Edward T. Shin, M.D., D.A.B.P.M.
Comprehensive Pain Management
American Society of Anesthesiology/ American Board of Pain Medicine
Office) 972-781-0300 Fax) 214-200-9135

PATIENT INFORMATION

Personal Information

Patient Name_____ SSN_____-_____-_____ DOB_____

Address_____ City_____ St._____ Zip_____

Home #_____ Cell #_____ Email_____

Married? □ Yes □ No □ Widowed □ Other Gender: □ Male □ Female □ Other □ Decline to answer

Race:
□ White
□ American Indian or Alaska Native
□ Asian
□ Black or African American
□ Native Hawaiian or Other Pacific Islander
□ Other Race
□ Decline to answer

Ethnicity:
□ Hispanic or Latino
□ Not Hispanic or Latino
□ Decline to answer

Employment

Employer_____Occupation_____ Work Phone #_____

Address_____ City_____ St._____ Zip_____

Emergency Contacts

Name_____ Relationship_____ Contact #_____

Name_____ Relationship_____ Contact #_____

►Primary Care Physician_____ Office #_____

►Referring Physician_____ Office #_____

►List any other physicians: _____ Office # _____

Insurance Information

►Primary Insurance_____ PPO HMO EPO MEDICARE

Policy #_____ Group#_____ Guarantor_____

►Secondary Insurance_____ PPO HMO EPO MEDICARE

Policy #_____ Group#_____ Guarantor_____

PHARMACY INFO: _____ Contact # _____

Address _____

EDWARD T. SHIN, M.D., D.A.B.P.M.
PAIN CLINIC
American Society of Anesthesiology/ American Board of Pain Medicine
Office) 972-781-0300 Fax) 214-200-9135

Room:_____

DATE:_____

NAME_____

AGE_____**HEIGHT:**_____**WEIGHT**_____

REFERRING DOCTOR: _____

1. Where is your pain?_____
2. When did it start? _____
3. Briefly describe the history of your pain_____

_____

_____

4. Where is the location of your pain? _____
5. When is the pain the worst? Morning Afternoon Night
6. Circle the best descriptions of your pain: Burning Aching Sharp Stabbing Shooting Throbbing
7. What activity makes the pain worse? Standing Sitting Walking Bending Lying down
8. What activity makes your pain better?_____
9. Grade your pain from 0 to 10 *(zero=no pain/10=worst pain ever)*: Usual pain_____ Pain w/ activity_____
10. Have you had any of these treatments: Physical therapy / Epidural steroid injections / Facet blocks / Trigger point injections Narcotic pump implant / Spinal cord stimulator implant / Botox injections / Chiropractic treatments
11. Is your case under Worker's Compensation? Y/ N If yes, date of injury is_____
12. Are you involved in any lawsuits concerning your case? Y / N
13. Please list all other physicians who are involved in your care_____

_____

Pain Clinic Page 2

Past Medical History: (Please circle)

Heart attack Stroke Diabetes Hypertension COPD Mitral valve prolapse Atrial fibrillation Seizures

Heart failure Emphysema Asthma Breast cancer Lung cancer Hepatitis Cirrhosis Pancreatitis Insomnia

Acid Reflux Gastric ulcers Crohn's disease Anxiety Depression Panic attacks Bipolar disorder Suicide attempt

Kidney disease Irritable bowel syndrome Liver disease Low thyroid High thyroid Osteoarthritis HIV Addiction

Rheumatoid arthritis Fibromyalgia Sleep Apnea Using Aspirin Using Coumadin Using Plavix Multiple sclerosis

Head injury Blood clots Lupus Ulcerative colitis Endometriosis Chronic fatigue syndrome TMJ Blood transfusions

Chronic back pain Chronic neck pain Scoliosis TB Peripheral neuropathy Restless leg syndrome Bleeding problems

Other:_____

Do you have allergies to steroids? Y/ N

Do you have allergies to anesthesia? Y/ N

Do you have any allergies to any medications? Y/ N **:** If yes, what are your allergies?

