Pain Reduction Center
Ben Tiongson, M.D.
4710 Bellaire Blvd., Suite 189
Bellaire, Texas 77401
Phone: 713-665-6076 **Fax: 713-665-8866**

General Information

Name: _____ Age: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Cell: _____

Emergency Information

Emergency Contact: _____ Relation: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Cell: _____

Referring Physicians

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Demographics

Date of Birth: _____ / _____ / _____

SSN: _____-_____-_____

Marital Status: Single ( ) Married ( ) Divorced ( ) Seperated ( ) Widowed ( )

Spouse's Name: _____

Patient's Current Employer: _____

Employer's Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

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AUTHORIZATION FOR THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

Explanation
This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Civil Code Section 56 et seq.

Authorization
Patient Name:_____ Date of Birth:_____
Address:_____
City/State/Zip Code: _____
Home Phone #:_____ Work #:_____
Social Security #:_____

I, hereby authorize Pain Reduction Center the use or disclosure of my individually identifiable information as described below. I understand that the information I authorize a person or entity to receive, my individually identifiable information, may be re-disclosed and no longer protected by the federal privacy regulations.

Description
[ ] The patient's entire medical record
[ ] The patient's demographic information
[ ] Medical Data/Information as related to _____
_____
_____
[ ] Other_____

Uses
The reason why I am requesting this information to be released is for the following purposes:_____

Informed Understanding
1. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment or payment or coverage of services.
2. I understand that I may inspect or receive a copy of the information used or disclosed and may refuse to sign this authorization.
3. I understand that I may revoke this authorization at any time by notifying Pain Reduction Center in writing, except to the extent that action (PHI already used or disclosed) has been taken in reliance of the authorization.

Duration
This authorization expires on:_____.

X_____ _____
Signature of patient or legal authorized representative Date

_____
Printed name of patient or authorized representative

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I, _____, understand that this contract is between myself and Benjamin Tiongson, M.D. It is designed to inform me fully of the manner in which my medications, especially narcotics, will be provided. It also outlines the criteria by which the doctor will determine whether or not to continue my medication.

1. Pain medications, especially of a narcotic type, will be provided only after it is determined that all reasonable alternatives for adequate pain control have been investigated / attempted.
2. I will agree to try other approached of techniques as felt appropriate by the team that may assist me in taking the lowest effective dose possible.
3. My "pain medications" will be prescribed by one doctor only, and filled at one pharmacy. Any attempt, successful or not, to obtain additional medication without the permission of the doctor may result in discontinuation of medication therapy.
4. When Dr. Tiongson consults with me for the first time and a prescription is given it is always for no more than 7 days (one week). When I require a refill I must call my pharmacy and they in turn will call the office with request. I am to allow 30 hours for approval of this refill. In other words, call my pharmacy a day in advance and tell them I will be picking up my medication the day it is due.
5. I may, at times, be requested to submit to a drug screen to confirm that I am taking only those medications prescribed.
6. Medications will be continued as long as a) there is associated pain relief of at least 30-50% b) my functional activity is commensurate with what would be expected, given my physical condition, and is enhanced by taking the medications, and c) there is no evidence of physical tolerance, as suggested by the need for increasing medicine.
7. Evidence of hoarding or other mismanagement of my pain medications may result in discontinuation of doctor services.
8. "Flare-ups" or exacerbation of my pain symptoms will be handled by other therapies, such as TENS unit, exercise, icing, heat relaxation, or non-habit forming preparations. Only when it is determined that there is a physiological basis for the flare-up, and additional medicine is required, a brief increase "rescue dose" will be considered.
9. If it is determined that the situation may be out of control, I agree to be hospitalized where medications and other therapies can be provided in a controlled fashion.

I have read and understand each of the above statements. I realize that the doctor will assume the responsibility of assisting me in my therapy as long as I comply with the above.

X_____ _____
Patient Signature Date

_____ _____
Witness Date

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CONSENT and DISCLOSURE
ASSIGNMENT OF BENEFITS/LONG TERM SIGNATURE AUTHORIZATION

Patient Name: _____ Date: _____

Authorization to Release Information: I hereby authorize the physician to release information concerning examination, testing, and treatment of the above patient to any insurance company, attorney, other medical facility, or other physicians requesting the same for purposes of determining eligibility for payment of insurance benefits for billing purposes.

Authorization to Obtain Information: I hereby authorize the physician, Dr. Tiongson, to obtain information concerning examination, testing and treatment of the patient form any insurance company, attorney, other medical facilities, or other physicians.

