PAIN MANAGEMENT ASSOCIATES, P.A.
REGISTRATION FORM

Today's date: / /	Primary Care Physician:		
PATIENT INFORMATION			
Last Name:	First:	Middle:	Sex: ☐ M ☐ F
Is this your legal name? ☐ Yes ☐ No	Former Name (if applicable):	DOB: / /	Age:
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced		SSN:	
Cell Phone #:	Home Phone #:	Email:	
Address:	City:	State:	Zip Code:
Employer:	Name:	Phone:	
Employer Address:	City:	State:	Zip Code:
Preferred Pharmacy Name:		Pharmacy Phone #:	
Pharmacy Address:	City:	State:	Zip Code:
How did you hear about us? ☐ Internet Search ☐ Doctor ☐ Family ☐ Friend ☐ Other: _____			
INSURANCE INFORMATION			
PLEASE SHOW YOUR ID AND INSURANCE CARD			
Work Comp or Car Insurance (if auto claim):		Claim #:	
Adjuster Name:		Adjuster Phone #:	
Adjuster Address:			
Health Insurance Company:		Phone #:	
ID #:	Group #:	Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child	
Secondary Insurance (if applicable):		Subscriber Name:	
Group #:	Policy #:	Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child	
IN CASE OF EMERGENCY			
Name:		Relationship to Patient:	
Home Phone:		Work Phone:	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize Pain Management Associates P.A. or insurance company to release any information required to process my claims.

I give consent to Dr. Korivi to diagnose and treat my condition.

Patient/Guardian Signature: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES

This notice describes how your health information (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This notice is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Commitment to your Privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws care complicated, but we must provide you with the following information.

Use and Disclosure of your Health Information in certain special circumstances:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a few law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosure to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including Veterans) if required by the appropriate authorities.
6. To federal officials for intellingence and national security activities authorized by law.
7. To correctional institutions or law enforcement agencies if you are an inmate or under custody of law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information:

1. You can request that our practice communicate with you about your health and related issues in particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.
2. You can request a restriction in our use and disclosure of your health information for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or payment of you care, such as family members and friends. We are to agree to your request: however, if we do agree we are bound by our agreement except otherwise required by law: emgencies, or when the information is necessary to you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you including patient medical records, but not including psychotherapy notes. You must submit your request in writing to Medical Records: 13636 Breton Ridge Street, Suite D, Houston, Texas 77070
4. You may ask us to amend your health information if you believed it is incorrect or incomplete, as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing a submitted to Medical Records: 13636 Breton Ridge Street, Suite D, Houston, Texas 77070. You must also provide us with the reason that supports your request for amendment.
5. You are entitled to receive a copy of the Notice of Privacy Practices. You may ask us to give you a copy of the Notice at any time. To obtain a copy of the notice, please contact our front desk personnel.
6. If you believe your privacy right has been violated, you may file a complaint with our practice; contact 13636 Breton Ridge Street, Houston, Texas 77070. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Dr. Korivi.

I hereby acknowledge that I have been presented with a copy of Pain Management Associates, PA's Notice of Privacy Practice.

Printed Name: _____ **Date:** _____

Signature: _____

PAIN MEDICATION AGREEMENT

I WILL NOT:

I will not see any other "Pain Management" type physician for my pain management while under the care of this group. All my medication from this clinic cannot be obtained from any other source. In the event of an acute case (dental work or surgical procedure), I must notify my physician in advance.

I will not use alcohol or illegal controlled substances (cocaine, marijuana, etc.). I have been made aware of the dangerous side effects of narcotic and tranquilizer use alone or in combination with other substances. Thus, I absolve the physicians and staff of any willful negligence.

I will not share, sell or trade any medication(s) or prescription(s) with anyone.

I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctors unless approved by my physician in advance.

I WILL:

I will provide the physician and staff with all my medical records pertaining to the past pain treatment. I understand that failure to provide such information gives the clinic the right to refuse to treatment.

I will be responsible for my pain medication, keeping it safe from loss or theft. Lost medications will not be replaced. Stolen medication will not be considered for a refill until a police report is filed and sent to the doctor's attention. I will use my medicines at the rate they are prescribed. If I use my medicines in a greater rate, it will result in my being without my medication for a period of time. Physicians will not authorize any early refills under any circumstances.

I will use only one pharmacy to fill all my prescriptions. I agree to use _____

Pharmacy, located at: _____

Telephone number _____ for filling prescriptions for all my pain medications.

I will agree that no refills will be available during evenings or weekends.

I will agree to authorize the doctor and the pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state Board or Pharmacy, in the investigation of any possible misuse or sale, etc. of my pain medications. I agree to waive any applicable privilege or right to privacy or confidentiality with respect to these authorizations.

I will submit to a blood or urine sample test if requested by my doctor.

I understand all the policies above and my signature below states my agreement to comply. I am aware that if I breach this agreement, then Pain Management Associations holds the absolute right to discharge me as a patient.

