Asad Hussain M.D. Mark Lowe M.D.

3537 S. I-35 E. Ste. 306, Denton, TX 76210 * DRMC Prof. Bldg.
P) 940-483-9898 F) 940-383-0643
Evaluation, diagnosis, and treatment of chronic, acute, and cancer pain.
Diagnostic and therapeutic nerve blocks, spinal cord stimulators, epidural, and intrathecal infusion systems.

1. PATIENT INFORMATION

Patient Name:_____ **DOB:**_____ **Age:**_____

Address:_____ **SS#:**_____

_____ **Martial Status:**_____

Phone (Home):_____ **(Cell/ Work):**_____

Emergency Contact:_____ **Relationship:**_____ **Phone:**_____

2. PHYSICIAN INFORMATION

Referring Physician:_____ **Phone:**_____

Address:_____ **Fax:**_____

_____

Primary Care Physician:_____ **Phone:**_____

Address:_____ **Fax:**_____

_____

3. INSURANCE INFORMATION

Primary:_____ **Secondary:**_____

Insured Name & ID Number:_____

Group/Policy #:_____ **Dates Covered:**_____

If Guarantor is different than patient, please put SS:_____ **DOB:**_____

4. WORKERS COMP

Employer:_____ **Adjustor:**_____

Phone:_____ **Phone:**_____

Work Comp Carrier:_____ **Date of Injury:**_____

Claim Number:_____

Pain Symptom Questionnaire

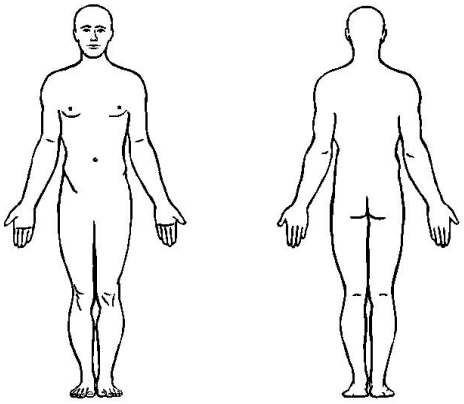
Patient Name:_____ Age:_____ Sex: M/F Date:_____

Referring Physician:_____ Primary Care Physician:_____

Primary site of pain:_____

Other areas of pain:_____

On the diagram on the right, shade the areas where you feel pain.
Place an X on the area that hurts the most.



When did you first notice your pain?_____

Was there an event that started the pain?_____

Did the pain start spontaneously? YES NO

Which of the following words most closely describes your pain?

Aching Burning Tingling Numbness Sharp Shooting Other

Pain Scores: (0= no pain, 10=worst you can imagine)

1. Please rate your pain by circling the one number that best describes your pain at its **worst** in the last 24 hours:
   0 1 2 3 4 5 6 7 8 9 10
2. Please rate your pain by circling the one number that best describes your pain at its **least** in the last 24 hours:
   0 1 2 3 4 5 6 7 8 9 10
3. Please rate your pain by circling the one number that best describes your pain at its **average** in the last 24 hrs:
   0 1 2 3 4 5 6 7 8 9 10
4. Please rate you pain by circling the one number that best describes your pain **right now**:
   0 1 2 3 4 5 6 7 8 9 10

What makes your pain worse?_____
What decrease your pain?_____

Do you have trouble with moving your bowels or urination? YES NO
If yes, please explain:_____

Which of the following test have you had to access this pain?

