriction. If we do agree, we must abide by it unless you agree in writing to remove it.

OUR RESPONISIBLITIES:

Comprehensive Pain Management Center is required to maintain the privacy of your health information. We will provide you with notice as to our legal duties and privacy practices with respect to information we collect and maintain about you, abide by the terms of these responsible requests you may have to communicate health information by alternative means or at alternative locations. We reserve the tight to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post a revised notice at our office. We will not use or disclose your health information without your authorization except as described in this notice.

FOR MORE INFORMATION OR TO REPORT A PROBLEM:

If you believe that there is a mistake or missing information in our records of you PHI, you may request in writing, that we correct or add to the record. We will respond within 60 days of receiving your request. We may deny the request if we determine that the PHI is (i) correct and complete; (ii) not created by us and/or part of our records, or; (iii) not permitted to be disclosed. Any denial will state the reason for denial and explain your rights to have the request and denial along with any statement in response that you provide, amended to your PHI. If we approve the request for amendment, we change the PHI and so inform you, and tell others what they need to know about the change in the PHI.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS

We will use your health information for treatment. For example: Information obtained by a nurse, physician or other members of your healthcare team will be recorded in you record and used to determine the course of treatment that should work best for you. Comprehensive Pain Mgmt Center will record the actions taken and observations made respect to your information.

We will use your health information for payment. For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well your diagnosis, procedure, and medications provided.

Health professionals, using their best judgement, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

We may disclose to the FDA health information relative to adverse events with respect to supplement, product and product defects, or post marketing information to enable product recalls, repairs or replacement.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION:

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written authorization. We must obtain your authorization separate from any notice we may have provided to you. If you give us authorization to use or disclose health information about you, you must revoke that authorization, in writing, ate any time. If you revoke your authorization, we will no longer use or disclose information about you for the reasons covered by your written authorization, but we cannot take back any uses or disclosures already made with your permission.

By signing this form and returning it to Dr. Tariq's office, I acknowledge that I have received a copy of the notice of the privacy practices.

____

Printed Name of Patient DOB

____

Authorized Signature of Patient Date

Informed Consent for Chronic Narcotic Analgesic Therapy

Treatment Information
Your physician may recommend that a maintenance narcotic analgesic be given in order to manage your pain and increase you activities at home and at work.

As you begin treatment program you should be aware of the following risks associated with the use of this medication:

1. Side effects for these medications may include drowsiness, dizziness, constipation, nausea, and/or confusion.

   You should see how this medication affects you before you drive a motor vehicle or do a task requiring concentration. You should not drive or operate machinery if the medication makes you drowsy. It usually takes 5 to 7 days for a person to get an idea of how he/she is affected. Frequently these effects diminish in a few days. Any time your dose is increased you may experience sedation and if sedation occurs you should not operate vehicles or machinery until sedation resolves.

   Cognitive Impairment or mental clouding may occur during treatment and may or may not decrease over time. If the medication is used with other sedatives or alcohol the resulting heightened impairment is potentially dangerous. It is strongly advised not to use alcohol while taking this medication.

   Constipation is a common side effect. If this is a problem for you, try a stool softener (Docusate, Colace) or mild laxative with increased fiber and fruit in your diet. Some people experience nausea with this medication. If you take this medication after you eat nausea may be decreased. Other side effects that infrequently occur ate disorientation and sleep disturbances.

   The use of other medications can increase side effects. If is important that your physician know any other medications you are taking. All medications that make you sleepy (for example antihistamines in cold preparations and alcohol) will make you sleepier while taking this medication. It is advised that you talk with your physician or pharmacist before buying over-the-counter products.

2. Risk of psychological dependence may occur in probably less than 1% of patients being treated with narcotic analgesics. This means there is a continued desire for the mood altering and other psychological effects of the medication and concern for its continued availability. Communication with you physician is necessary for you to understand the role of the medications in your pain management program and to avoid development of this type of dependence.