Print Name: _____

Signature: _____ **Date:** _____

MEDICAL RECORDS RELEASE FORM

Patient Name: _____

DOB: _____

To Whom It May Concern,

Please release medical records for the above-mentioned patient for treatment with Dr. Korivi, Pain Management Associates, P.A., located at

13636 Breton Ridge Street, Suite D.
Houston, Texas 77070

Phone: 832-688-9160
Fax: 832-688-9251
Email: tapainmgmt@gmail.com

EMG ☐ **MRI** ☐ **X-RAY** ☐ **CT** ☐

CLINIC NOTES ☐ **BILLING RECORDS** ☐

Name (Print): _____

Patient Signature: X _____

Date: _____

Sincerely, Dr. Naveen Korivi/Pain Management Associates

The office has Privacy Practices in place which explains how your medical information will be used and disclosed by the office. A copy is available for review at any time.

INITIAL MEDICAL QUESTIONNAIRE

Name: _____ **Date:** _____ **Height:** _____ **Weight:** _____

Have you had: ☐ X-ray ☐ MRI ☐ CT ☐ EMG **Location:** _____

Past Medical History – Do you suffer from any of the following?

	YES	NO		YES	NO
Chronic Headaches	☐	☐	Urine/Stool Leakage (incontinence)	☐	☐
High Blood Pressure	☐	☐	Seizures	☐	☐
Heart Disorders	☐	☐	Strokes	☐	☐
Diabetes	☐	☐	Recent Infections	☐	☐
Thyroid Problems	☐	☐	Reactions to Anesthesia	☐	☐
Asthma	☐	☐	Hemophilia/Easy Bleeding	☐	☐
Emphysema/COPD	☐	☐	Recent Weight Lo ss	☐	☐
Heartburn or Ulcers	☐	☐	Depression	☐	☐
Hepatitis	☐	☐	Suicidal Thoughts	☐	☐
Pancreatitis	☐	☐	Cancer	☐	☐
Kidney Stones	☐	☐	Type: _____		

Past Surgical History

	YES	NO		YES	NO
Spine (Neck or Back)	☐	☐	Tubal Ligation	☐	☐
Tonsillectomy	☐	☐	Bladder/Kidney	☐	☐
Appendectomy	☐	☐	Bowel/Colon/Ulcer	☐	☐
Gallbladder	☐	☐	Shoulder/Knee/Hip/Joint	☐	☐
Lung	☐	☐	Hysterectomy	☐	☐
Heart	☐	☐	Other: _____		

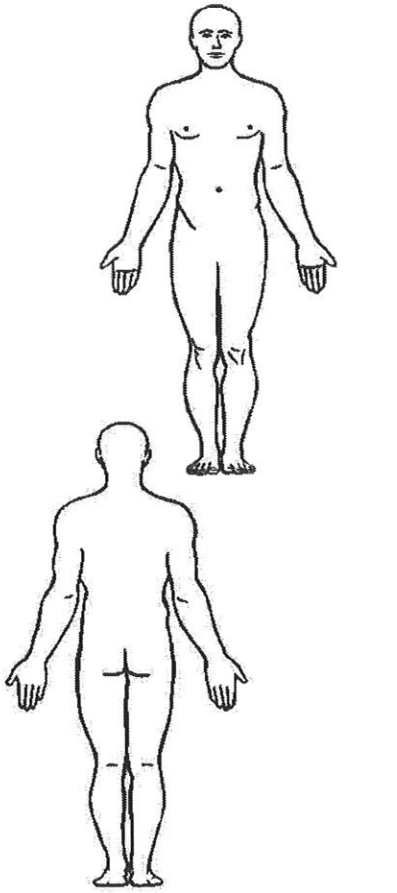
Family History – Do your parents, siblings, etc. suffer from any of the following?

	YES	NO		YES	NO
Heart Disease	☐	☐	Migraines	☐	☐
Hemophilia/Bleeding	☐	☐	Anesthetic Reactions	☐	☐
Sickle Cell Anemia	☐	☐	Muscular Disorders	☐	☐
Cancer	☐	☐	Other: _____		

Social History – Do you use any of the following?

	YES	NO		YES	NO
Smoking/Tobacco	☐	☐	Cocaine	☐	☐
Alcohol	☐	☐	CBD Products	☐	☐
Marijuana	☐	☐	Other substances: _____		

Please circle area(s) of concern:



Work Status: ☐Employed ☐Unemployed ☐Retired ☐Homemaker ☐Disabled

Relationship Status: ☐Married ☐Separated ☐Divorced ☐Single ☐Widowed

Lawsuits Pending: ☐Yes ☐No ☐Settled

Allergies: _____ Iodine Allergy? ☐Yes ☐No

All medications you are currently taking (name, dose, and frequency)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Estimate the severity of your pain by checking one of the boxes.

☐ 1-3 (Mild Pain)
☐ 4-7 (Moderate Pain)
☐ 8-10 (Severe Pain)

Patient Signature: _____

OFFICE USE ONLY

Temp: _____ **Pulse Ox:** _____

BP: _____/_____ **Pulse:** _____

AMP	MTD	BZO	BAR	BUP	THC	MET	PCP	COC	MDMA	OXY	MOP
+☐	+☐	+☐	+☐	+☐	+☐	+☐	+☐	+☐	+☐	+☐	+☐
-☐	-☐	-☐	-☐	-☐	-☐	-☐	-☐	-☐	-☐	-☐	-☐