Phone: 832-286-4546
Fax: 832-461-1138
www.BetterLifeHouston.com
12518 Cutten Road
Houston, TX 77066
(Parking lot entrance on Theall Rd)

Welcome!

Thank you for choosing Better Life Spine & Pain Center as your healthcare provider. We are happy to work with you to decrease your pain, improve your functional status and quality of life.

Please fill out the following forms as accurately as you can. If you have any questions regarding your forms, we will be happy to assist you when you check-in at the office.

Thank you,
Better Life Team

Checklist:

Please bring the following to your first visit if possible:

- ❏ Photo ID (**required**)
- ❏ Insurance card(s) (**required** if using insurance)
- ❏ Imaging reports, such as X-rays and MRI (if applicable)
- ❏ Recent lab reports, such as blood tests (if applicable)
- ❏ All of your current medications (if applicable)
- ❏ Completed New Patient Packet, ie this packet (suggested)

How did you hear about Better Life Spine & Pain Center?

- ❏ My Physician
- ❏ My chiropractor
- ❏ Facebook
- ❏ Yelp
- ❏ Google
- ❏ Other: _____

Are you seeking consultation for?

- ❏ Minimally invasive surgery
  - ❏ Spinal cord stimulators
  - ❏ Pain pumps
  - ❏ Kyphoplasty for compression fractures
  - ❏ Intracept procedure
  - ❏ Minuteman (minimally invasive fusion)
  - ❏ *mild* (minimally invasive decompression)
- ❏ Conservative options
  - ❏ Pain injections
  - ❏ Regenerative injections
  - ❏ Medication management
- ❏ Other/ I'm not sure.

Patient Registration:

Last Name:_____
First Name:_____
Legal Sex: _____
Date of Birth: _____
Social Security Number: _____

Race: _____
Ethnicity:_____
Marital Status:_____
Gender identity: _____

Address: _____
City, State, Zip: _____
Home Phone: _____
Mobile Phone:_____
Email: _____

Emergency Contact:_____
Emergency Contact Phone: _____

Employer: _____
Work Phone:_____

Primary Insurance

Insurance Name: _____
Member ID#:_____
Group #: _____
Relationship to policy holder:_____
Policy holder's Name:_____
Policy holder's DOB:_____
Policy holder's Sex: _____

Secondary Insurance

Insurance Name: _____
Member ID#:_____
Group #: _____
Relationship to policy holder:_____
Policy holder's Name:_____
Policy holder's DOB:_____
Policy holder's Sex: _____

Pharmacy Information

Pharmacy Name: _____
Pharmacy Phone: _____

Primary Care Physician

Physician/ Practice Name:_____
Physician/ Practice Phone:_____

I certify that the information completed in this form is accurate to the best of my knowledge. I will not hold my doctor or any member of his staff responsible for any errors or omissions that I may have made in the completion of the form.

Patient Signature:_____Date: _____

Allergies & Medications:

Please list all **ALLERGIES**: _____

Please list all your current medications (or attach a list); please include dose and frequency:

_____

_____

Family History:

Please list any medical problems in your family:

Mother_____

Father_____

Sister_____

Brother _____

Social History:

Smoking (please select): ❑ Never Smoker ❑ Current smoker ❑ Former smoker

Do you drink alcohol (please select): ❑ No, ❑ Yes

Past Surgical History:

Please list all your surgeries:

_____

_____

Past Medical History:

Please select your medical conditions:

❑ Acid Reflux (GERD)	❑ Depression	❑ Liver disease	❑ Obstructive sleep apnea
❑ Anxiety	❑ Diabetes	❑ Osteoporosis	❑ Glaucoma
❑ Asthma	❑ Heart Attack (MI)	❑ Stroke	❑ Seizures
❑ COPD	❑ Kidney disease	❑ Substance Abuse	

Please list any other Medical Problems not listed above:

_____

_____

Review of Systems (please select all that apply)