3. Risk of physical dependence on these types of medication is very high. It refers to the fact that at higher doses of this type of medication, your body will get used to it. If you stop taking the medication abruptly, your body may react adversely with withdrawal symptoms, which may include: excessive tearing, runny nose, dilated pupils, "goose pimples" flesh, sweating, yawning, diarrhea, muscle aches, headache and insomnia. To prevent these uncomfortable symptoms you should take your medication regularly and communicate to your physician any side effects. When discontinuing use of the medication, taper it down slowly over a period of a few day to a few weeks under supervision of you physician.

Clinic: ______

Comprehensive Pain Management Center
Patient Comfort Assessment Guide

NAME:______________________ **DOB:**____________ **DATE:** ____________

PHONE:__________________ **ADDRESS:**____________________________

W:

BP:

P:

WHERE IS YOUR PAIN?____

1. CIRCLE THE WORDS THAT DESCRIBE YOUR PAIN

Aching	Sharp	Penetrating
Throbbing	Tender	Nagging
Shooting	Burning	Numb
Stabbing	Exhausting	Miserable
Gnawing	Tiring	Unbearable

2. WHAT TIME OF DAY IS YOUR PAIN WORST?
MORNING AFTERNOON EVENING NIGHTTIME

3. RATE YOUR PAIN BY CIRCLING THE NUMBER THAT BEST DESCRIBES IT AT ITS WORST LAST MONTH:
NO PAIN 1 2 3 4 5 6 7 8 9 10 PAIN AS BAD AS YOU CAN IMAGINE

4. RATE YOUR PAIN BY CIRCLING THE NUMBER THAT BEST DESCRIBES IT AT ITS LEAST LAST MONTH:
NO PAIN 1 2 3 4 5 6 7 8 9 10 PAIN AS BAD AS YOU CAN IMAGINE

5. RATE YOUR PAIN BY CIRCLING THE NUMBER THAT BEST DESCRIBES IT AT ITS AVERAGE LAST MONTH:
NO PAIN 1 2 3 4 5 6 7 8 9 10 PAIN AS BAD AS YOU CAN IMAGINE

6. RATE YOUR PAIN BY CIRCLING THE NUMBER THAT BEST DESCRIBES YOUR PAIN RIGHT NOW:
NO PAIN 1 2 3 4 5 6 7 8 9 10 PAIN AS BAD AS YOU CAN IMAGINE