Statement of Financial Responsibility: The undersigned agrees whether he / she signed as agent or a patient, that in consideration of services to be rendered to the patient, he / she individually obligated himself to pay the account in accordance with the regular rate charged by the provider. Should the account be referred to collections, whether it be a collection agency or attorney, the undersigned agrees to pay the collection expense and reasonable attorney fees equal to 32 % of the outstanding payable due. Should protracted litigation result, the court may set an attorney fee in excess or 32 % of the outstanding balance.

Consent for Treatment: The undersigned hereby consents to examination and treatment of the patient by the physician and to the performance of any surgical or diagnostic procedure which the physician treat the patient deem necessary under the circumstances.

Authorization to Pay Insurance Benefits and Guarantee of Payment: I authorize payment to any and all physicians involved in my treatment or diagnosis of any benefits specified and otherwise payable to me, but not to exceed the reasonable and customary charges. I understand I am financially responsible to these physicians for charges not covered by this assignment.

Statement to Permit Payment of Medical Insurance Benefits to Physicians: I certify that the information given by me in applying for payment under titles V, XVII and XIX of the Social Security Act is complete and correct. I authorize any holder of medical of other information about me to the Social Security Administration or its carrier any information needed for this or any related Medicare / Medicaid Claim. I request that payment of authorized benefits by made on my behalf to the physician or its designated representative. I hereby authorize the physician or its designated representative to obtain, from the Social Security Administration, and the agency, to release any information to establish my entitled to Medicare / Medicaid benefits.

Patient Signature: X_____ Date: _____

Witness: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

1. I acknowledge that I have received or have access of the Privacy Notice

X _____ _____

Patient Signature / Representative Date

2. If personal representative's signature appears above, please describe Personal representative's relationship to patient.

_____

3. I authorize Pain Reduction Center to disclose any Personal Health Information that is necessary on my answering machine or with friend / family member.

X _____

Patient's Signature

Name: _____ Age: _____ Date: _____

Primary Doctor: _____

PAIN DESCRIPTION AND HISTORY

1. I am here in the office today because:

   I have pain in _____

   Other: _____

2. My Problems Started in (Month, day, year) _____
3. Explain what happened:

_____

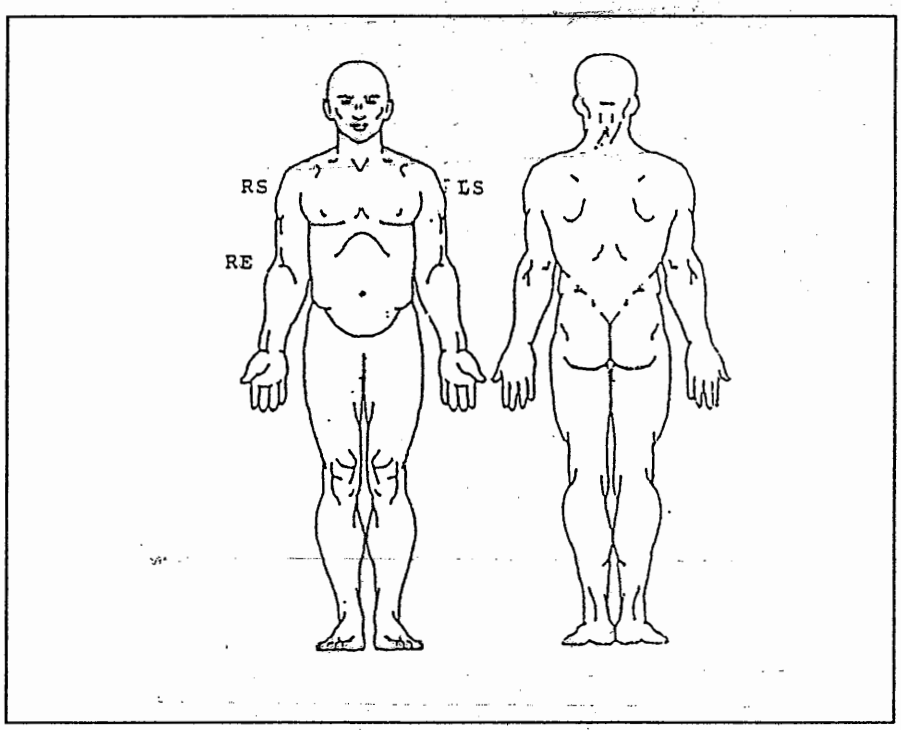
_____

_____

_____

4. I have pain as described in the diagram below: (use the symbols which apply to your pain on the diagram).

Dull Pain	Burning Pain	Stabbing or Sharp Pain	Numbness	Pins & Needles
++++++	BBBBBBB	SSSSSSSSSSSSS	0000000	///////////



Patient Name: _____ Date: _____

5. What do you believe to be the cause of your pain?

[ ] Injury or accident at home
[ ] Injury or accident at work
[ ] Cause Unknown
[ ] Result of Illness
[ ] Result of Surgery
[ ] Other _____

