DENNIS SLAVIN, M.D.

PATIENT INFORMATION

Last Name | First Name | Middle Initial | Nickname/AKA

Date of Birth | Social Security Number | Gender Male Female

Home Address | Apt # | City | State | Zip Code

Home Phone | Work Phone | Other Phone Cell Pager ___Fax

Email Address

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician | Referring Physician

How did you hear about us?

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient (If self, skip to Emergency Contact) ___Spouse ___Parent ___Other

Last Name | First Name | Middle Initial

Date of Birth | Social Security Number

Home Address | Apt # | City | State | Zip Code

Home Phone | Work Phone | Other Phone Cell Pager ___Fax

EMERGENCY CONTACT INFORMATION

Last Name | First Name | Relationship to Patient

Address | Apt # | City | State | Zip Code

Home Phone | Work Phone | Other Phone Cell Pager Fax

INSURANCE INFORMATION

Primary Insurance	ID Number	Group Number	Telephone Number
Secondary Insurance	ID Number	Group Number	Telephone Number
Insured Member	*Social Security Number*	*Date of Birth*	*ID Number*

Rio Grande PAIN Team
Get out of Pain... Get on with Life

DENNIS SLAVIN, M.D.

ASSIGNMENT OF BENEFITS

Private insurance authorization for assignment of benefits and information release:

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

Date ________________ Signed ______________________________________

MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made on my behalf to Rio Grande Pain Team 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.

Date ________________Signed ______________________________________

CERTIFICATION

Rio Grande Pain Team is pleased to offer you treatment for your injury or suffering. However, you are advised that according to most commercial insurance policies and generally accepted practice, treatment for work related chronic injuries must first be filed under Texas Workman's Compensation.

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

MVA / Date of Incident ______________________________________

Print Patient Name ______________________________Date ________________

Patient Signature ______________________________

Health Insurance Portability and Accountability Act

By signing this document, I acknowledge that I have been given the opportunity to read the Notice of Privacy Practices of Rio Grande Pain Team.

Print Patient Name ______________________________Date ________________

Patient Signature ______________________________

Welcome to Rio Grande Pain Team! We appreciate the opportunity to work with you. The following information is provided for your benefit so that we may serve you better. Please read and sign at the bottom. A copy will be given for your records.

1. **PAYMENTS.** All applicable fees, deductibles, coinsurance, or co-pays must be paid at the time of your appointment.
2. **CANCELLATIONS.** If you need to cancel your appointment, please call us 24 hours prior to your appointment time.
3. **APPOINTMENT POLICY.** We ask that our patient arrive on time for their appointments. This will facilitate our ability to see you as scheduled. If a patient misses three (3) consecutive appointments while under prescription medical care, we reserve the right to discharge patients that are non-compliant and will no longer be able to treat you.
4. **HMO &PPO REFERRALS.** If your policy requires written authorization from your Primary Care Physician, we will request authorization, in advance, for established patients. This is done as a courtesy for our patients; however, we cannot guarantee authorization will be granted. Please keep in touch with your physician to ensure your visit is pre-authorized, to avoid having to make payment in full.
5. **CHANGE OF INFORMATION.** Please provide us with any change regarding your address, phone number or insurance information as soon as possible. Change of insurance will require the completion of a new Patient Information Form and may not be changed over the telephone.
6. **PRESCRIPTION REFILLS.** It is your responsibility to request medication refills three days prior before your refill is due. We cannot guarantee same day refills. At times, you may be required to submit to a urine drug screen prior to receiving your refill.
7. **MEDICAL RECORDS REQUEST.** Request for copies of your medical records must be made in writing on a form provided by our office. Our office will respond within 15 days to properly completed written requests. FEES: As per the rules adopted by the Texas State Board of Medical Examiners, our office will charge $25.00 for the first 20 pages and $.50 for each page thereafter and the actual cost of mailing, shipping or delivery where applicable.
8. **RETURNED CHECK FEES.** In the event that your check is returned for insufficient funds or for closed account status, we will assess a $50.00 fee per check returned. The check will not be reprocessed at the bank and the fee and check amount is payable only in cash.
9. **DISCLOSURE NOTICE.** Our Practice, Rio Grande Pain Team, owns an ownership or investment interest in Doctors Hospital at Renaissance, Ltd. I may refer you to Doctors Hospital at Renaissance for treatment or testing. This notice is provided to you as required by federal law and the hospital's rules and regulations.
10. **HIPAA INFORMATION RELEASE.** I authorize Rio Grande Pain Team to talk with the following persons regarding my appointments and medical care:

Name: ______________________________ **Relationship:** ______________________________

Name: ______________________________ **Relationship:** ______________________________

____________________________________ ______________________________ __________________

Signature Patient Name Date

PAST MEDICAL HISTORY

NAME: ________________________________ Date: ________________

DO YOU HAVE A HISTORY OF?