_____

_____

Please list all Major surgeries: **Date:**

1._____ _____

2._____ _____

3._____ _____

4._____ _____

5._____ _____

Name of Medications and their Doses: **Frequency:**

1._____ _____

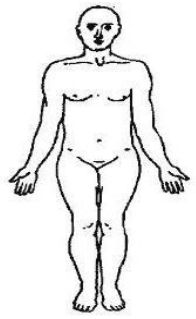
2._____ _____

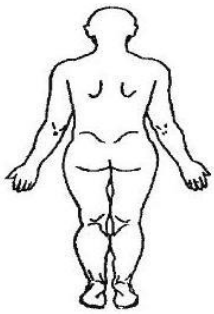
3._____ _____

4._____ _____

5._____ _____

6._____ _____





Pain Clinic Page 3

Have you had an MRI? Y/ N If yes, Date of last MRI_____

Have you had an EMG/NCV? Y/ N If yes, Date of last EMG?_____
(Muscle testing and nerve testing)

Have you had an EKG? (Cardiac tracing) Y/ N If yes, Date of last EKG_____

Previous Medications used: (Please circle)

Demerol Dilaudid Morphine Codeine MS Contin Kadian Avinza Methadone Percocet Percodan Talwin
Hydrocodone Tylenol#3 Tylox Ultram Ultracet Lortab Lorcet Vicodin Oxycontin Oxycodone Opana
Duragesic Patch Actiq Elavil Neurontin Lyrica Xanax Ativan Valium Flexeril Soma Zoloft Trazadone

Have you had any problems with over use or abuse with any of the prescription drugs as listed above? Y / N

Social History: (Please circle)

Married / Single/ Widowed?

Current or past Occupation_____

Do you collect social security disability or work related disability?_____

Do you Smoke? Y/ N If yes, how much do you smoke?_____

Do you drink alcohol? Y/ N Have you been through alcohol rehab? Y / N Have you been through Drug rehab? Y / N

Do Have you ever been convicted on DUI? Y / N

Do you have any history of current or past drug abuse? Y/ N

If yes, please list: _____

Family History: (Please circle)

Mother's medical history:

Living or Deceased

If deceased, cause of death_____

*Father's medical history***:**

Living or Deceased

If deceased, cause of death_____

Are there any family members with a history of alcoholism? Y/ N If yes, who_____

Are there any family members with a history of drug abuse? Y/ N If yes, who_____

Pain Clinic Page 4

Do you currently suffer from any of these problems? (Please circle)

1. General: frequent fever chronic insomnia chronic fatigue

2. Eyes and ears: double vision or blurred vision as a result of medication side effects?

3. Skin: easy bleeding get infections easily

4. Psychiatric: uncontrolled anxiety uncontrolled depression thoughts of suicide

5. Neurologic: new onset headache new onset dizziness confusion

6. Cardiovascular: new onset chest pain shortness of breath dizziness

7. Respiratory: new onset cough problems breathing

8. Gastrointestinal: new onset abdominal pain chronic constipation chronic diarrhea

9. Genitourinary: new bladder control problems new bowel control problems

10. Musculoskeletal: new onset muscle pain new onset joint pain

11. Endocrine: unexpected weight loss unexpected weight gain

Important patient information:

Please do not drive while taking any prescription medications

Please do not drink alcohol while taking your medications.

Please bring your bottle of pain medications with you if you need refills. We will perform random pill counts.

We perform random urine screens. If you are positive for illegal drugs, including marijuana, we may not be able to provide any prescriptions. As per pain management protocol, random urine screens will be done according to risk stratification.

If you have been treated at a previous pain clinic and are already taking pain medications, we may not be able to refill your medications.