Constitutional: ❑Fever, ❑Night sweats, ❑Weight gain, ❑Weight Loss

EENT: ❑Dry mouth, ❑Frequent nosebleeds, ❑Snoring

Cardiovascular: ❑Chest pain, ❑Ankle swelling

Respiratory: ❑Cough, ❑Wheezing, ❑Shortness of breath

Gastrointestinal: ❑Nausea, ❑Vomiting, ❑Constipation, ❑Diarrhea, ❑Bloody vomit, ❑Heartburn, ❑Bloody stools, ❑Black or tarry stools,

Genitourinary: ❑Difficulty urinating, ❑Urinary incontinence

Musculoskeletal: ❑Muscle aches, ❑Joint pain, ❑Joint swelling, ❑Back pain, ❑Neck pain

Integumentary: ❑Rash

Neurological: ❑Weakness, ❑Numbness, ❑Seizures, ❑Dizziness, ❑Frequent/ severe headaches, ❑Dizziness, ❑Daytime sleepiness

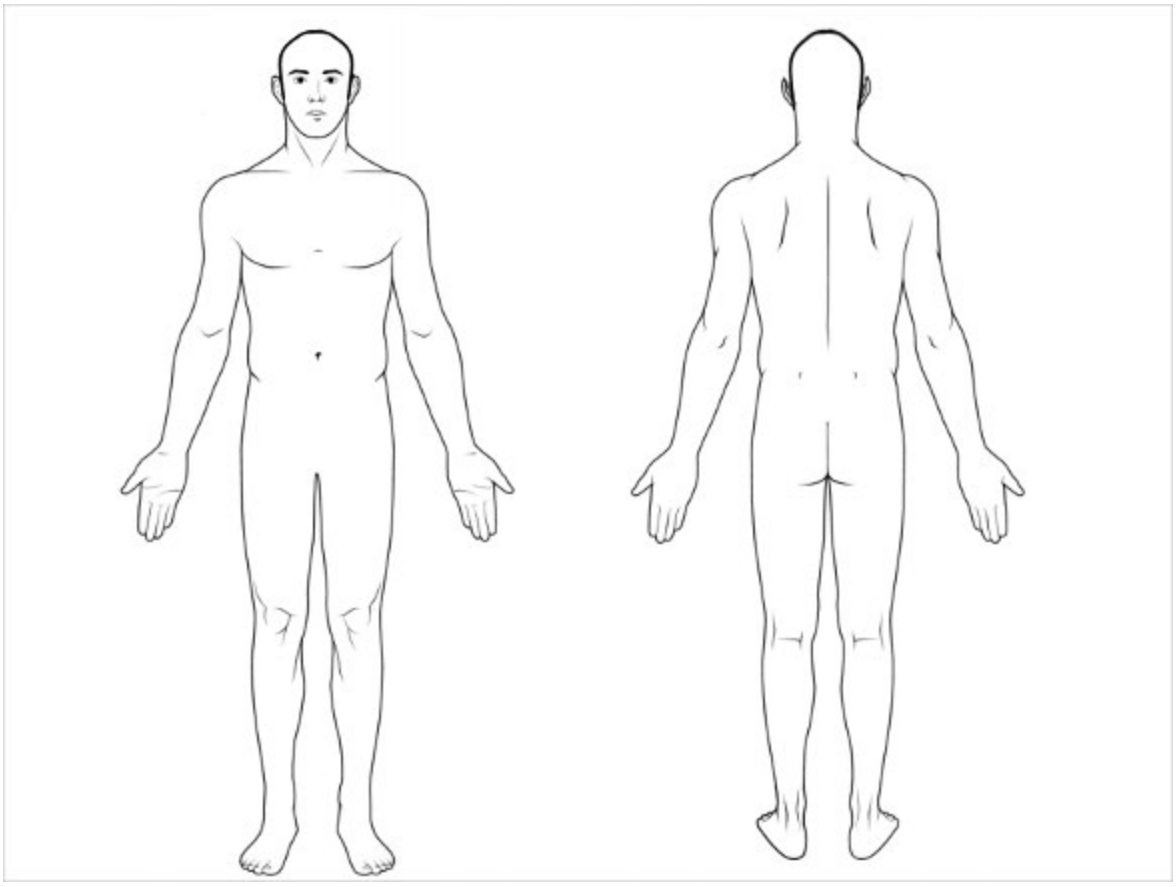
Psychiatric: ❑Depressed mood, ❑Sleep disturbances, ❑Frequent anxiety, ❑Foggy thinking, ❑Suicidal thoughts