MRI Date:_____ Location:_____
CT Date:_____ Location:_____
Nerve Conduction Studies Date:_____ Location:_____
EMG Date:_____ Location:_____
X-Ray Date:_____ Location:_____

Management History

Please list below any physicians, or specialists, you have seen for this pain (please specify their specialty):

Physician **Specialty** **Phone** **Diagnosis**

1._____
2._____

Have you been to Physical Therapy? YES NO
If yes, please specify when you started:_____and when you stopped:_____
The name of the physical therapy center:_____
Have you consulted a Chiropractor? YES NO
Have you have any nerve blocks? YES NO
If yes, explain what type of block:_____
Performed By:_____ Date:_____
Have you had any surgery for the pain? YES NO
If yes, what type?_____
Performed By:_____ Date:_____

Review of Symptoms:

Have you ever had any heart problems?	YES	NO	Have you ever had metabolic problems?	YES	NO
Chest pain/angina			Diabetes		
Heart Failure			Thyroid		
Heart Attack			Rheumatoid arthritis		
Irregular Heartbeat			Lupus		
Heart Murmur			Other		
High blood pressure			Have you ever had neurological problems?		
Rheumatic Fever			Headaches		
Other			Stroke		
Have you ever had any respiratory problems?			Seizures		
Asthma			Other		
Difficulty breathing			Have you ever had bleeding disorders?		
COPD			Bleeding tendency		
Tobacco Use (packs per day)			Anemia		
History of pneumonia			Sickle cell disease/trait		
History of tuberculosis			Hemophilia		
Other			Miscellaneous problems		
Gastrointestinal tract?			Cancer; if yes, what type?		
Ulcers			Radiation therapy		
Hiatal hernia			Chemotherapy		
Colitis/Crohn's Disease			Arthritis; if yes, where?		
Hepatitis/jaundice			Psychiatric problems; if yes, what type?		
Pancreatitis			Who is your Psychiatrist?		
Cirrhosis					
Other			Who is your Psychologist?		
Genitourinary?					
Kidney failure			Medical Problems not mentioned above:		
Kidney stones					
Enlarged prostate (male patients)					
Other					

Management History Continued

List all surgeries you have had:

_____
_____
_____

Personal History

Marital status: Single Married Divorced Widowed Separated

What is your occupation:_____
Are you currently working: YES NO
If no, when was your last day at work?_____
Have you had any problems with depression: YES NO
Do you have problems sleeping at night? YES NO
If yes, please explain:_____

Are you involved or do you plan to be involved in any litigation? YES NO
If yes, with whom (specify)?_____

List ALL medications (including dose and frequency) that you are currently taking:

_____
_____
_____

List all medications that you have tried in the past to treat this pain:_____
_____

Are you allergic to any medications YES NO If yes, which one(s):_____

Current height:_____ **Current weight:**_____

Thank you for completing this questionnaire. This will help your doctor better understand your pain condition. Please read, fill out and sign the medication policy.

Patient signature:_____ **Date:**_____

Pain questionnaire reviewed
Additional history/comments:_____
_____

Physical Examination: BP: Pulse:

Diagnosis:_____
Plan:_____

Medications filled this visit:_____
Schedule procedure_____ **Recheck**_____

Pinnacle Pain Clinic Agreement for the use of Pain Medication

Opiodis, which are sometimes called narcotics, are medications useful for treating a variety of pain conditions. These medications have significant side effects and are tightly regulated by the state and federal government. They must be used carefully, appropriately, and with adequate medical supervision.

Your pain physician at Pinnacle Pain Clinic has decided to use opioids as a part of your treatment plan with a goal of improved pain relief and a higher level of function (ability to do more activities in and out of your home and possibly return to work when relevant). They may be used along with other medications, physical therapy, nerve blocks and, sometimes, psychological treatment.
One of the concerns with the use of opioids is the potential for abuse. Tolerance may also develop over time. Tolerance is defined as the need for more medication to achieve the same effect. In patients on chronic opioid therapy, this may occur slowly over a period of time. Tolerance is a totally different entity from abuse. Abuse is the uncontrolled or inappropriate use of these medications.
Given the nature of these medications and their regulation by the government, these are important responsibilities for both the physician and the patient. The physician is accountable for all opioids prescribed. If all prescribed opioids are not accounted for correctly, the state can penalize the clinic or the individual physician.

You as the patient are ultimately responsible for your medication and prescriptions. Outlined below are the expectations of the patients on opioid therapy with Pinnacle Pain Clinic.