For patients receiving injection treatments:
The risk of injury while undergoing any type of injection therapy is very low. Many safeguards are used to maximize our chance of success. Possible side effects of steroid injections are swelling, weight gain, feeling feverish, irritability, anger, anxiety, depression, insomnia, hyperglycemia, increased appetite, allergic reactions, and pituitary dysfunction. Patients with diabetes must monitor for possible large rises in serum glucose. Patients with psychiatric conditions must monitor for worsening anxiety or depression. Possible complications of injection treatments include bleeding, infection, nerve injury, paralysis, pneumothorax, meningitis, weakness, numbness, worsening of the pain and possible death

Patient's Signature_____

I give my permission to text messages with the office staff and the physician:

Patient's Signature_____

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SOAPP®-R

Please answer the questions using the following scale:	Never 0	Seldom 1	Sometimes 2	Often 3	Very Often 4
1. How often do you have mood swings?					
2. How often have you felt a need for higher doses of medication to treat your pain?					
3. How often have you felt impatient with your doctors?					
4. How often have you felt that things are just too overwhelming that you can't handle them?					
5. How often is there tension in the home?					
6. How often have you counted pain pills to see how many are remaining?					
7. How often have you been concerned that peope judge you for taking pain medication?					
8. How often do you feel bored?					
9. How often have you taken more pain medication that you were supposed to?					
10. How often have you worried about being left alone?					
11. How often have you felt a craving for medication?					
12. How often have others expressed concern over your use of medication?					
13. How often have any of your close friends had a problem with alcohol or drugs?					
14. How often have others told you that you had a bad temper?					
15. How often have you felt consumed by the need to get pain medication?					
16. How often have you run out of pain medication early?					
17. How often have others kept you from getting what you deserve?					
18. How often, in your lifetime, have you had legal problems or been arrested?					
19. How often have you been in an argument that got out of control that someone got hurt?					
20. How often have you been sexually abused?					
21. How often have others suggested that you have a drug or alcohol problem?					
22. How often have you had to borrow pain medications from your family or friends?					
23. How often have you been treated for an alcohol or drug problem?					

Online Psychological Screening Results

Please circle yes or no

1.	I often feel sad	Yes	No	7. I worry a lot	Yes	No
2.	I often don't enjoy life	Yes	No	8. I feel I am a burden to my family	Yes	No
3.	I have a loss of appetite	Yes	No	9. I often stay at home and do not go out much	Yes	No
4.	I do not seem to have any energy	Yes	No	10. My friends and family say I looked depressed	Yes	No
5.	I have a hard time focusing	Yes	No	11. Life doesn't seem worth living	Yes	No
6.	I often feel depressed	Yes	No	12. I have thought of suicide	Yes	No

Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. Have you felt low in spirits or sad?					
2. Have you lost interest in your daily activities?					
3. Have you felt lacking in strength and energy?					
4. Have you felt less confident?					
5. Have you had a bad conscience or feelings of guilt?					
6. Have you felt that life wasn't worth living?					
7. Have you had difficulty concentrating, for example reading a newspaper or watching tv?					
8a. Have you felt restless?					
8b. Have you felt subdued or slowed down?					
9. Have you had trouble sleeping at night?					
10a. Have you suffered from reduced appetite?					
10b. Have you suffered from increased appetite?					

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INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT

TEXAS MEDICAL BOARD MINIMUM OPERATIONAL STANDARDS FOR THE TREATMENT OF PAIN PATIENTS. TAC, Title 22, Part 9, RULE 172.4(a)(3)(C)

9th Edition: Developed by the Texas Pain Society, February 2025 (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 pain physician. It is essential for the trust and confidence required for a proper patient-physician relationship and is intended to inform you of your pain 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 pain physician but also your pain 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 pain 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 pain 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, 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 an 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 PAIN PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATELY FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT HAS 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 pain physician at any time) and psychological evaluations if and when it is considered necessary. 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 prescribed 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 understand that I will be provided with 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 pain physician immediately if I become pregnant.
_____**If I am pregnant or am uncertain, I WILL NOTIFY MY PAIN PHYSICIAN IMMEDIATELY**.