Endocrine: ❑Fatigue, ❑Excessive thirst, ❑Increased urination

Hematologic/ lymphatic: ❑Excessive bleeding from minor cuts, ❑Excessive bruising

Allergic/ immunologic: ❑Recent allergic reaction

Where does it hurt? (Please indicate on the figure.)



Right Left Left Right

Evaluation Form (History of Present Illness):

Previous pain physician (if applicable): _____

Where is your pain (such as neck, low back, or knee)? _____

How long ago did your pain first begin? _____

Do you remember a specific injury or accident that started your pain? _____

Is your pain constant or intermittent? _____

Does anything make the pain better? _____

Does anything make the pain worse? _____

What words best describe your pain (select all that apply):

❑Ache ❑Stiff ❑Sharp ❑Dull ❑Stabbing ❑Shooting

❑Tingling ❑Burning ❑Numb ❑Feels “asleep” ❑Electric ❑Other: _____

*Only complete this box if you have **neck pain**:*	*Only complete this box if you have **low back pain**:*
Does the neck pain go down your arms? _____	Does the back pain go down your legs? _____
❑Right ❑Left ❑Both ❑None	❑Right ❑Left ❑Both ❑None
Have you ever had **neck** surgery? _____	Have you ever had **low back** surgery? _____

What does your pain interfere with (select all that apply):

❑Sleeping ❑Dressing ❑Using bathroom ❑Cooking ❑Cleaning ❑Shopping ❑Hobbies ❑Working

Any side effects with your current pain medications (such as constipation, nausea or drowsiness)? _____

Do you take any blood thinners (such as plavix, coumadin, effient, xarelto, or others)?_____

Conservative Care:

	Have you used this therapy?	Did it help?	Any side effects? (please specify):
Ice/ cooling pack	❑No ❑Yes	❑No ❑Yes	
Heat/ heating pad	❑No ❑Yes	❑No ❑Yes	
TENS unit	❑No ❑Yes	❑No ❑Yes	
Behavioral therapy	❑No ❑Yes	❑No ❑Yes	
Exercise regimen	❑No ❑Yes	❑No ❑Yes	
Yoga, tai chi	❑No ❑Yes	❑No ❑Yes	
Weight loss	❑No ❑Yes	❑No ❑Yes	
Acupuncture	❑No ❑Yes	❑No ❑Yes	
Massage	❑No ❑Yes	❑No ❑Yes	
Chiropractic	❑No ❑Yes	❑No ❑Yes	

Physical therapy:

Have you had physical therapy for your pain? _____

If yes, what body areas were treated? _____

When was your most recent session? _____

How many sessions and/or how many weeks did you complete? _____

Did it improve your pain and/or functionality? _____

Did it worsen your pain and/or functionality? _____

Procedures:

If you have had procedures for pain (ie, spinal stimulators, epidurals, injections, etc), please list them here:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Pain Medications:

Medications	Have you ever taken this?	Did it improve your pain &/or functionality.	Any side effects? (please specify):
Tylenol (acetaminophen)	❑No ❑Yes	❑No ❑Yes	
Aspirin (Bayer, BC powder, Goody's)	❑No ❑Yes	❑No ❑Yes	
Advil (Duexis, Motrin, ibuprofen)	❑No ❑Yes	❑No ❑Yes	
Aleve (Naprosyn, naproxen)	❑No ❑Yes	❑No ❑Yes	
Mobic (meloxicam)	❑No ❑Yes	❑No ❑Yes	
Celebrex (celecoxib)	❑No ❑Yes	❑No ❑Yes	
Voltaren (diclofenac)	❑No ❑Yes	❑No ❑Yes	
Elavil (amitriptyline)	❑No ❑Yes	❑No ❑Yes	
Pamelor (nortriptyline)	❑No ❑Yes	❑No ❑Yes	
Norpramin (desipramine)	❑No ❑Yes	❑No ❑Yes	
Sinequan, Silenor (doxepin)	❑No ❑Yes	❑No ❑Yes	
Cymbalta (duloxetine)	❑No ❑Yes	❑No ❑Yes	
Effexor (venlafaxine)	❑No ❑Yes	❑No ❑Yes	
Savella (milnacipran)	❑No ❑Yes	❑No ❑Yes	
Flexeril (cyclobenzaprine)	❑No ❑Yes	❑No ❑Yes	
Zanaflex (tizanidine)	❑No ❑Yes	❑No ❑Yes	
Robaxin (methocarbamol)	❑No ❑Yes	❑No ❑Yes	
Skelaxin (metaxalone)	❑No ❑Yes	❑No ❑Yes	
Lioresal (baclofen)	❑No ❑Yes	❑No ❑Yes	
Neurontin (gabapentin)	❑No ❑Yes	❑No ❑Yes	
Lyrica (pregabalin)	❑No ❑Yes	❑No ❑Yes	
Tegretol (carbamazepine)	❑No ❑Yes	❑No ❑Yes	
Topamax (topiramate)	❑No ❑Yes	❑No ❑Yes	
Ultram (tramadol)	❑No ❑Yes	❑No ❑Yes	
Tylenol #3 & #4 (codeine)	❑No ❑Yes	❑No ❑Yes	
Dolophine (methadone)	❑No ❑Yes	❑No ❑Yes	
Belbuca (Suboxone, Butrans patch buprenorphine)	❑No ❑Yes	❑No ❑Yes	
Lidoderm patch, Aspercreme with lidocaine (lidocaine)	❑No ❑Yes	❑No ❑Yes	
Voltaren gel/ Flector patch (topical diclofenac	❑No ❑Yes	❑No ❑Yes	

New Patient Questionnaire

What number best describes your pain on average in the past week?

None	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	Worst pain
	0	1	2	3	4	5	6	7	8	9	10	

What number best describes how, during the past week, pain has interfered with your enjoyment of life?

None	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	Completely interferes
	0	1	2	3	4	5	6	7	8	9	10	

What number best describes how, during the past week, pain has interfered with your general activity?

None	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	Completely interferes
	0	1	2	3	4	5	6	7	8	9	10	

How often do you have mood swings?

Never	❑	❑	❑	❑	❑	Often
	0	1	2	3	4	

How often do you smoke a cigarette within an hour after you wake up?

Never	❑	❑	❑	❑	❑	Often
	0	1	2	3	4	

How often have you taken medication other than the way that it was prescribed?

Never	❑	❑	❑	❑	❑	Often
	0	1	2	3	4	

How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?

Never	❑	❑	❑	❑	❑	Often
	0	1	2	3	4	

How often, in your lifetime, have you had legal problems or been arrested?

Never	❑	❑	❑	❑	❑	Often
	0	1	2	3	4	

			Gray Box for Staff Use Only
Age between 16 and 45 years old?	❑No	❑Yes	1
History of alcohol abuse?	❑No	❑Yes	3
History of illegal drug abuse?	❑No	❑Yes	4
History of prescription drug abuse?	❑No	❑Yes	5
History of depression?	❑No	❑Yes	1
History of ADHD, OCD, bipolar, or schizophrenia?	❑No	❑Yes	2
History of pre-adolescent sexual abuse?	❑No	❑Yes	M0-F3
Family history of alcohol abuse?	❑No	❑Yes	M3-F1
Family history of illegal drug abuse?	❑No	❑Yes	M3-F2
Family history of prescription drug abuse?	❑No	❑Yes	4

