PARAGON
Health Partners
PAIN - OBESITY - ADDICTION

Patient Name: _____ **Date:** _____

If you have an open Work Comp or Car Accident Please stop here and inform front Desk. We cannot file on your Medical Insurance

Referral

Were you referred to our clinic by another physician? If so, whom? _____

↳ If not, how did you hear about us? ❑ PRMC ❑ Other_____ ❑ Family ❑ Friend ❑ PCP

❑ Facebook ❑ Instagram ❑ Other Website _____

Pain Description

Where is your **worst** area of pain located? _____

Does this pain radiate? ❑ Yes ❑ No. If so, where? _____

Please list any additional areas of pain: _____

Approximately when did this pain begin? _____

What caused your current pain episode? _____

How did your current pain episode begin? ❑ Gradually ❑ Suddenly

Since your pain began, how has it changed? ❑ Decreased ❑ Increased ❑ Stayed the same

Use the pain scale described below to rate your pain for the questions below:

0 – Pain-free
1 – Very minor annoyance, occasional minor twinges
2 – Minor annoyance, occasional strong twinges
3 – Annoying enough to be distracting
4 – Can be ignored if you are really involved in your work/task, but still distracting
5 – Cannot be ignored for more than 30 minutes
6 – Cannot be ignored for any length of time, but you can still go to work and participate in social activities
7 – Makes it difficult to concentrate, interferes with sleep, but you can still function with effort
8 – Physical activity is severely limited. You can read and talk with effort. Nausea and dizziness caused by pain.
9 – Unable to speak, crying out or moaning uncontrollably, near delirium
10 – Unconscious, pain makes you pass out

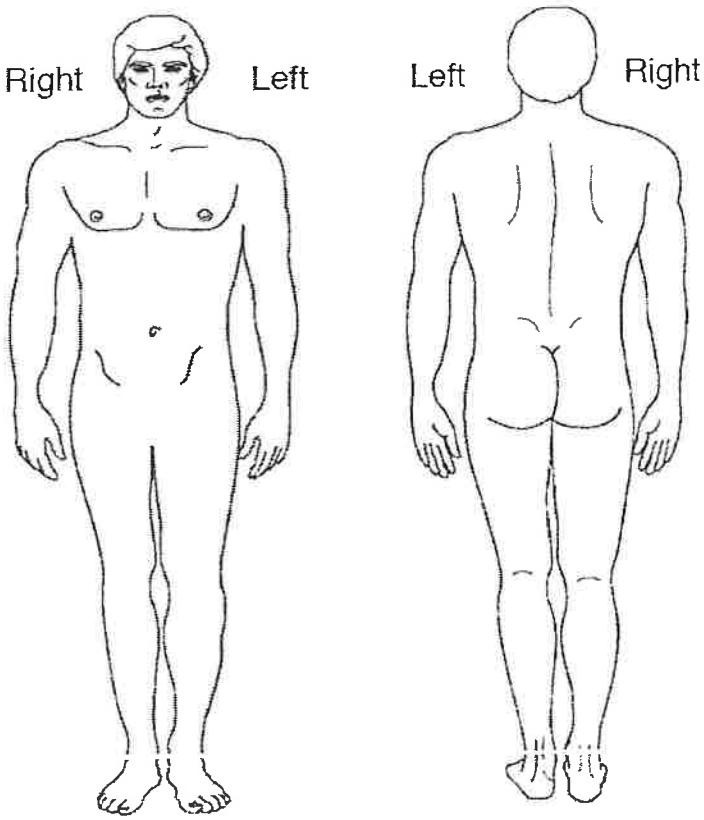
What number on the pain scale (0-10) best describes your pain **right now**? _____

What number on the pain scale (0-10) best describes your **worst pain**? _____

What number on the pain scale (0-10) best describes your **least pain**? _____

What number on the pain scale (0-10) best describes your **average pain over the last month**? _____

Use this diagram to draw the location of your pain and check all of the following that describe your pain.



- ❑ Aching
- ❑ Cramping
- ❑ Dull
- ❑ Hot/Burning
- ❑ Numbness
- ❑ Shock-like
- ❑ Shooting
- ❑ Spasming
- ❑ Squeezing
- ❑ Stabbing/Sharp
- ❑ Throbbing
- ❑ Tingling/Pins & Needles
- ❑ Tiring/Exhausting

Pain Frequency

What word best describes the frequency of your pain? ❑ Constant ❑ Intermittent

When is your pain at its worst? ❑ Mornings ❑ During the day ❑ Evenings ❑ Middle of the night

Mark all of the following activities that are adversely/negatively affected by your pain

❑ Enjoyment of Life	❑ Normal Work	❑ Sleep
❑ General Activity	❑ Recreational Activities	❑ Walking
❑ Mood	❑ Relationships with People	❑ Other: _____