1. Take your medication exactly as directed by your physician. Increasing the dose of the opioids on your own is not permitted. You will run out of your medication too soon and additional medications will **NOT** be prescribed until your next scheduled visit.
2. Please keep a close count of your medications. Generally these medications are written for one month and are calculated exactly. If you would run out of your medications before your next visit, please notify the clinic five to seven days before your medications are out.
3. Keep your medications in a safe and secure place. We will not be able to justify prescribing them before the next appropriate date if they are stolen or lost.
4. Do not give your opioid medications to anyone else for any reason.
5. Do not alter your prescriptions in any way. If there has been a mistake in writing the prescription it should be returned to the clinic and another one will be issued.
6. Failure to abide by these obligations may result in discontinuation of opioid therapy or discharge from the clinic.
7. Emergency prescriptions are not to be issued after business hours or on weekends or holidays for opioids. This is to facilitate proper accounting and record keeping of these prescriptions.
8. All of your opioid prescriptions should be filled at **ONE** pharmacy of your choice.
9. Unless otherwise arranged, all opiod medications must come from one physician at Pinnacle Pain Clinic. We will be communicating with your primary care physician periodically.
10. Telephone calls with questions about medications will be returned as soon as a staff member is available. Repeated telephone calls may cause confusion and may slow response time. Necessary phone calls including emergencies such as severe reaction to medication (rash, confusion, difficulty breathing) or problems following a procedure. If it is necessary to speak to a staff member, our office should be called before 3:00 p.m.
11. A urine sample will be taken from time to time as the provider feels necessary. Recreational drugs or non-prescribed prescriptions found in the urine test may result in discontinuation of opioid therapy or discharge from the clinic.

The pharmacy I will be using is _____

Address:_____ Telephone:_____

By signing the above agreement, I consent to the administration of opioids and certify that I completely understand the contents of the agreement and agree to comply with the guidelines/principles outlines.

Signature of patient:_____ Date:_____
Signature of Witness:_____ Date:_____

GUIDELINES FOR OPIATE THERAPY

Side effects for Opiate/Narcotic Medications may include…

- Drowsiness, sedation, disorientation, resulting in falls and resultant significant injury
- Constipation and bowel obstruction, possibly requiring surgical intervention and potentially resulting in ischemic (dead) bowel, sepsis and death
- Allergic and/or anaphylactic reactions to the medications resulting in hypotension (low blood pressure), tachycardia (fast heart rate), arrhythmia (irregular heart rhythm), respiratory or cardiac arrest and death
- Respiratory depression resulting in respiratory arrest and/or death, as well as resultant cardiac arrest and/or death
- Tolerance to the medication may develop after long-term use, which means that ultimately this medication may become less effective
- Physical dependency, psychological dependency and addiction are possible with all narcotic medications. These situations may result in discontinuation of the pain medication by your doctor.
- Withdrawal phenomenon may occur with abrupt discontinuation of the pain medication. This may cause significant side effects such as heart palpitations, diaphoresis (sweating), anxiety, nausea, vomiting, elevated pulse and blood pressure. Do not abruptly discontinue this medication. Your health care provider will guide you on how to stop narcotics using a slow weaning process.

Precautions while taking Opiate Medications:

- Patients taking anticoagulants (blood thinners) are at particularly high risk of any kind of trauma (falls, etc.) as a resultant life-threatening hemorrhage, intracranial bleeding, or death may occur.
- The elderly may exhibit marketed or dramatic side effects from narcotic medications, even in low doses.
- Patients with other significant medical problems (including heart or lung disease) are at high risk for complications related to the use of narcotic medications.
- Patients taking sedative medications or central nervous system depressants should use narcotics sparingly and in reduced doses due to additive and/or synergistic interactions and greater than expected or enhanced side effects.
- Narcotic analgesics should not be used during pregnancy.