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug(s) after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent/permission to use the drug(s) recommended to you by me, as your physician. For the purpose of this agreement the use of the word "physician" is defined to include not only my physician but also my physician's authorized associates, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat my condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request Better Life Pain Clinic to treat my condition which has been explained to me as chronic pain, which is a state of pain that persists beyond the usual course of an acute disease or healing of an injury. I hereby authorize and give my voluntary consent for my physician to administer or write prescription(s) for dangerous and/or controlled drugs (medications) as an element in the treatment of my chronic pain. It has been explained to me that these medication(s) include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I have discussed the risks and benefits of the use of controlled substances for the treatment of chronic pain, including an explanation of the following: (a) diagnosis; (b) treatment plan; (c) anticipated therapeutic results, including realistic expectations for sustained pain relief and improved functioning and possibilities for lack of pain relief; (d) therapies in addition to or instead of drug therapy, including physical therapy or psychological techniques; (e) potential side effects and how to manage them; (f) adverse effects, including the potential for dependence, addiction, tolerance, and withdrawal; and (g) potential complications and impairment of judgment and motor skills. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATE FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT HAVE BEEN APPROVED BY THE DRUG COMPANY AND THE GOVERNMENT (THIS IS SOMETIMES REFERRED TO AS "OFF-LABEL" PRESCRIBING). MY DOCTOR WILL EXPLAIN HIS OR HER TREATMENT PLAN(S) FOR ME AND DOCUMENT IT IN MY MEDICAL CHART.

I have been informed and understand that I will undergo medical tests and examinations before and during my treatment. Those tests include random unannounced checks (urine, blood, saliva, or any other testing indicated and deemed necessary by my physician at any time) for drugs and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances or absence of authorized substances may result in my being discharged from your care.

For female patients only: All of the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s), i.e. opioids/narcotics, to ensure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo/fetus/baby.

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention (inability to urinate), orthostatic hypotension (low blood pressure), arrhythmias (irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance to medication(s), physical and emotional dependence or even addiction, and death. I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction times might still be slowed. Such activities include but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself.

The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me, and I still desire to receive medication(s) for the treatment of my chronic pain.

The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and functional life. I realize that I may have a chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored specifically for me. I understand that I may withdraw from this treatment plan and discontinue the use of the medication(s) at any time and that I will notify my physician of any discontinued use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

I understand that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any

condition. The long-term use of medications to treat chronic pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment; risks of nontreatment and the drug therapy; medical treatment or diagnostic procedure(s) to be used to treat my condition; and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give this informed consent.

I UNDERSTAND AND AGREE TO THE FOLLOWING: That this pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called “narcotics, painkillers,” and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand that there are federal and state laws, regulations, and policies regarding the use and prescribing of controlled substance(s). Therefore, medication(s) will only be provided so long as I follow the rules specified in this Agreement.

The term “pain management physician” below means your primary pain management physician or another physician covering for the primary pain management physician.

My pain management physician may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior:

Patient Shall Indicate All Provisions by INITIALING:

_____ I am aware that all controlled substance prescriptions are now being monitored by the Texas State Board of Pharmacy and that information will be accessed by my pain management physician each time a prescription is written

_____ I agree to submit to laboratory tests for drug levels upon request, including urine and/ or blood screens, to detect the use of nonprescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), such as marijuana, speed, cocaine, etc., treatment for chronic pain may be terminated. Also, a consult with, or referral to, an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an addictionologist or a physician who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.

_____ Refill(s) will not be ordered before the scheduled refill date. However, early refill(s) are allowed when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out. My pain management physician may limit the number and frequency of prescription refills.

_____ I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money. If either are lost or stolen, they may NOT BE REPLACED

_____ My pain management physician will manage all of my acute and chronic pain symptoms. Only my pain management physician may prescribe dangerous and scheduled drugs for the treatment of chronic pain. I will receive controlled substance medication(s) only from ONE pain management physician, unless it is for an emergency or the medication(s) that is being prescribed by another physician is approved by my pain management physician. Information that I have been receiving medication(s) prescribed by other physicians that has not been approved by my pain management physician may lead to a discontinuation of medication(s) and treatment. All other health related issues must be managed by my primary care physician.