❑ My goal is to resume normal activities

In the past three months have you developed any new:

❑ Balance Problems	❑ Bladder incontinence	❑ Bowel incontinence	❑ Chills
❑ Difficulty Walking	❑ Fevers	❑ Nausea	❑ Vomiting
❑ Numbness/Tingling – Where? _____		❑ Weakness – Where? _____	

❑ **I HAVE NOT RECENTLY DEVELOPED ANY OF THE ABOVE CONDITIONS**

What makes the pain worse? _____

_____

_____

What makes the pain better? _____

_____

_____

Diagnostic Tests and Imaging

ist the ost recent test(s) you have had that are related to your current pain complaints:

- ❑ MRI of the _____ Date: _____ Facility: _____
- ❑ X-ray of the _____ Date: _____ Facility: _____
- ❑ CT scan of the _____ Date: _____ Facility: _____
- ❑ EMG/NCV study of the _____ Date: _____ Facility: _____
- ❑ Ultrasound of the _____ Date: _____ Facility: _____
- ❑ Other diagnostic testing: _____

❑ **I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS**

Pain Treatment History

Mark all of the following pain treatments you have undergone prior to today's visit:

❑ Physical Therapy ❑ Psychological Therapy ❑ Podiatrist Treatment

- ❑ Chiropractic
- ❑ Epidural Steroid Injection – (circle proper levels) Cervical / Thoracic / Lumbar
- ❑ Joint Injection – Joint(s)_____
- ❑ Medial Branch Blocks or Facet Injections – (circle proper levels) Cervical / Thoracic / Lumbar
- ❑ Pain Pump _____
- ❑ Radiofrequency Ablation – (circle proper levels) Cervical / Thoracic / Lumbar
- ❑ Spinal Column Stimulator – (circle one) Trial Only / Permanent Implant
- ❑ Spine Surgery _____
- ❑ Trigger Point Injection
- ❑ Vertebroplasty / Kyphoplasty – Level(s) _____
- ❑ Other:

❑ **I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS**

Medications

Please list **ALL** of the medications you are taking, **Pain meds listed first.** Attach an additional sheet if necessary.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

Please list ALL pain medications you have taken in the past and are now **not** taking.

_____

_____

_____

_____

Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

General Medical

- ❑ Cancer – Type _____
- ❑ Diabetes – Type _____
- ❑ HIV / AIDS

Head/Eyes/Ears/Nose/Throat

- ❑ Glaucoma
- ❑ Headaches
- ❑ Head Injury
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Migraines

Cardiovascular / Hematologic

- ❑ Anemia
- ❑ Bleeding Disorders
- ❑ Coronary Artery Disease
- ❑ Heart Attack
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Mitral Valve Prolapse
- ❑ Murmur
- ❑ Pacemaker/Defibrillator
- ❑ Phlebitis
- ❑ Poor Circulation
- ❑ Stroke

Respiratory

- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema / COPD
- ❑ Pneumonia
- ❑ Tuberculosis
- ❑ Exposure to mold

Gastrointestinal

- ❑ Bowel Incontinence/IBS
- ❑ Acid Reflux (GERD)
- ❑ Gastrointestinal Bleeding
- ❑ Constipation

Musculoskeletal

- ❑ Amputation
- ❑ Bursitis
- ❑ Carpal Tunnel Syndrome
- ❑ Chronic Low Back Pain
- ❑ Chronic Neck Pain
- ❑ Chronic Joint Pain
- ❑ Fibromyalgia
- ❑ Joint Injury
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Phantom Limb Pain
- ❑ Rheumatoid arthritis
- ❑ Tennis Elbow
- ❑ Vertebral Compression fracture

Genitourinary/Nephrology

- ❑ Bladder Infection(s)
- ❑ Dialysis
- ❑ Kidney Infection(s)
- ❑ Kidney Stones
- ❑ Urinary Incontinence

Hepatic

- ❑ Hepatitis A (active / inactive / unsure)
- ❑ Hepatitis B (active / inactive / unsure)
- ❑ Hepatitis C (active / inactive / unsure)

Neuropsychological

- ❑ Alcohol Abuse
- ❑ Alzheimer Disease
- ❑ Bipolar Disorder
- ❑ Depression
- ❑ Epilepsy
- ❑ Prescription Drug Abuse
- ❑ Multiple Sclerosis
- ❑ Paralysis
- ❑ Peripheral Neuropathy
- ❑ Schizophrenia
- ❑ Seizures
- ❑ Complex Regional Pain Syndroe

❑ **Other Diagnosed Conditions**

_____

_____

_____

_____

Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the **date, type,** and any pertinent **details.**