____Diabetes ____Blood Pressure ____Heart Disease ____Lung ____Depression
____Cancer ____Seizures ____Blood Disease ____Kidney ____Arthritis
____Stroke ____Tuberculosis ____GI Problems ____Cholesterol ____Other

FEMALE PATIENTS ONLY:

____Regular Medications ____Hysterectomy ____Bilateral Hysterectomy
____Last Menstrual Period ____Tubal Ligation

CURRENT MEDICATIONS YOU ARE TAKING

1)______________________________ 6)______________________________

2)______________________________ 7)______________________________

3)______________________________ 8)______________________________

4)______________________________ 9)______________________________

5)______________________________ 10)______________________________

PAST SURGICAL HISTORY

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

PERSONAL/SOCIAL HISTORY

Are both your parents still living? ____YES ____NO Cause of Death? Mother ______________ Father ______________

Do you drink alcoholic beverages? ___YES ___NO

Social <1 drink/day _____drinks per day

How much smoking daily? ______ packs per day

For how long? ______ years If quit, when? _______

Do you use any street drugs (like cocaine/marijuana?) ___YES ___NO

What and when last used?

Marital Status: Single Married Divorced Widowed

With whom do you live? ______________________

Are you currently working? ___YES ___NO If not, when worked last? ______________________

What is/was your occupation? ______________________________

Do you attend Adult Activity Centers? ____YES ____NO

Rio Grande PAIN Team
Get out of Pain... Get on with Life

DENNIS SLAVIN, M.D.

MEDICAL RECORDS REQUEST

To:	Attention: Medical Records
Fax:	Date:
Re: Request for Medical Records	No. of pages (including cover sheet): 1

Please fax the following records to our office:

- Last three office notes
- Initial evaluation
- Medication log
- Radiology report

Patient Information

Last Name	First Name	MI
Date of Birth	SS #	

Delivery Instructions

Fax the records to the our office at the number indicated below.

Provider	Direct Fax	
Contact Person	Direct Phone	
Please RUSH (patient is at our office)	Send By	2nd Request

Comments

The contents of this fax message and any attachments are intended solely for the addressee named in this message. This communication is intended to be and to remain confidential and may be subject to applicable attorney/client and/or work product privileges. If you are not the intended recipient of this message, or if this message has been addressed to you in error, please immediately alert the sender by fax and then destroy this message and its attachments. Do not deliver, distribute or copy this message and/or any attachments and if you are not the intended recipient, do not disclose the contents or take any action in reliance upon the information contained in this communication or any attachments.

WESLACO: 910 East Eight Street, Suite 1 • Weslaco, Texas 78596 • 956-973-0565 • Fax: 956-973-0683
MCALLEN: 1900 South Jackson Road • McAllen, Texas 78503 • 956-992-0319 • Fax: 956-973-0683

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

Treatment
We are permitted to use and disclose your medical information to those involved in your treatment. For example, the physician in this practice is a specialist. When we provide treatment, we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.

Payment
We are permitted to use and disclose your medical information to bill and collect payment for the services provided to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. This form will contain medical information, such as a description of the medical service provided to you, that your insurer or HMO need to approve payment to us.

Health Care Operations
We are permitted to use or disclose your medical information for the purpose of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we may ask another physician to review this practice's charts and medical records to evaluate our performance so that we may ensure that only best health care is provided by this practice.

Disclosures That Can Be Made Without Your Authorization
There are situations in which we are permitted by law to disclose or use your medical information without your written authorization, or an opportunity to object. In other situations we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

Additional Uses or Disclosures
- Public Health, Abuse or Neglect and Health Oversight
- Legal Proceedings and Law Enforcement
- Military, National Security and Intelligence Activities, Protection of The President
- Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors

Workers' Compensation
We may disclose your medical information as required by the Texas workers' compensation law.

Inmates
If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Required by Law
We may release your medical information where the disclosure is required by law.

Your Rights Under Federal Privacy Regulations
The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPA A). Those regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their HIPA A rights.