_____ I agree that I shall inform any physician who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.

_____ I hereby give my pain management physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s). I give my pain management physician permission to obtain any and all medical records necessary to diagnose and treat my painful conditions.

_____ I will use the medication(s) exactly as directed by my pain management physician. Any unauthorized increase in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.

_____ If anyone other than my pain management physician prescribes me medication(s) to treat acute or chronic pain, then I will disclose this information to my pain management physician at or before my next date of service, which must include at a minimum the name and contact information for the person who issued the prescription, the date of the prescription, the name and quantity of the drug prescribed, and the pharmacy that dispensed the medication.

_____ All medication(s) must be obtained at one pharmacy designated by me, with exception for those circumstances for which I have no control or responsibility, that prevent me from obtaining prescribed medications at my designated pharmacy. Should the need arise to change pharmacies, my pain management physician must be informed at or before my next date of service regarding the circumstances and the identity of the pharmacy. I will use only one pharmacy, and I will provide my pharmacist a copy of this agreement. I authorize my pain management physician to release my medical records to my pharmacist as needed.

_____ My progress will be periodically reviewed and, if the medication(s) are not improving my function and quality of life, the medication(s) may be discontinued.

_____ I must keep all follow-up appointments as recommended by my physician or my treatment may be discontinued.

_____ I agree not to share, sell, or otherwise permit others, including my family and friends, to have access to these medications.

_____ I will not allow or assist in the misuse/diversion of my medication; nor will I give or sell it to anyone else.

_____ If it appears to my pain management physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then my pain management physician may try alternative medication(s) or may taper me off all medication(s). I will not hold my pain management physician liable for problems caused by the discontinuance of medication(s).

_____ I recognize that my chronic pain represents a complex problem that may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize that my active participation in the management of my pain is extremely important. I agree to actively participate in all aspects of the pain management program recommended by my pain management physician to achieve increased function and improved quality of life.

_____ I understand many prescription medications for chronic pain produce serious side effects including drowsiness, dizziness, and confusion. Alcohol will enhance all of these side effects and should be discontinued before starting these medications.

I certify and agree to the following (Patient Shall Indicate All Provisions by Initialing):

_____ 1) I am not currently using illegal drugs or abusing prescription medication(s), and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

_____ 2) I have never been involved in the sale, illegal possession, misuse/diversion, or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin, etc.).

_____ 3) No guarantee or assurance has been made as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life.

_____ 4) I have reviewed the side effects of the medication(s) that may be used in the treatment of my chronic pain. I fully understand the explanations regarding the benefits and the risks of these medication(s), and I agree to the use of these medication(s) in the treatment of my chronic pain.

_____ 5) If I become a patient in this clinic and receive controlled substances to control my pain, this pain management agreement supersedes any other agreement that I may have signed in the past.

For female patients only (Indicate by Initialing):

_____ To the best of my knowledge I am NOT pregnant.

_____ If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment. I accept that it is MY responsibility to inform my physician immediately if I become pregnant.

_____ If I am pregnant or am uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY.

I acknowledge and agree to the Informed Consent and Pain Management Agreement.

Patient Signature: : _____ Date: _____

Patient Name (Printed): _____Patient Date of Birth: _____

Patient Name (Printed): _____Patient Date of Birth: _____

Privacy Policy & Release of Information

Better Life Pain Clinic has a duty to protect your protected health information (PHI). I authorize Better Life Pain Clinic to obtain or disclose PHI for the purposes of treatment, payment and healthcare operations. This may include communication with other healthcare professionals, insurance companies, health information exchanges, or other entities involved with providing your healthcare. Your PHI will not otherwise be disclosed unless at your request, or as required by law. I have received and reviewed the HIPAA Privacy Policy and Notice of Privacy Practices.

Patient Signature: : _____ Date: _____

Authorization to Release Personal Health Information/ HIPAA Authorization

I authorize Better Life Pain Clinic to release any and all of my protected health information to the person listed below. I understand that this may include medical and billing information. This may be revoked at any time with a written request.