_____

_____

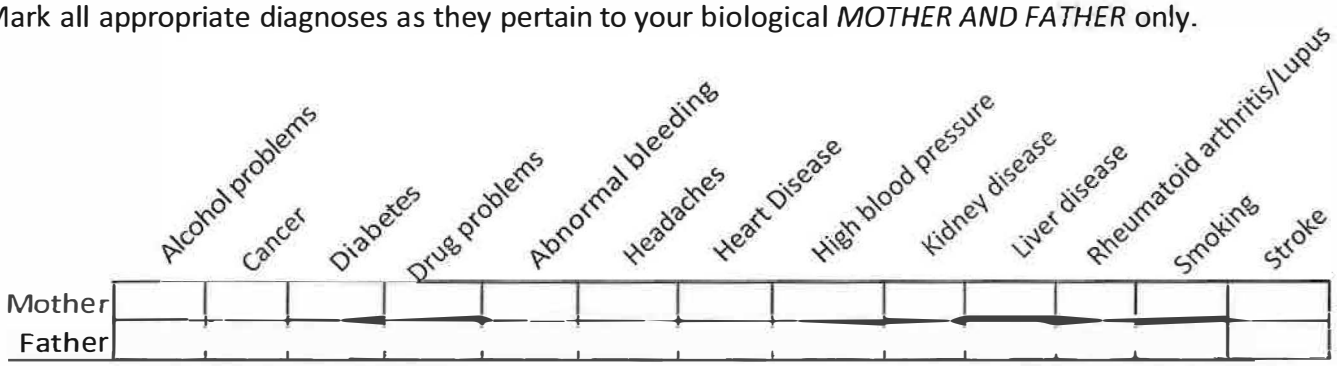
_____

_____

❑ **I HAVE NEVER HAD ANY SURGICAL PROCEDURES DONE**

Family History

Mark all appropriate diagnoses as they pertain to your biological *MOTHER AND FATHER* only.



Other medical problems: _____

❑ **I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY** ❑ **I AM ADOPTED (No Medical History Available)**

Social History

Are you capable of becoming pregnant? ❑ Yes ❑No *If so*, are you currently pregnant? ❑ Yes ❑No

Highest level of education obtained: ❑ Grammar school ❑ High school ❑ College ❑ Post-graduate

Are you currently working? ❑ Yes ❑ No What is/was your occupation?_____

Illicit Drug Use: ❑ Denies any Illicit drug use ❑ Currently using Illicit drugs Which? _____

❑ History of illicit drug use

Have you ever abused narcotic or prescription medications? ❑ Yes ❑ No; *If So*, which_____

Are you currently in remission for alcohol or any other addictions ❑ Yes ❑ No ❑ not applicable

Is the injury or pain the result of a work-related injury? Yes ☐ No ☐
Date of Injury? _____ _____ Have you reported it to your employer? Yes ☐ No ☐

Is the injury or pain motor vehicle related? ☐ Yes ☐ No
Date of Injury? _____ ___

Is there a lawsuit (pending or considered)? ☐ Yes ☐ No

Do you have a history of sexual abuse? ☐ Yes ☐ No
Do you have a history of physical abuse? ☐ Yes ☐ No
Do you have a history of emotional abuse? ☐ Yes ☐ No
If yes to any please describe: ☐

Please check if you are allergic to ❑ Iodine or ❑ Tape

Are you allergic to latex? ❑Yes ❑No

Anesthesia History

Have you ever had anesthesia (sedation for a surgical procedure)? ❑ Yes ❑No

If so, have you ever had any adverse reaction to anesthesia? ❑ Yes ❑No

Which type of anesthesia did you react adversely to? Please check all that apply.
❑ Local anesthesia ❑ Epidural ❑ General anesthesia ❑ IV Sedation

What was the reaction? _____

Do you have a family history of adverse reactions to anesthesia? If so, to which of the following?
❑ Local anesthesia ❑ Epidural ❑ General anesthesia ❑ IV Sedation

Allergies

Do you have any known drug allergies? ❑Yes **Allergic Reaction Type (What Happens?)**

If so, please list all medications you are allergic to: ❑No
Medication Name

Goals of Treatment

Please explain your goals of treatment_____ _____

_____

_____

_____

If on opioids, **please explain how they help you**, what they allow you to do if you were not taking them otherwise_____ _____ _____

_____

_____

Review of Systems

Mark the following symptoms that you **currently** suffer from. *Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.*

Constitutional: ❑ Weakness ❑ Fatigue ❑ Weight gain ❑ Weight loss ❑ Fever ❑ Chills ❑ Night sweats

Eyes: ❑ Recent visual changes ❑ Eye glasses/contact lenses ❑ Double vision

Ears/Nose/Throat: ❑ Dental Problems ❑ Ear aches ❑ Hearing probles ❑ Nosebleeds
❑ Recurrent sore throats ❑ Ringing in the ears ❑ Sinus problems