Requested Restrictions
You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or health care operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.
To request a restriction, submit the following in writing:
(a) The information to be restricted, (b) what kind of restriction you are requesting (i.e. on the use of information, disclosure of information or both), and (c) to whom the limits apply. Please send the request to the address and person listed below.
You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

Receiving Confidential Communications by Alternative Means
You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only reasonable requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information
You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that request for inspection of your health information also be made in writing. Please send your request to the person listed below.
We can refuse to provide some of the information you ask to inspect or ask to be copied if the information:
- Includes psychotherapy notes
- Includes the identity of a person who provided the information promise of confidentially
- Is subject to the Clinical Laboratory Improvements Amendments of 1988
- Has been compiled in anticipation of litigation

We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make any such review. Texas law requires that we are ready to provide copies or a narrative within 15 days of your request. We will inform you of when the records are ready, or if we believe access should be limited. If we deny access, we will inform you in writing. HIPA A permits us to charge a reasonable cost based fee. The Texas State Board of Medical Examiners (TSBME) has set limits on fees for copies of medical records that under some circumstances may be lower than the charges permitted by HIPA A. In any event, the lower of the fee permitted by HIPA A or the fee permitted by the TSBME will be charged.

Amendment of Medical Information
You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed below. We will respond within 60 days of your request. We may refuse to allow an amendment if the information:
- Was not created by this practice or the physicians here in this practice
- Is not part of the Designated Record Set
- Is not available for inspection because of an appropriate denial
- If the information is accurate and complete

Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know have the incorrect information

Accounting of Certain Disclosures
The HIPA A privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting of disclosure to the person listed below. Your first accounting of disclosures (within a 12 month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you and you may choose to withdraw or modify your request before any costs are incurred.

Appointment Reminders, Treatment Alternatives, and Other Health-related Benefits
We may contact you by telephone, mail, or both to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

Complaints
If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us. The contact information for the United States Department of Health and Human Services is:

HIPAA Complaint
7500 Security Blvd, C524-04
Baltimore, MD 21244

Questions and Contact Person for Requests
If you have any questions or want to make a request pursuant to the rights described above, please contact:

Dennis Slavin, M.D.
910 East Eighth Street, Suite 1
Weslaco, Texas 78596

This notice is effective on the following date: April 14, 2003. We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If, or when we change our notice, we will post the new notice in the office where it can be seen.

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT

AS REQUIRED BY THE TEXAS MEDICAL BOARD

REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9, CHAPTER 170

3[Rd] Edition: Developed by the Texas Pain Society, April2008 (www.texaspain.org)

NAME OF PATIENT: ______________________________ DATE: ________________

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 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 my physician (name at bottom of agreement) to treat my condition which has been explained to me as chronic pain. 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 further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. 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 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 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 may result in my being discharged from your care.

______ Initials

For female patients only:

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.

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 assure 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 understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.

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 active 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 non-treatment 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.

______ Initials

PAIN MANAGEMENT AGREEMENT:

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.**

My 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:

- My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the **medication(s) may be discontinued**.
- I will **disclose** to my physician **all medication(s)** that I take at any time, prescribed by any physician.
- I will use the medication(s) **exactly as directed by my physician**.
- 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 them** to anyone else.
- All medication(s) must be obtained at **one pharmacy, where possible**. Should the need arise to change pharmacies, my physician must be informed. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my physician to release my medical records to my pharmacist as needed.
- 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.**
- 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.
- I will receive medication(s) **only from ONE physician** unless it is for an emergency **or** the medication(s) that is being prescribed by another physician is approved by my physician. Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.
- If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then **my physician may try alternative medication(s) or may taper me off all medication(s)**. I will not hold my physician liable for problems caused by the discontinuance of medication(s).
- I **agree to submit to urine and/or blood screens** to detect the use of non-prescribed 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.

______ Initials

- I recognize that my chronic pain represents a complex problem which 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 physician to achieve increased function and improved quality of life.
- I agree that I **shall inform any doctor** 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 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 must take the medication(s) as instructed by my physician. **Any unauthorized increase** in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.
- I must **keep all follow-up appointments** as recommended by my physician or my treatment may be discontinued.

I certify and agree to the following:

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) **I understand that I may be asked to bring all my medicines for a random pill count. Early refill request, misuse or abuse of medication will lead to dismissal from practice.**

____

Patient Signature

____

Physician Signature (or Appropriately Authorized Assistant)

____

____

Name and contact information for pharmacy

______ Initials