Full name	Date of Birth	Relationship

Patient Signature: : _____ Date: _____

Financial Responsibility & Assignment of Benefits

Payment is due at the time of service. The patient is responsible for all copays, co-insurance, deductibles, or non-covered charges. We verify your insurance benefits as a courtesy and necessary forms will be filed with insurance carriers. We cannot guarantee coverage or payment. All charges are your responsibility, whether your insurance company pays or not. Returned checks will be subject to a $35 collection charge. Unpaid balances over 180 days may be subject to collections via a collection agency. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your outstanding balance. Pre-payment plans are available for procedures and surgeries.

Patients will be subject to no-show fees if less than 24 hours notice is given for a clinic visit ($25); or less than 3 days notice is given for an appointment at the hospital or surgery center ($50); patients will be subject to a late fee for hospital or surgery center appointments ($25).

I hereby assign all medical and surgical benefits, and authorize and direct my insurance carrier(s), including Medicare, private insurance, other health plans or payors, to issue payment directly to Better Life Spine & Pain Center for services rendered to myself and/or my dependents regardless of my insurance benefits. I understand that I am responsible for any amount not covered by insurance. I am responsible for notifying Better Life Spine & Pain Center if my insurance coverage changes.

I certify that the information completed in this form is accurate to the best of my knowledge. I will not hold my doctor or any member of his staff responsible for any errors or omissions that I may have made in the completion of the form.

Patient Signature: : _____ Date: _____

Telecommunications Consent

The purpose of this form is to obtain your consent for communications through phone, text, patient portal, &/or telemedicine visits.

Your medical history, exams, studies, and care plan may be discussed through the use of technology. All existing laws regarding your access to medical information and records apply to these modalities. Reasonable and appropriate efforts have been made to minimize any confidentiality risks associated with these technologies. However, despite these safeguards, there are potential risks to the use of this technology, including but not limited to interruptions, unauthorized access by third parties, and technical difficulties. You may withhold or withdraw consent to these modes of communication at any time.

It is the patient's responsibility to take appropriate precautions regarding the security of their own personal electronic devices, including safe storage, strong passwords, periodic password updates, and not sharing passwords. I agree to take full responsibility for any communications on my devices.

Phone & Text Consent

_____ (Initials) Better Life Pain Clinic requires a contact number in order to reach you regarding appointments, test and imaging results, billing or other necessary operations. I agree to receive phone calls & texts from Better Life Pain Clinic.

Patient Portal Consent

_____ (Initials) The Patient Portal offers access to part of your medical record, the ability to manage appointments, and secure communication. The Portal should not be used for urgent communication. The system is secured and encrypted, but all forms of communication have risk of compromise. In order to minimize that risk, please provide accurate information, and do not allow unauthorized users to access your account. I acknowledge and agree to the Patient Portal Consent.

Telemedicine Consent

_____ (Initials) I authorize Better Life Pain Clinic to contact me for telemedicine.

Telemedicine is the electronic exchange of medical information via an audio-visual medium (ie, telecommunications device). It requires appropriate equipment at both locations. You will need an internet connection, camera, microphone device; these are included with most modern phones and laptops.

The benefits of telemedicine visits include convenience, lack of travel, and decreased exposure to infectious diseases.

Telemedicine is safe and secure. Better Life Pain Clinic utilizes a secure platform that is encrypted and follows HIPAA guidelines. However, despite these safeguards, there are potential risks to the use of this technology, including but not limited to interruptions, unauthorized access by third parties, and technical difficulties. Telemedicine visits are not recorded.

For most intents and purposes, telemedicine visits are very similar to typical in-person visits. The standard of care will be maintained, and patients will receive appropriate, quality care. Not all visits are appropriate for telemedicine visits. If indicated, patients may be asked to followup in the clinic for a more in-depth physical exam or other evaluation.

I agree to participate in the communication methods initialed above. All my questions have been answered and I understand the information provided.

Patient Signature: _____ Date: _____

Patient Name (Printed): _____ Date of Birth: _____