Cardiovascular: ❑ Chest pain ❑ Irregular heartbeat ❑ Murmur ❑ Rapid heartbeat ❑ Blood clots
❑ Swollen extremities ❑ Palpitations ❑ Fainting

Respiratory: ❑ Cough ❑ Shortness of Breath on Exertion/Effort ❑ Wheezing ❑ Shortness of breath at rest

Gastrointestinal: ❑ Acid reflux ❑ Abdominal cramps ❑ Constipation ❑ Diarrhea ❑ Vomiting
❑ Coffee ground appearance in vomit ❑ Dark and tarry tools

Genitourinary/Nephrology: ❑ Blood in Urine ❑ Decreased urine flow/Frequency/Volume ❑ Flank pain
❑ Erectile dysfunction ❑ painful urination ❑ Incontinence

Integumentary/Skin: ❑ Change in skin color ❑ Rashes ❑ Puritis ❑ Dry skin

Musculoskeletal ❑ Joint swelling ❑ Back pain ❑ Muscle spasms ❑ Joint pain ❑Neck pain
❑ Pelvic pain ❑ Joint stiffness

Psychiatric: ❑ Depressed mood ❑ Anxiety ❑ Stress ❑ Suicidal Thoughts

Endocrine: ❑ Heat Intolerance ❑ Cold Intolerance ❑ Hair changes ❑ Excessive thirst

Neurological: ❑ Dizziness ❑ Seizures ❑ Headaches ❑ Numbness/tingling ❑ Memory loss
❑ Difficulty with speech ❑ Uncoordination ❑ Difficulty walking

Hematologic/Lymphatic: ❑ Easy bruising ❑ Easy bleeding ❑ Impaired wound healing ❑ Lymphadenopathy

Allergic/Immunologic: ❑ Recurrent infection ❑ Hives ❑ Swelling ❑ Itching eyes or nose

Tobacco use assessment form

Name: _____ **Today's Date:** _____

Date of Birth: _____

1. **Have you ever smoked cigarettes or used any other tobacco product?**
   ___Yes
   ___No

2. **Do you currently smoke cigarettes or use any other tobacco product?**
   ___Yes
   ___ No -- Date Stopped _____ _____

   If you answered yes to questions 1 or 2, please answer the following:
   Type of tobacco and brand name _____ _____
   Length of use (in months or years) _____ _____ _____
   Amount used per day on average _____ _____ _____

3. **Does anyone you live with or who is close to you smoke cigarettes or use other forms of tobacco?**
   ___Yes
   ___No

   (Continue only if you answered *Yes* to #2)

4. **How soon after you wake up do you smoke your first cigarette or use other forms of tobacco?**
   ___Within 30 minutes
   ___More than 30 minutes

5. **How interested are you in stopping smoking or stopping use of other forms of tobacco?**
   ___Not at all
   ___A little
   ___Some
   ___ Very

6. **If you decided to quit smoking or using other forms of tobacco completely during the next 2 weeks, how confident are you that you would succeed?**
   ___Not at all
   ___A little
   ___Some
   ___ Very

7. **Have you ever intentionally quit smoking/using other forms of tobacco for 24 hours or longer?**
   ___Yes ___No

   In the past year? ___Yes ___No
   In the past month? ___Yes ___No
   Since the last visit? ___Yes ___No

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ALCOHOL MISUSE/ABUSE (AUDIT C)

1. Did you have a drink containing alcohol in the past year?
    - Yes
    - No
2. If 'Yes': How often did you have six or more drinks on one occasion in the past year?
    - Never
    - 2 to 4 times a month
    - 2 to 3 times per week
    - 4 or more times a week
    - Decline to specify.
3. If 'Yes': How many drinks did you have on a typical day when you were drinking in the past year?
    - 1 or 2 drinks
    - 3 or 4 drinks
    - 5 or 6 drinks
    - 7 to 9 drinks
    - 10 or more drinks
    - Decline to specify.
4. If 'Yes': How often did you have a drink containing alcohol in the past year?
    - Never
    - Monthly or less
    - 2 to 4 times a month
    - 2 to 3 times a week
    - Daily or almost daily
    - Declined to specify.

New Patient Demographic Information

- ☐ Driver's License or State Issued Photo ID.
- ☐ Photocopy of the front and back of your insurance card.

Preferred Pharmacy I understand I am only allowed to use ONE pharmacy by Paragon	☐ Yes	☐ No
Pharmacy Name	Pharmacy Location	

Patient Information					
Name (First, Middle, Last)		Birth Date	Age	Social Security #	Birth Gender ☐ M ☐ F
Mailing Address	Apt #	City, State ZIP			
Email Address		Primary Phone ☐ Home ☐ Cell		Okay to leave message? ☐ Yes ☐ No	
Employer (or parent/guardian employer if patient is a minor)				Work Phone	
Primary Care Provider (where you go for your routine medical care)					
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino		Race ☐ Black or African American ☐ Asian ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ American Indian/Alaska Native ☐ Prefer not to answer			

Emergency Contact		
Contact Name	Phone Number	Relationship to Patient

Medicare Patient: Are you enrolled in Chronic Care Management with PCP?

