



James V. Stonecipher, M.D.
James T. Gray, R.N., F.N.P.
3841 Sagebriar Drive
Bryan, Texas 77802
(979)774-1377 phone, (979) 774-6147 fax

CONSENT FOR MEDICAL TREATMENT

I hereby authorize and give my consent for medical treatment and procedures by the providers of Texas Pain and Spine Consultants, and certify that no guarantee of assurances have been made as to the result which may be obtained.

CONSENT FOR INSURANCE BENEFITS

For hospital or office services provided (if applicable), I hereby assign and transfer to Texas Pain and Spine Consultants my rights and benefits due from my insurance companies provided for on the new patient information sheet. I hereby agree to update Texas Pain and Spine Consultants should my insurance coverage change. I hereby understand that ultimate financial responsibility for all medical services performed by Texas Pain and Spine Consultants lies with myself.

CONSENT TO RELEASE MEDICAL RECORDS

This consent will authorize Texas Pain and Spine Consultants to provide a copy, summary, or narrative of my medical records to my referring physician(s), insurance company, pharmacies and/or workman's compensation carrier (if applicable). I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of the document at my request.

CONSENT TO RELEASE MEDICAL RECORDS

I hereby allow Texas Pain and Spine Consultants to obtain medical records from any hospital, pharmacy, laboratory or any past physicians, as he feels necessary. This would include both previous testing and current evaluation, which he or other physicians may have ordered.

CONSENT TO RELEASE HIV RECORDS

I consent to release of my positive or negative test result for AIDS or HIV infections, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.

I UNDERSTAND THAT PAYMENT ARRANGEMENTS FOR ALL SERVICES MUST BE MADE AT THE TIME OF THE VISIT.

SIGNED: _____

DATE: _____

Texas Pain & Spine Consultants
James V. Stonecipher, M.D.

Agreement for Controlled Substance Medications

The long-term use of such substances as opioids (narcotic analgesics), benzodiazepines (tranquilizers), and barbiturates (sedatives) is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient, as consideration for, and condition of, the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain. **The prescription of controlled substances is a PRIVILEGE, not a RIGHT, and adherence to the following guidelines is mandatory.**

1. All controlled substances must come from the physician whose signature appears below, or during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment.)
2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed.
3. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.
4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.
5. You may not share, sell, or otherwise permit others to have access to these medications.
6. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.
7. Unannounced urine or serum toxicology screens may be requested, and your cooperation is required.
8. Original containers of medications should be brought in to each office visit upon request.
9. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of the reach of such people.
10. Medications may not be replaced if they are lost.
11. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentially is waived and these authorities may be given full access to our records of controlled substances administration.
12. Renewals are contingent on keeping scheduled appointments. All refills require 24 hours notice. No refills after hours.
13. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

Patient Signature

Physician Signature

Patient Name (Print)