Take precautions with the following activities while taking Opiate Medications:

- Any kind of activity where judgment is required (i.e. driving, signing important documents, caring for the sick, the elderly, or the very young).
- Narcotic medications may affect the ability to drive or operate machinery.
- Avoid working on high-risk area (i.e. construction sites, elevated work sites, working with power tools, etc.).
- Drinking alcohol is prohibited while on narcotics due to potent and unpredictable enhancement of central nervous system depression if these two substances were taken together.
- If you experience the side effects such as sedation with opiate use, do not participate in the above activities.

If you have questions regarding these items, please ask your physician or nurse practitioner during your visit.

Pinnacle
Pain Medicine®
Building Healthy Relationships
In Partnership with U.S. Anesthesia Partners

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION - PLEASE REVIEW IT CAREFULLY

Pinnacle Anesthesia Consultants, P.A., Pinnacle Consultants, L.P. ("Pinnacle") and Pinnacle Pain Medicine are affiliated entities that have entered into an Organized Health Care Arrangement and are jointly issuing this Notice of Privacy Practices about the information we share in common and your legal rights and our common duties with respect to your health information.

OUR PLEDGE TO YOU

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care, bill for your care, and comply with legal requirements. This notice applies to all of the records of your care that we maintain, whether made by our staff and authorized trainees, or by your personal doctor. This notice tells you about the ways in which Pinnacle may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe our obligations regarding the use and disclosure of your health information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

Pinnacle doctors, nurses, pharmacists, laboratory technicians, and other health care professionals may use health information about you to provide you with health care **treatment** or services. We may also disclose health information about you to others who are involved in taking care of you. For example, we may send health information about you to a specialist as part of a referral.

Pinnacle may use and disclose health information about you to obtain **payment** for the treatment and services you receive from us. For example, we may send billing information to your insurance company or Medicare. We may also tell your insurance company about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. Pinnacle may send you a statement of your account if payment is due from you. We may send the guarantor (responsible party for payment) monthly statements for charges for all patients under that guarantor.

Pinnacle may use and disclose health information about you to support our health care **operations**. For example, we may use health information to review the treatment and services and to evaluate the performance of our staff in caring for you. We may combine health information about many patients to decide what additional services we should offer. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning who our specific patients are.

We may disclose information to notify **a family member or other person responsible for your care** about your condition, status, and location.

Pinnacle Anesthesia Consultants, P.A.
Pinnacle Consultants, L.P.

If you are admitted and unless you tell us otherwise, we may provide your name, location in the hospital, and your general condition (good, fair, etc.) for information to be included in a **patient directory** and make this information available to anyone who asks for you by name.

We may use and disclose health information to contact you for an **appointment reminder**, to tell you about **health-related services** or recommend **possible treatment options or alternatives** that may be of interest to you, or to contact you about supporting **our fundraising** (of which you have the right to opt out) efforts.

Subject to certain requirements, we may use or disclose health information about you **without your prior authorization** for other reasons:

We may give out health information about you for **public health** purposes; to **report abuse or neglect**; for **health oversight reviews**; in **research** studies; for **funeral arrangements** and **organ donation**; in response to special **law enforcement** requests, valid judicial or administrative orders, or for authorized national security and intelligence activities; for **workers' compensation** purposes; to **avert a serious threat** to your health or safety or those of the public or another person; and when **required by law**. If you are or were a member of the armed forces, we may release information about you as required by military command authorities or the Department of Veterans Affairs. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official.

In any other situation not covered by this notice (i.e. psychotherapy notes, marketing, remuneration), we will ask for your written **authorization** before using or disclosing your health information. You may **revoke** this authorization for any subsequent disclosures by notifying us in writing.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the right to request in writing that you **inspect and obtain a copy** of the health information that we use to make decisions about your care. We may charge a fee for the costs of copying, mailing or other supplies and services associated with your request. If we deny your request to inspect or obtain a copy in certain limited circumstances, you may request that the denial be reviewed. Another licensed health care professional chosen by Pinnacle will review your request and the denial and we will comply with the outcome of that review.