Medicare Patient: Are you enrolled in Remote Patient Monitoring with any Physician?

1. I understand that professional services are rendered and charged to the patient and not to the insurance company. Not all issues/conditions/problems which are the focus of psychotherapy or an evaluation are reimbursed by insurance companies. It is my responsibility to verify the specifics of my coverage. I am responsible for payment for any services or charges not covered by my insurance. I understand that this office does not assume responsibility for claim denials, claim disputes, or for insurance payment of my account.
2. I agree to pay all deductibles, co-payments, and/or co-insurance amounts not paid by my insurance(s). These will be paid at the time services are rendered, unless other arrangements have been made. Under no circumstances does this office accept liens as payment on an account.
3. I understand that if my insurance(s) require a referral from my primary care physician, Norberto Vargas, M.D or JP Benavides, D.O. at Paragon Pain & Rehabilitation, LLP. must have verification of the referral **prior** to my first appointment. I will bring my insurance information or insurance card(s) to my first appointment so that the office can properly identify my program(s).
4. I authorize the release of information concerning my treatment or the treatment of my dependent(s) to my insurance company(s), including that an insurance company representative may review the clinical record.
5. I authorize direct payment by my insurance company(s) to Paragon Pain & Rehabilitation, LLP.

Signature

PARAGON
Health Partners

Medical Record Release of Information

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (____)_____ **ALT. PHONE** (____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name:
PARAGON HEALTH PARTNERS/PARAGON PAIN & REHABILITATION
Address 2895 Lewis Lane Paris, TX 76034
Phone (972)-203-3600 Fax (972) 203-3601 Email: info@paragonphp.com

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**

Patient Name **Date:**

Consents	Initital
Consent For Treatment: I hereby consent to the treatment by the providers at Paragon Health Partners and its employees or designees. I auathorize the mental and physical health care services deemed necessary or advisable by my caregivers to address my needs.	
Consent for Medication History: I authorize Paragon Health Partners and its employees or designee to access my medication history via PMP portal and from participating pharmacies that Paragon Health Partners request medication History.	
Consent of Picture for Electronical Medical Record Chart: I understand and consent and authorize that my photo is taken for my Electronical medical record chart. If I am being treated for obesity medicine this picture will be attached to my progress note.	
Authorization for Release of personal health Information: I aurthorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or the purposes of conducting the healthcare operations of Paragon Health Partners. I authorize Paragon Health Partners to release any information required in the process of applicationts ofr financial coverage for the services rendered. This authorization provides that Paragon Health Partners may release clinical information related to my diagnosis and treatments for pain management, addiction medicine, alcohol or opioid, street drugs use, obesity medicine, which may be requested by my insurance or its designated agent.	
Assignment of Insurance Benefits/Payment Gurantee/Collection Fee: I authorize payment to be made directly to Paragon Health Partners, Paragon Primary Care, Paragon Pain & Rehabilitation, and/or any of its providers. For insurance payment payable to me. I understand that I am financially responsible to practice for any non-coverred servcies , as defined by my insurer. I understand that if my account balance becomes overdue if may be referred to collection agency. I understand payment is due at time of service.	
Privacy Policy: I acknowledge having received Paragon Health Partners, "Notice of Privacy Practices" My rights including the right to see a copy of my medical records, to limit disclosure of my health information, and to request an amendment to my record, is explained in the policy. I understand that I may revoke in writing my consent fo release of my healthcare information, excep to the extent Paragon Health Partners has already made disclosures with my prior consent.	
Disclaimer: By Typing your name above, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this paperwork from Paragon Health Partners.	
Payment Policy __All Co-payments and any past due balances are due at the time of visit. If you receive a bill and would like to make payment. Our website has a online payment option. Simply go to website at www.paragonphp.com and in the upper right click online payment and follow steps.	
Late/No Show/Cancellation Fees: **Late is considered arriving for New Evaluation less than 30 minutes prior to appointment time. You can be rescheduled and will be charges a $50.00 Fee. Late for a Follow Up over 5 minutes will be rescheduled and charged a $25.00 Fee. _A missed appointment, reschedule less than 48 hours prior will result in a $50.00 Fee, and a $25 fee if it is a follow up appointment . Telemedicine or Office Appointment.**	

My signature below signifies that I have read, understood, and agree to the above terms of the office policies, this financial agreement and office billing/insurance policies.

_____
Patient Name (Printed)

_____
Responsible Party (Printed) (If patient is a minor or dependent adult)

Patient Signature Date

Cancellation/Late Policy

Payment Policy

All Co-payments and any past due balances are due at the time of visit. If you receive a bill and would like to make payment. Our website has a online payment option. Simply go to website at www.paragonphp.com and in the upper right click online payment and follow steps.