I understand that, at present, there have not been enough studies conducted on the long-term use of many medications to ensure complete safety of my unborn child(ren). With full knowledge of this, I consent to its use and hold my pain 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 pain 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, your physician 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 choose to discontinue medication(s) at any time. 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 the Texas State Board of Pharmacy is now monitoring all controlled substance prescriptions. This information must be accessed by my Pain Medicine Physician every time a prescription is written and by my pharmacist every time a 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 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.**

_____I agree to adherence monitoring to assess and sustain appropriate use, including submitting 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) or test negative for prescribed medications, my treatment for chronic pain may be terminated. Also, a consult with, or referral to, an expert may be necessary, such as submitting to a psychiatric or psychological evaluation by a qualified physician such as an addictionologist or a physician who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.

_____Refill(s) **will not be ordered before the scheduled refill date**. However, early refill(s) are allowed when I am traveling, and I make arrangements before 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) runs 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 know 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 provided 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 another physician is prescribing is approved by my Pain Medicine Physician. Information that I have been receiving medication(s) prescribed by other physicians that my Pain Medicine Physician has not approved may lead to a discontinuation of medication(s) and treatment. My primary care physician and my other specialists must manage all other health-related issues.

_____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 prescribes me medication(s) to treat acute, post-surgical, or chronic pain, 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 pain 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**, except for 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 with 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 to safely store and dispose of unused medication and **not to** share, sell, or otherwise permit others, including my family and friends, to have access to my medications. It is best to store opioids in a locked container and keep them out of sight, keep opioids in their original package, and keep opioids out of children's reach. The most appropriate way to dispose of expired, unwanted, and unused medications is to dispose of them in a local "take back 'or mail back program or medication drop box at a police station, Drug Enforcement administration-authorized collection site, or pharmacy.

_____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 discontinuing medication(s).

_____ I recognize that my chronic pain represents a complex problem that 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 treatment 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 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 am **not currently using illegal drugs or abusing prescription medication**(s), and I am not undergoing treatment for substance dependence (addiction) or abuse.

_____ 3) 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.).

_____4) **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 with an opportunity to lead a more productive and active life.

_____5) 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 medications, and I agree to the use of these medications in the treatment of my chronic pain.**

_____6) 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 the pharmacy

_____ _____

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

_____ _____

Patient Signature Pain Physician Signature *(or Appropriately Authorized Assistant)*

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Consent for the Use and Disclosures of Protected Health Information ("PHI")

I, the undersigned patient, give my consent to the provider entity, Edward Shin, M.D., P.A., and its agents to use or disclose my protected health information ("PHI") to carry out treatment, payment, or health care personnel including, but not limited to, physicians, certified registered nurses anesthetists, anesthesia assistants, nursing staff, nurse practitioners, physicians assistants, child life specialists, physical therapists, respiratory therapists, X-ray personnel, audiologists, students in each of the above disciplines, and other such entities or persons as deemed related to treatment, payment, and health care operations, as determined in sole discretion of the provider, his/her/practice group, and their respective agents.

Permission to Release Medical Records or Providers

If another provider who is involved with treatment, payment, or health care operations relating to me requests my medical records, I consent to the release of my entire medical records maintained by the provider to those other providers.

Permission to Call and Leave Voice Messages

I agree that the provider, Edward Shin M.D., P.A, or its agents or representatives may call and leave a voice mail message at my home or other numbers I provide them regarding medical appointments, billing or payment issues, or other information related to treatment, payment, or health care operations.

Permission to Discuss Protected Health Information with Third Persons

I agree that the provider, Edward Shin M.D., P.A., may discuss my PHI with any person that accompanies me to a visit or is present with me when the provider is present. The provider may rightly assume that if another person is with me, I have no objection to disclosure of my PHI to that person. I also agree the provider may discuss my PHI with any persons that identifies him or herself as active in my mental, physical, emotional, spiritual care, including but not limited family, friends, clergy, and patient advocates. I also agree that the provider, his/her practice group, and their agents may disclose my PHI to employers who arrange and pay, directly or indirectly, for my medical treatment.