6. How much time of each day do you experience the pain?

[ ] 100 % (day and night)
[ ] 50 % (1/2 day / night)
[ ] Not every day
[ ] 75 % (most of day / night)
[ ] 25 % (part of day / day)

7. What time of the day is the pain worse?

[ ] Upon waking / morning
[ ] Midday
[ ] Evening
[ ] Later / morning
[ ] Afternoon
[ ] Nights

8. Your pain condition when it is really bad is: (in the past week)

0 1 2 3 4 5 6 7 8 9 10
(no pain) (unbearable pain)

9. Your pain condition when it is not all that bad:

0 1 2 3 4 5 6 7 8 9 10

10. Your pain on the average is :

0 1 2 3 4 5 6 7 8 9 10

11. Your pain condition at the present time:

0 1 2 3 4 5 6 7 8 9 10

12. What makes your pain worse? (check all that apply)

[ ] Walking
[ ] Bending
[ ] Lifting
[ ] Standing
[ ] Sitting
[ ] Laying
[ ] Weather
[ ] Other _____

13. What makes you pain better? (check all that apply)

[ ] Walking
[ ] Bending
[ ] Lifting
[ ] Sitting
[ ] Laying
[ ] Weather
[ ] Standing
[ ] Pain Medication
[ ] Therapy
[ ] Biofeedback
[ ] Other _____

Patient Name: _____ Date: _____

14. How well do you cope with your pain condition?

0 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
(Do not cope at all) (Cope very well)

15. As a cause or result of my pain / injury, I have:

[ ] Thoughts of killing myself
[ ] Difficulty in my relationship
[ ] Lost of self-esteem
[ ] Difficulty sleeping

16. What do you expect to accomplish by seeking medical attention now?

Pain relief	[ ] Yes	[ ] No	[ ] N/A
Improvement in function	[ ] Yes	[ ] No	[ ] N/A
Improvement in relationships	[ ] Yes	[ ] No	[ ] N/A
Discontinue use of medications	[ ] Yes	[ ] No	[ ] N/A
Sleep better	[ ] Yes	[ ] No	[ ] N/A
Return to work	[ ] Yes	[ ] No	[ ] N/A

17. If your treatment here does not bring you the relief you expected, what else would you consider trying?

_____
_____

18. List all doctors you have visited in the last 2 years

_____
_____

19. I have had the following treatment for my pain: (Check all that apply)

	Date	Helped	Did not help
[ ] Surgery	_____	_____	_____
[ ] Physical therapy	_____	_____	_____
[ ] Nerve Blocks (Epidurals)	_____	_____	_____
[ ] Pain medications	_____	_____	_____
Narcotics	_____	_____	_____
Non-narcotics	_____	_____	_____
[ ] Hospitalization	_____	_____	_____
[ ] Antidepressants	_____	_____	_____
[ ] Anticonvulsants	_____	_____	_____

20. I have had the following studies done: (check all that apply)

	Date		Date
[ ] X-Rays	_____	[ ] Bone Scan	_____
[ ] MRI	_____	[ ] EMG – NCV	_____
[ ] CT Scan	_____		

Patient Name: _____ Date: _____

21. At one time or another I have had: (check all that apply)

[ ] Heart disease	[ ] Lung disease / asthma	[ ] Kidney disease
[ ] Liver	[ ] High blood pressure	[ ] Diabetes
[ ] Ulcer	[ ] Easy bruising / hemophilia	[ ] Thyroid disorder

22. I have had the following surgeries: (include date)

_____

_____

23.

I smoke	[ ] Yes	[ ] No
I drink	[ ] Yes	[ ] No
I have abused drugs	[ ] Yes	[ ] No
I have "shot up"drugs	[ ] Yes	[ ] No

24. I am [ ] unemployed [ ] disabled [ ] employed as _____
My profession is or used to be _____

25. I am involved in litigation: [ ] Yes [ ] No

26. I am allergic to: (drugs, other, include symptoms) _____

_____

27. I take the following drugs:_____

_____

28. I have the following: (check all that apply)

[ ] Constitutional:	Fever, night sweats, weight loss
[ ] Gastrointestinal:	Heartburn, vomiting, nausea, diarrhea, constipation, stomach or rectal bleeding.
[ ] Neurological:	Weakness, numbness, loss of balance
[ ] Psychiatric:	Loss of appetite, depression, suicidal thoughts, aggression, hostility
[ ] Cardiovascular:	Chest pain, palpitation, heart failure
[ ] Respiratory:	Shortness of breath, wheezing
[ ] Genitourinary:	Stool, bladder, sexual dysfunction