Cancellation Policy

As our practice continues to grow, we have updated our cancellation policy to better serve our patients. Your appointment time is reserved especially for you. Please call 972-203-3600 at least 48 hours before your scheduled appointment if you will be unable to keep your appointment. This allows our practice to offer that appointment to another patient who needs medical care. Conversely, the situation may arise when another patient fails to cancel and we are unable to schedule you for a visit, due to seemingly "full" calendar for the day. **If you do not cancel your appointment at least 48 hours in advance, you will be charged a no-show or late cancellation fee. This fee is not covered by insurance. Payment will be required before another appointment is scheduled**

We understand that life gets busy. However, a pattern of missed appointments without proper notice does not show mutual consideration. Patients who fail to provide advanced cancellation for three appointments in the span of one year may be subject to dismissal from the practice.

Late Arrival Policy

We know that delays can happen when you are trying to get to your appointment. However, we must try to keep the other patients and doctors on time. If you arrive 10 minutes past your scheduled time, we may have to reschedule your appointment.

Fee Amounts:

$50.00 Fee- New Evaluation, Procedure, Injection, EMG/

NCV $25.00 Fee- Follow Up Appointment.

PARAGON
Health Partners

PATIENT'S ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Paragon's Notice of Privacy Practices. The Notice of Privacy Practices provides information about how Paragon may use and disclose your health information. I understand that the Notice is subject to change.

_____ _____

Name of Individual (Printed) Signature of Individual

_____ _____

Signature of Personal Representative Relationship (e.g., Attorney-In-Fact, Guardian, Parent if a a minor)

Date Signed _____/_____/_____

PARAGON
Health Partners

HIPAA NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information may be used and disclosed and how you can get access to this information. Please review it carefully.

As a health care provider, we are committed to maintaining the privacy and confidentiality of your health information in accordance with Federal and State law and we are required by law to provide you with this Notice of Privacy Practices (Notice) that describes how health information that we maintain about you may be used or disclosed. This Notice also describes your rights and the obligations we have regarding the use and disclosure of health information. This Notice applies to Paragon Pain Rehabilitation LLP d/b/a Paragon Health Partners and Paragon Primary Care, PLLC d/b/a Paragon Health Partners, which are separate legal entities that are under common ownership and control and have thus organized themselves as a single Affiliated Covered Entity (Paragon) for purpose of compliance with the Health Insurance Portability and Accountability Act (HIPAA). This status permits Paragon to maintain a single Notice of Privacy Practices and to share health information as one organization as described in this Notice. Each of the Paragon entities will follow the terms of this notice.

Uses and Disclosures of Your Health Information
We are permitted to use and disclose your health information under a variety of circumstances. Some of the reasons that we may use or disclose your information include:

- For Treatment: We may use and disclose health information about you to provide you with medical treatment or services. For example, your doctor might use your name, age, possible diagnosis, and other information required to obtain laboratory testing.
- For Payment: We can use and disclose your health information to bill and get payment from you, your health insurers or other entities. For example, we may need to give your health plan information about your visit so that they will pay us or reimburse you.
- For Health Care Operations: We may use and disclose your health information for our operations. For example, we may need to use your information when in the course of quality assurance or utilization review activities. We may also combine medical information about our patients to decide what services we should offer or to see where we can make improvements..
- Use or Disclosure Required By Law. We may use or disclose your health information to the extent such use or disclosure is required by law.
- Health Agency Oversight Activities. We may disclose your health information to governmental, licensing, auditing and accrediting agencies for health oversight activities.
- Law Enforcement. We may disclose your health information for law enforcement purposes.
- To Avert a Serious Threat to Health or Safety. We may use or disclose your health information when necessary to prevent a serious threat to health or safety of a person.
- Public Health Risks: We may disclose health information about you for public health activities.
- Workers' Compensation. We may disclose your health information to covered entities that are government programs providing public benefits and for workers' compensation.
- To Respond to Lawsuits and Legal Actions: We may disclose your health information in response to a court or administrative order, or in response to a subpoena.
- Business Associates: We may disclose your health information with third-party vendors that provide services on our behalf, which are referred to as "Business Associates."
- Individuals Involved in Your Care or Payment for Your Care: We may use or disclose health care information to a family member or friend involved in your care or payment for your care.
- Marketing and Sale of Health Information: We must obtain your written authorization prior to most uses of your health information for any marketing purposes or disclosures that constitute a sale of your health information.
- Appointment Reminders and Communications. We may use and disclose your health information and the contact information you provide us with to contact you with appointment reminders or other health-related communications, including via email, text message or telephone or mail. While email or text messages may not be encrypted or secure and could be intercepted in transit, we will assume you understand these risks if you provide us with your mobile telephone number or email address and that you consent to us communicating with you in this manner.