7. WHAT MAKES YOUR PAIN BETTER? ______________________________________

8. WHAT MAKES YOUR PAIN WORSE?______________________________________

9. WHAT TREATMENT OR MEDICATION ARE YOU RECEIVING FOR YOUR PAIN?

A) ______________________
TREATMENT OR MEDICATION NO RELIEF 1 2 3 4 5 6 7 8 9 10 COMPLETE RELIEF

B) ______________________
TREATMENT OR MEDICATION NO RELIEF 1 2 3 4 5 6 7 8 9 10 COMPLETE RELIEF

C) ______________________
HOW LONG DID INJECTION LAST NO RELIEF 1 2 3 4 5 6 7 8 9 10 COMPLETE RELIEF

PATIENT SIGNATURE:______________________________

PHYSICIAN SIGNATURE:______________________________

BRIEF PAIN INVENTORY

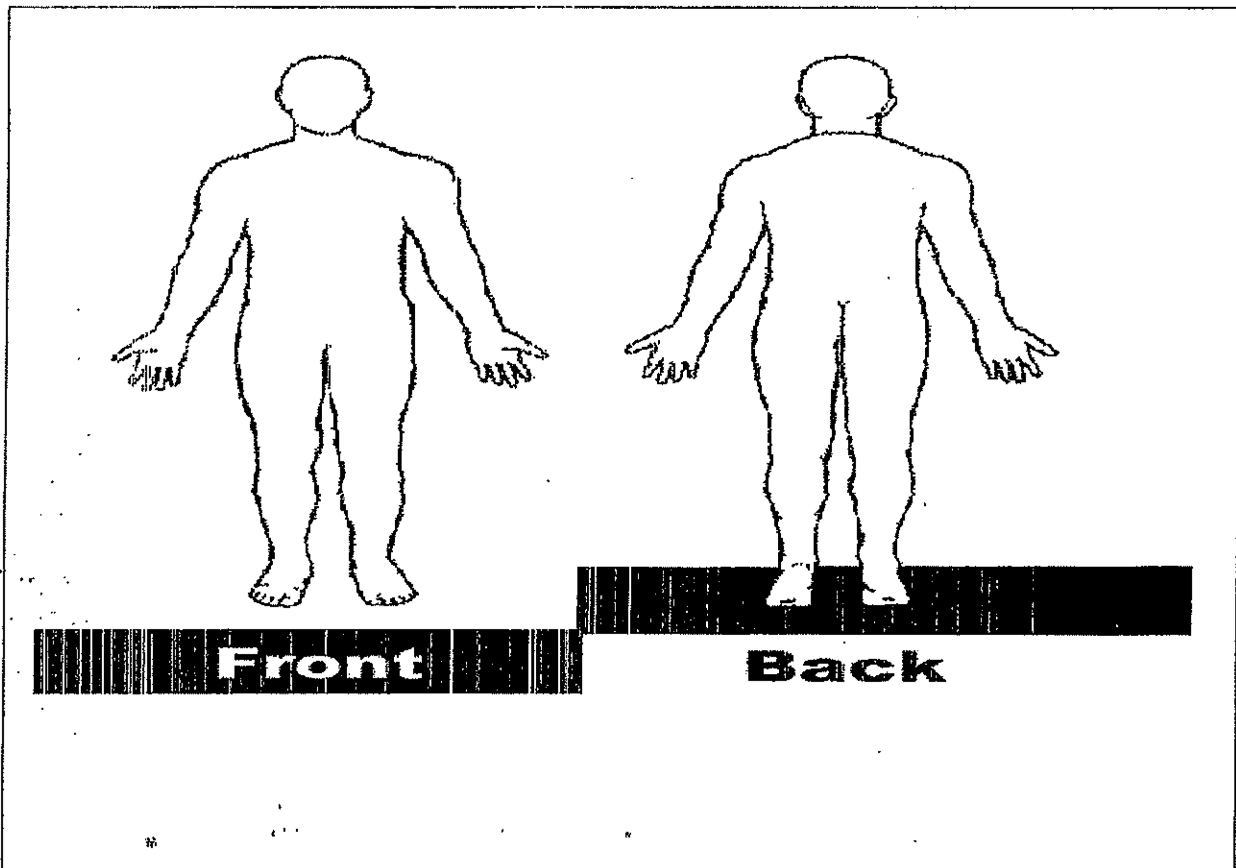
DATE:____________________ TIME:____________________

PATIENT NAME:____

1 THROUGHOUT OUR LIVES,MOST OF US HAVE HAD PAIN FROM TIME TO TIME (SUCH AS MINOR HEADACHES, SPRAINS, AND TOOTHACHES) HAVE YOU HAD PAIN OTHER THAN THESE EVERYDAY KINDS OF PAIN TODAY?

1.YES 2. NO

2. ON THE D AGRAM , SHADE IN WHERE YOU FEEL THE PAIN. PUT AN X ON THE AREA THAT HURTS.



3. CIRCLE THE NUMBER THAT DESCRIBES HOW, DURING THE PAST 24 HOURS, PAIN HAS INTERFERRED WITH YOUR:

A)GENERAL ACTIVITY

1	2	3	4	5	6	7	8	9	10

B) MOOD

1	2	3	4	5	6	7	8	9	10

C) WALKING ABILITY

1	2	3	4	5	6	7	8	9	10

D)NORMAL WORK (INCLUIDES BOTH WORK OUTSIDE THE HOME AND HOUSEWORK)

1	2	3	4	5	6	7	8	9	10

E)RELATIONS WITH OTHER PEOPLE

1	2	3	4	5	6	7	8	9	10

F)SLEEP

1	2	3	4	5	6	7	8	9	10

G)ENJOYMENY OF LIFE

1	2	3	4	5	6	7	8	9	10