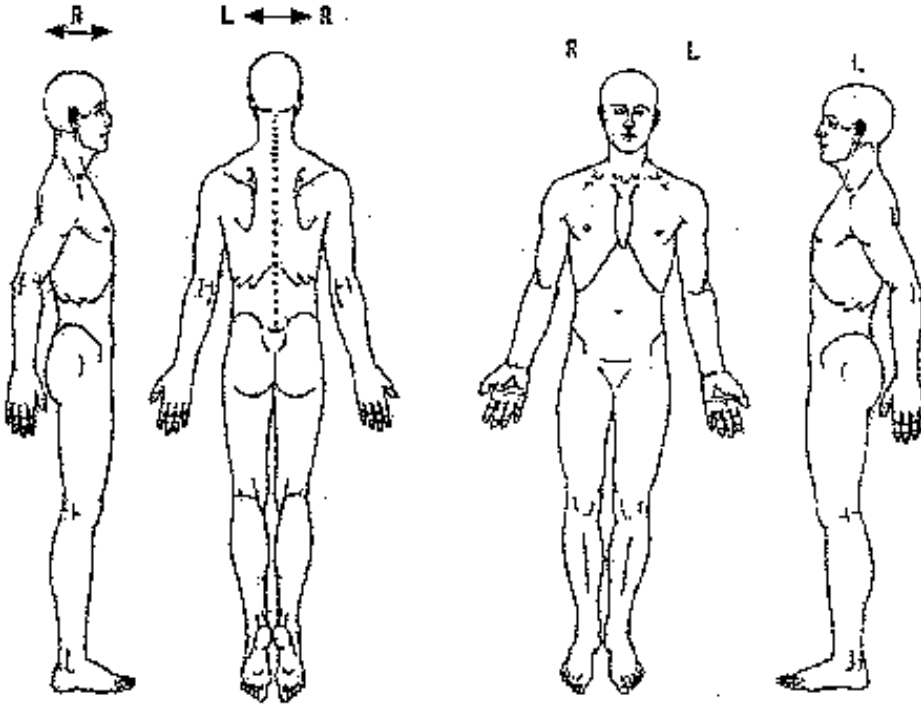
Date

Name _____ Age _____ Height _____ Weight _____
 Last First

Referring Health Care Provider _____ How long have you had this pain? _____

Allergies _____

Please shade in the areas where your pain is located:



Please circle the words that best describe your pain.

Aching Throbbing Cramping Stabbing Stinging Burning Radiating

1. Please rate how bad your pain is along a line where 0 is no pain and 10 is the worst pain you can imagine.
 0 _____ 10

2. Is your pain the result of an:
 Illness Yes _____ No _____ If yes, please explain and give dates _____
 Accident _____

3. Are you presently involved in litigation resulting from this accident? Yes _____ No _____
 If yes, what is the name of your attorney? _____

4. Please indicated which of the following affects your pain:

	Increases Pain	Decreases Pain	No Change
Liquor	_____	_____	_____
Stimulants	_____	_____	_____
Eating	_____	_____	_____
Heat	_____	_____	_____
Cold	_____	_____	_____
Physical Activity	_____	_____	_____
Movement	_____	_____	_____
Lying Down	_____	_____	_____
Sitting	_____	_____	_____
Standing	_____	_____	_____
Sexual Intercourse	_____	_____	_____
Urination	_____	_____	_____
Bowel Movement	_____	_____	_____
Tension	_____	_____	_____
Bright Lights	_____	_____	_____
Loud Noises	_____	_____	_____
Fatigue	_____	_____	_____
Sneezing, Coughing	_____	_____	_____

5. How many hours do you sleep at night? _____ Does your pain awaken you from sleep? _____
6. Do you smoke? _____ If yes, how much & for how long? _____
7. How much caffeinated beverages do you drink in a day? (coffee, tea, cola, etc.) _____
8. What is your usual occupation? _____ Are you presently working? _____
9. What diagnostic test have you had? Please indicate when and where they were done.

	Date	Facility
X-Ray	_____	_____
EMG	_____	_____
CT Scan	_____	_____
Myelogram	_____	_____
Discogram	_____	_____
MRI Scann	_____	_____

10. Please check any of the treatments you have had for this pain problem. Include dates and results.

Treatment	Pain Relief		Date
	Yes	No	
Nerve Blocks	_____	_____	_____
Epidural Steroids	_____	_____	_____
Physical Therapy	_____	_____	_____
Traction	_____	_____	_____
Chiropractor	_____	_____	_____
Psychologist	_____	_____	_____
Hypnosis, Biofeedback	_____	_____	_____
Comprehensive Pain Clinic	_____	_____	_____

11. Please list all the medications you are currently taking: _____

12. Have you ever taken anticoagulants (blood thinners such as Coumadin and Heparin) _____, Cortisone _____, local anesthetics _____?

13. HAVE YOU EVER HAD A REACTION TO A LOCAL ANESTHETIC? _____ If yes, please explain: _____

14. Please list the surgeries that you have had:

Surgery	Date	Surgeon
_____	_____	_____
_____	_____	_____
_____	_____	_____

15. Please list any serious illnesses or hospitalizations you have had in the past: _____

16. Please check the appropriate space if you have had or presently have any of the following health problems:

_____ Diabetes	_____ Hypertension	_____ Heart Disease	_____ Vascular Problems
_____ Kidney Problems	_____ AIDS	_____ Hepatitis	_____ Emphysema
_____ Asthma	_____ Epilepsy	_____ CVA (Stroke)	_____ Shingles
_____ Tuberculosis	_____ Other		

Patient Signature (or parent, guardian or legal representative): _____

Date: _____