Other Uses of Your Health Information

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. Your written, signed authorization is required before Paragon may use or disclose health information containing psychotherapy notes, if Paragon intends to use your health information for marketing purposes, or for the sale of your health information. You may revoke this permission for any of those purposes requiring authorization, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Your Rights

You have the following rights regarding health information we maintain about you:

- Right to Inspect and Copy: You have the right to inspect and obtain a copy of your health information maintained in a designated record set. We may charge a reasonable, cost-based fee. We may require you to submit your request in writing.
- Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of health information about you other than our own uses for treatment, payment and health care operations, as those functions are described above. We will provide you one accounting of disclosures each year free of charge but will charge a reasonable, cost-based fee if you ask for another one within twelve (12) months. We may require you to submit your request in writing.
- Right to Amend: If you feel the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our organization. We may require that you submit a request in writing and provide a reason to support the requested amendment.
- Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care. We may require you to submit such a request in writing. Because any restrictions of your information may hinder the quality of care provided by our facility, according to the law, we reserve the right to deny such request. However, we must agree to the request for a restriction if the request involves a disclosure about your health information to a health plan (1) when the disclosure regards carrying out payment or health care operations (and is not otherwise required by law), and (2) the health information solely pertains to health care that you, or a person other than a health plan, has paid to Paragon in full.
- Right to Request Confidential Communications: You have the right to request that we communicate your health information with you in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.
- Right to be Notified of a Breach. You have the right to be notified if there is any impermissible use or disclosure of your health information that compromises the privacy or security of your health information.
- Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time.

Changes to this Notice.

We are required to abide by the current version of this Notice, and we reserve the right to change this Notice. The revised or changed Notice will be effective for health information we already have about you as well as any information we receive in the future. The new notice will be available upon request, in our office and on our website.

Complaints

If you believe that we may have violated your privacy rights, or you disagree with a decision about your health information, you may file a complaint with us by contacting the Privacy Officer at the address listed below or with the Secretary of the Department of Health and Human Services. You will not face retaliation for filing a complaint. **Privacy Officer**

For further information, please contact our Privacy Officer, Karen McNerney at: **POBox 1200 Colleyville, TX 76034 (972) 203-3600**

4881-1519-2356.2

Paragon Health Partners
2895 Lewis Lane Paris, TX 75460
Phone: 972-203-3600 Fax: 972-203-3601

INFORMED CONSENT AND PAIN MEDICINE AGREEMENT

AS REQUIRED BY THE TEXAS MEDICAL BOARD

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

6th Edition: Developed by the Texas Pain Society, January 2024 (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 (medication) therapy to be used, so that you may make an informed decision about whether or not to take the drug(s) knowing the benefits, 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. It is essential for the trust and confidence required for a proper patient-physician relationship and is intended to inform you of your physician's expectations that are necessary for patient safety and compliance. For this agreement the use of the word "physician" is defined to include not only your physician but also your physician's authorized associates, physician assistants, nurse practitioners, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat your condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician (name at bottom of agreement) to treat my condition of 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 a prescription(s) for dangerous and/or controlled drugs (medications) as a part of the treatment of my chronic pain.

It has been explained to me that these medication(s) include opioid/narcotic drug(s). I have discussed with my Pain Medicine Physician 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, 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 accidental overdose, injury and death are also possibilities as a result of taking these medication(s).

I understand that concurrently consuming sedating substances like alcohol or taking additional types of sedating controlled medications such as benzodiazepines and gabapentenoids along with opioids increases my chance for accidental overdose, injury, and death. If in the unusual situation, it is medically indicated for me to receive multiple types of controlled substances, I understand that I will require close supervision of medical specialists

to maximize my safety. I agree to follow their direction on the proper use of these medications. Deviation from using medications as directed is grounds for discontinuation of pain therapy.

THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATELY 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 (urine, blood, saliva or any other testing indicated and deemed necessary by my physician at any time) and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the tests, and 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 my Pain Medicine Physician's care.

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 want 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 to live a more productive and functional life. I realize that I may have a chronic illness and there is a limited chance for a complete cure, but the goal of taking medication(s) regularly is to reduce (but probably not eliminate) my pain so that I can enjoy an improved quality of life. I realize that the treatment may 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 benefits. I have been given the opportunity to ask questions about my condition, treatment, risks of non-treatment, drug therapy, 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.

For female patients only:

_____To the best of my knowledge **I am NOT pregnant.**

_____If I am not pregnant, I will take appropriate precautions to avoid pregnancy 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 understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) to ensure complete safety of 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, or baby.