If you believe that health information we have about you is incorrect or incomplete, you may make a written request to ask us to **amend information**. The request should state the reason for the amendment and specific information to be amended. The amendment must be limited to one page. Any amendment we make to your health information will be disclosed to those with who we disclose information as previously stated.

We may deny your request for an amendment if the information to be amended was not created by us, is no longer maintained by us, is not part of the information which you would be permitted to inspect and copy; or is accurate and complete. We will notify you if we deny your request for amendment and you may appeal, in writing, our decision. Any statements of disagreement or rebuttal will be linked to your health information and made a part of any subsequent disclosure we make of such information.

Pinnacle Anesthesia Consultants, P.A.
Pinnacle Consultants, L.P.

You have the right to make a written request for a **list of disclosures** we have made of your health information, except for uses and disclosures for treatment, payment, and health care operations, as previously described, and those for which you have authorized disclosure. Your request must state a time period which may not be longer than six years. We will not charge you for the first list you request within a 12-month period, additional requests will be charged according to our cost for producing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

You have the right to **request a restriction** on the health information we use or disclose about you for treatment, payment, or health care operations. There may be risks associated with such restrictions and we may ask you to acknowledge these risks in writing for certain requests you may make. ***We are not required to agree to your request for restrictions*** if it is not feasible for us to ensure our compliance or believe it will negatively impact the care we may provide you. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. If you have paid for a healthcare item or service in full, out-of-pocket, we must honor your request to restrict the information that is disclosed to a health plan for purposes of payment or operations.

You have the right to request, in writing without requiring you to state a reason, that **confidential communications** with you be made in an alternative manner or location. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

You have the right to be notified of a breach of unsecured PHI in the event that you are affected.

WRITTEN REQUESTS

If you have any questions about this notice, please contact: Pinnacle Partners In Medicine, to the attention of the Privacy Officer at 6606 LBJ Freeway, Suite 200, Dallas, Texas, 75240 or call (972) 715-5000.

COPIES OF NOTICE AND CHANGES

You have the right to obtain a paper copy of this notice at any time.

We reserve the right to change this notice, and to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future.

COMPLAINTS

If you are concerned that your privacy rights may have been violated or you disagree with a decision we make about your health information, you may contact Pinnacle's Privacy Officer at 6606 LBJ Freeway, Suite 200, Dallas, Texas, or call (972) 715-5000. You may also send a written complaint to the U.S. Department of Health and Human Services. We can provide you with the address.

Under no circumstances will we ever ask you to waive your rights under this notice or retaliate against you in any manner for filing a complaint.

Please sign the attached acknowledgement that you have received our Notice of Privacy Practices, effective September 23, 2013.

Pinnacle
Pain Medicine®
Building Healthy Relationships
In Partnership with U.S. Anesthesia Partners

Acknowledgement of Receipt of Notice of Privacy Practices
Pinnacle Anesthesia Consultants, P.A.
Pinnacle Consultants, L.P., Pinnacle Pain Medicine

I received a copy of the Notice of Privacy Practices from the above noted entities.

Signature:_____ Date: _____

Print Name:_____

Personal Representative:_____

If personal representative, please note relationship to patient: _____

Prescription Pick-up Authorization

If you would like to give consent for another individual to pick up your prescriptions or documentations, please provide that name below:

_____

I give consent for my provider to discuss my medical care with the persons listed below.

Name: _____ Relationship:_____

Patient Signature:_____
(*Authorized Representative must present valid photo ID upon pick up*)

Name: _____ Relationship:_____

Patient Signature:_____
(*Authorized Representative must present valid photo ID upon pick up*)

FOR OFFICE USE ONLY

By:_____ Date:_____

PATIENT RESPONSIBILITIES

To better serve you and maintain a professional environment, Pinnacle Pain Medicine has established guidelines to outline patient responsibilities. The guidelines have been established so that our patients can fully benefit from treatment received in our clinic. Your responsibilities as a patient of our clinic are as follows:

1. Please arrive at least 15 minutes (30 minutes on your first visit) prior to your appointment time for clinic appointment in order to take care of any insurance issues or required paperwork. If you are 15 minutes or more late for your appointment time and/or your initial paperwork is not complete by your appointment time, your appointment will be rescheduled.
2. We require at least 24 hours notice for cancellations/rescheduling of appointments. A missed clinic appointment or appointment for a scheduled procedure without calling to reschedule will be considered a "no show" for the appointment.
3. Prescriptions will only be filled during office hours by appointment only. No prescriptions will be filled after hours, on weekends, or holidays.
4. State law requires compliance and close monitoring for narcotic medications. If these are prescribed for you, you will be asked to sign a *Patient Responsibility Agreement for Controlled Substance Prescriptions*.

Noncompliance with these guidelines will result in discharge from treatment at Pinnacle Pain Medicine. Your signature below constitutes acknowledgement and acceptance of the terms of these guidelines.

_____

Patient Name Date

_____

Signature of Patient/Legally Responsible Person Signature of Witness

Financial Policy

Thank you for choosing Pinnacle Pain Medicine. Our goal is to provide you with the highest quality care possible. We find that communication with our patients regarding our financial policy assists us in providing the best service to you. Therefore, we take this opportunity to answer some of the most commonly asked questions. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Payment Methods
Payment is expected at the time services are rendered. We accept a variety of payment methods, including cash, check, money order, or credit card Visa, Mastercard, Discover and AMEX. Credit card payments are also accepted via telephone.

Insurance Information
We must emphasize that your health is our primary concern, regardless of your insurance. Because your insurance policy is a contract between you and your insurance company, please check with your insurance carrier to determine any pre-existing limitation or other benefit restrictions that you may have, prior to your appointment.

We will file your insurance as a courtesy and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

Most insurance companies do not cover 100% of the cost of services, and there is a portion that the patient is responsible for. There are several patient responsibility components that may apply to an insurance payment.

> *Co-pay* – A set dollar amount per office visit that is the patient's responsibility.
> *Co-insurance* – A percentage of the charge that is the patient's responsibility.
> *Deductible* – A set annual amount that the patient is responsible for paying prior to his or her insurance making a payment.

Because of the contract you have with your insurance company, we are obligated to collect payment from you for your portion of the balance. All co-payments, co-insurance and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

To bill your insurance accurately and in a timely manner, we will need assistance from you. We ask that you provide our office with accurate demographic information (address, phone number, etc.) and proof of insurance. All patients will be required to show proof of insurance and a Government issued Photo ID.

Insurance Changes
If there are any changes in your insurance, you are required to call our office and give the detailed changes of your insurance at least twenty-four (24) hours prior to your appointment. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance.

Managed Care: All managed care (i.e. HMO, PPO, POS)
Co-payment, co-insurance & deductible amounts are due at the time of check-in. If your insurance plan requires a referral authorization from a primary care physician you are responsible for obtaining prior approval from your PCP prior to treatment & will need to present this at your visit. If you request an office visit or procedure without a referral authorization, your insurance plan may deem this as non-covered treatment and you will be responsible for the charges.

Medicare
We accept assignment with Medicare. Medicare pays 80% of their allowed amount after satisfaction of the yearly deductible. You are responsible for 20% of Medicare's allowed amount. All co-payments or deductibles are due and payable at the time of service.

Secondary & Tertiary Plans
We will bill your secondary insurance as a courtesy. We do not bill tertiary insurance. If you have supplemental insurance to cover the portion of the charges that Medicare or your primary insurance carrier does not pay, please provide us with a copy of this insurance card. Medicare and secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding.

Preauthorization
Please remember that it is up to you to understand the requirements of your individual insurance plan and know whether prior authorization from your insurance company is required

Non-covered Services
Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

Auto Injury Cases
This office does NOT bill auto insurance for auto accident cases. We do NOT accept liens or letters of protection (LOP's).

Worker's Compensation
If your injury is work-related, we will need the claim number, date of injury, employer, and worker's compensation carrier prior to your visit in order to bill the worker's compensation insurance company.