Permission to Discuss Protected Health Information Regarding Minors

I agree that the provider, Edward Shin M.D., P.A, his/her practice group, and their agents may discuss my child's PHI with the person accompanying the child. I agree that the provider may discuss PHI with both natural parents and step parents. I acknowledge that state may grant my child certain privacy rights regarding the child's PHI, and that I have no right to receive this information.

Person(s) or Organization(s) NOT authorized to receive this information:

_____

_____

Notice to the Patient

By signing this form, you grant us consent to use and disclose your protected healthcare information for the purpose of treatment, various activities associated with payment and healthcare operations. If there is not a copy of the Notice with this form, please ask for one. By signing this form, you understand that if the person or organization that receives the information is not a healthcare provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations. We reserve the right to change our privacy practices. Since revisions may apply to your healthcare information, you have a right to receive a copy and can do so by contacting our office. You have the right to revoke your consent by giving a written notice to our office. The revocation will not affect actions that were already taken in reliance upon this consent. You should also understand that if you revoke this consent we may decline to treat you. Upon request, you are entitled to a copy of this consent form after you have signed it

_____ _____

Patient's Signature Date

_____ _____

Patient's Name or Patient's Representative Relationship to Patient

EDWARD T. SHIN, MD
PAIN MANAGEMENT CLINIC

5804 Communications Pkwy. Suite 100
Plano, TX 75093
Phone: (972) 781-0300 Fax: (214) 200-9135
www.EdwardShinMD.com

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize all insurances, healthcare & other benefits, proceeds, and other monies payable to the Patient of for the Patient's benefit for services and/or supplies provided, including but not limited to liability settlements, group medical, indemnity, self-insured, ERISA, COBRA, personal injury protection, uninsured motorist, underinsured motorist, liability, automobile, and/or homeowner insurance benefits and coverage and I direct all such entities to make checks jointly payable to the beneficiary or covered person and Edward Shin, M.D., P.A. and to mail payment to the covered person in care of Edward Shin, M.D., P.A. and I authorize Edward Shin, M.D., P.A. to open such correspondence. I agree, as part of this consent for payment operations, that the provider, its group, and their billing personnel, billing agents, or management company can disclose billing information to any person that calls the provider with billing questions after the provider inquires as to the identity of the calling person and the calling person provides my correct social security number or health plan number

I understand that I am fully financially responsible for any and all charges incurred for the above-named patient by Edward Shin, M.D., P.A. I understand that I am responsible for all charges whether or not paid by insurance. I further acknowledge that I am responsible for any financial charges even if there is no recovery from person(s) responsible for the condition. This assignment authorizes but does not obligate Edward Shin, M.D., P.A. to file or prosecute suits or insurance claims or appeals.

I have read the above and understand it. In exchange for and in consideration of treatment provided to the Patient, I agree to the above terms and conditions.

PATIENT NAME _____

PATIENT SIGNATURE _____ DATE _____

PHYSICIAN DISCLOSURE

The purpose of this Disclosure is to notify you, the patient, that your attending physician may receive remuneration in connection with referring you to various facilities. Some of these facilities may be:

List of Facilities:
Baylor Scott & White Alliance Plano
Baylor Scott & White Surgicare
West Plano Anesthesia

I acknowledge that my attending physician has disclosed to me that he may receive, directly or indirectly, remuneration for the referral. I understand that I, the patient, have the right to choose the providers of my health care services and/or products.

You are free to choose these facilities or any other facility for treatment or testing services required, without penalty, subject to any limitations of your health insurance plan. Please let us know if you would like to be referred to any other facility.

PATIENT NAME _____

PATIENT SIGNATURE _____ DATE _____