PAIN MEDICINE AGREEMENT:

I UNDERSTAND AND AGREE TO THE FOLLOWING:

This pain medicine agreement relates to my use of any and all medication(s) called dangerous drugs and/or controlled substances (i.e., opioids, also called narcotics or painkillers, and other prescription medications) for chronic pain prescribed by my physician. I understand that there are many strict 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 Medicine Physician" below means your primary Pain Medicine Physician or your physician who is managing your pain, or that physician's Physician Assistant or Nurse Practitioner, or another physician covering for your primary Pain Medicine Physician.

My Pain Medicine Physician may at any time choose to discontinue 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 Acknowledge 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 must be accessed by my Pain Medicine Physician every time a prescription is written, and by my pharmacist every time before my prescription is dispensed.

_____ I will not consume alcohol or use any illegal substances (such as marijuana, heroin, cocaine, methamphetamines, etc.) while being prescribed dangerous and/or controlled substances for the treatment of chronic pain. NOTE: Prescription THC is not marijuana, but it does show up on urine drug tests, therefore I will inform my provider if I have been prescribed the FDA-approved synthetic THC compounds such as nabilone and/or dronabinol which are available for managing chemotherapy-induced nausea and vomiting, as well as for stimulating appetite in cases of AIDS-related anorexia in patients.

_____ I will not use any Low-THC cannabis unless my Pain Medicine Physician also gives me written permission to use the Low-THC cannabis (as defined in the Texas Occupations Code) that has been prescribed by a registered Texas compassionate-use physician.

_____I agree to submit to laboratory tests for drug levels upon request, including urine and/or blood or saliva screens, to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for alcohol or illegal substance(s), treatment for chronic pain may be terminated. Also, a consultation 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) before the time of my next scheduled refill, even if my prescription(s) run out. My Pain Medicine Physician may limit the number and frequency of prescription refills.

_____ I understand that my medication(s) will be refilled regularly. 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. But if my medications were stolen and I provide my Pain Medicine Physician with a copy of the police report, my Pain Medicine Physician after carefully reviewing my situation, may issue an early refill.**

_____ My Pain Medicine Physician will manage all of my chronic pain symptoms**. Only my Pain Medicine Physician may prescribe Dangerous Drugs and Controlled Substances for the treatment of chronic pain**. I will receive controlled substance medication(s) **only from ONE Pain Medicine Physician** unless it is for an emergency **or** the medication(s) that is being prescribed by another physician is approved by my Pain Medicine Physician. Information that I have been receiving medication(s) prescribed by other physicians that has not been approved by my Pain Medicine Physician may lead to a discontinuation of medication(s) and treatment. All other health-related issues must be managed by my primary care physician and my other specialists.

_____I agree that I **will inform any physician** who may treat me for any other medical problem(s) that I am enrolled in a pain medicine program and have signed this Pain Medicine Agreement.

_____I hereby give my Pain Medicine Physician **permission to** discuss all diagnostic and treatment details with my other physician(s) and my pharmacist(s) regarding my use of medications prescribed by my other physician(s). I give my Pain Medicine 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 Medicine Physician**. **Any unauthorized increase** in the dose of medication(s) may cause the discontinuation of my pain treatment(s).

_____ If anyone other than my Pain Medicine Physician prescribed me medication(s) to treat acute, post surgical or chronic pain, then I will **disclose** this information to my Pain Medicine 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.

____I will alert my physician if I receive a prescription for Naloxone or any opioid antagonist which are designed to reverse the effects of an accidental or intentional overdose of pain medication.

_____ All medication(s) must be obtained at **one pharmacy designated by me**, with the 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 Medicine 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 Medicine 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 Pain Medicine 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 my medications.

_____ I understand that if my behavior in the office is viewed as disrespectful, inappropriate, verbally abusive or offensive, or hostile I will be discharged from the practice.

_____ I will not consume Kratom while being prescribed dangerous and controlled substances for the treatment of chronic pain. I understand that the use of Kratom increases my risk of failing a urine drug test, and could result in dismissal from the practice.

_____ I will **not use any cannabidiol (CBD) products unless one of my physicians has prescribed me Epidiolex, and I will immediately provide you with that physician's name and lab work so that I can make sure it is not causing problems with my current medications. I understand that the use of over-the-counter CBD products increases my risk of failing a urine drug test because of the presence of illegal substances present in many over-the-counter CBD products.**

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

_____ I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, interventional pain medicine (e.g. steroid injections, nerve ablations, implants to relieve pain, etc.) 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 medicine program** recommended by my Pain Medicine 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 I will discontinue it before starting these medications.

I certify and agree to the following (*Patient Shall Acknowledge 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** to me 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 with 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 Medicine Agreement supersedes any other pain management agreement that I may have signed in the past.

_____

Name and contact information for pharmacy

_____

Patient Printed Name Physician Printed Name *(or Appropriately Authorized Assistant)*

_____

Patient Signature Physician Signature *(or Appropriately Authorized Assistant*

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