Cash Patients Cash patients are accepted on a case by case basis. All uninsured patients will be required to pay in full at time of treatment. No Checks accepted for self-pay patients.

Surgery & Injection Fees
All co-pays, co-insurance, deductibles, and payments for non-covered surgical procedures are due prior to surgery. We will make every attempt to determine your coinsurance amount prior to your surgery. This will be based on your insurance benefits and an estimate of the services to be provided. We will provide you with that estimate & we will expect to collect that amount prior to the time of surgery. If any changes are made to the scope of services provided and the coinsurance amount has changed, we will either refund or bill you upon final resolution of your account. Fees are ultimately the responsibility of the patient, whether your insurance company pays or not, and are due within thirty days of your receipt of Pinnacle Pain Medicine statement.

Nonpayment
Please be aware that patient accounts over 180 days without satisfactory payment will be turned over to a collection agency and patients will face possible termination from the program.
Returned checks A $25.00 fee will be charged for any returned checks and we will report bad checks to the District Attorney's Office. We will be unable to accept your check for any services thereafter.

Missed Appointments
A scheduled appointment is a commitment of time between you and our practice, a time we have reserved just for you. If you are unable to keep a scheduled appointment, please cancel or reschedule your appointment at least 24 hours in advance to avoid a service charge and help us meet the needs of other patients. Patients who habitually fail to keep scheduled appointments and do not give a 24 hour cancellation notice will face treatment termination.

Children of Divorced Parents
Responsibilities for payment of patients, who are minor children, whose parents are divorced, rest with the parent who seeks the treatment.

Medical Records
Please direct all medical record requests or questions to your physicians' business office.

Charges for Forms
A $30.00 fee will be charged for disability, life insurance, and other forms requested by a third party or patient.

Special Circumstances
We are aware that circumstances in our daily lives may vary. If you need to establish a payment plan or require additional assistance, please contact our Business Office prior to your scheduled appointment. Unless you have made prior arrangements for payment of your balance, our financial policy will stand.

Account Billing Questions & Refunds
Questions or concerns regarding your account or insurance claim should be directed to our business office staff. If your account has a credit balance, we will promptly release a refund check to you once your insurance carrier has processed all pending insurance claims remaining on your account. If you feel an error appears on the statement or if you have any questions or concerns please contact our billing office immediately at (972) 715-5000.

Printed Name _____

Signature/Date_____

Pinnacle Pain Medicine

A Division of Pinnacle Partners in Medicine and U.S. Anesthesia Partners

Dr. Asad Hussain M.D. Dr. Mark Lowe, M.D.

Certified Nurse Practitioner Consent

Dr. Asad Hussain and Dr. Mark Lowe want you to know that they employ Certified Nurse Practitioners (CNP) to assist them in a "team approach" to a high quality delivery of medical care.

A Certified Nurse Practitioner (CNP) is a Registered Nurse who has received advanced education, training and a degree in the provision of health care. Although CNP's are not doctors, our CNP's are trained to **diagnose, treat, and monitor routine or complex pain disorders.** They are trained to follow-up with you and are able to evaluate you and make recommendations for further care, including writing prescriptions and authorizing prescription refills. If you are seen by a CNP, rest assured, you doctor **will** review your care with the CNP as part of the care plan.

I have read the above and understand that in this practice a "team approach" is used, with my unique problems and/or needs presented and discussed with one or more physicians in the development of my care plan. I also understand that typically one M.D. will direct my overall care, but from time-to-time, I may be seen by any or all the practitioners of the Pinnacle Pain Medicine group, including Certified Nurse Practitioners.

I hereby consent to the services of a Nurse Practitioner for my health care needs.

I understand that I can refuse to see the Nurse Practitioner, and request to see a Physician only. I understand that this may require my appointment to be re-scheduled.

☐ ***Please check this box to acknowledge that you have read and accept the above.***

_____ _____

Signature Date