Brazoria County Pain Center
Dr. Manjit S. Randhawa
Anesthesiology / Pain Management
Diplomat of American Board of Anesthesiology
Diplomat of American Academy of Pain Management
1980 E. Mulberry St, Angleton, Texas 77515
☎ (979) 848-3068 / Fax (979) 849-1423

You have been referred to this program for pain management. The program has three components. Medical, substance abuse, and outsourced physical therapy.

The medical department evaluates and treats with conventional medicine techniques such as drug therapy, injections, surgical procedures, and also, electrical stimulation.

Your evaluation by Dr. Randhawa with be the start of your treatment plan according to his assessment. We must be contracted with your insurance and obtain all proper authorizations before all scheduled treatments.

The frequency of your urine drug screen is determined by Dr. Randhawa during your initial office visit. His decision is based off of the COT Risk Assessment form listed in this packet and your initial evaluation.

Please sign on the line below, that you have read and agreed to the information we have provided you on this form.

_____

I hereby consent to treatment

If you have any questions please do not hesitate to ask the office staff.

Thank You,
Dr. Manjit S. Randhawa/Medical Director

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Patient Information

Patient Name: _____ Sex: Male _____ Female _____

Home Address: _____ Single ____ Married ____ Divorced ____

City, State, Zip: _____ Separated _____ Widow _____

Home Phone: (___)_____ Social Security Number: _____

Cell Phone: (___) _____ Date of Birth: _____

Employed _____ Unemployed _____ Retired _____ *Allergic to any Medication:* _____

Employer Name: _____ Employer PH#: _____

Address: _____ City, State, Zip: _____

Emergency Contact/Relation to patient: _____ PH#: _____

Emergency Contact/Relation to patient: _____ PH#: _____

Please check below that you have provided us with your insurance card and acknowledge that a copy will be scanned into your medical record.

Primary Insurance: ___ Yes ___No

Secondary Insurance: ___ Yes ___ No

Are you being seen under worker's compensation insurance? Yes ___ No ___

Authorization and Assignments of Benefits

I authorize payment of medical benefits to Manjit S. Randhawa, D.O., P.A. medical/professional services rendered. I further authorize release of any medical information necessary to process this claim.

_____ Date: _____
Patient's Signature/Insured's Signature

Medicare Patients

I hereby authorize Medicare to furnish Manjit S. Randhawa, D.O., P. A. any information obtained in the adjudication of any claim in regard to services furnished to me under Title XVIII of the Social Security Act.

_____ Date: _____
Patient's Signature/Insured's Signature

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Comprehensive Medical History

In order to evaluate and assist with your pain program properly, it is essential that we learn as much about you as we can and we learn it directly from you. Pain is a very complex matter and we have found it essential to know many things about you that you may not readily see as important. This questionnaire requests a great deal of such personal information. Please read carefully and answer each and every question.

The information you provide is strictly confidential and for pain management use only, and cannot, and will not be released to anyone else without a signed medical release and your consent.

Name:	Today's Date:
Date of Birth:	Male ☐ Female ☐
Race:	Age: Weight: Height:
Who is your primary care physician? Who is your referring physician?	

Describe the pain for which you are now seeking help in one sentence. (Example: "My back hurts.")

_____

PRESENT ILLNESS-PLEASE LIST ONLY PROBLEMS THAT IS RELEVANT TO YOUR PAIN:

Headaches/Since: _____

Neck Pain/Since: _____

__L__R Shoulder Pain/Since: (any part from arm to fingers) _____

Thoracic Spine Pain/Since: _____

Chest Wall Pain/Since: (not heart related chest pain) _____

Low Back Pain/Since: _____

__L__R Hip Pain/Since: _____

__L__R Lower Extremity Pain/Since: (any part from thighs to toes) _____

__L__R Abdominal Wall Pain/Since: _____

Abdominal Pain/Since: _____

__L__R Groin Pain/Since: _____

Other/Since: _____

Briefly state the primary reason/ problem for seeing the doctor today?

_____

What caused the pain? _____

When did your current episode begin? Approx. Date/Time? _____

How did your current episode begin? __Suddenly __Gradually _____

PRESENT PAIN HISTORY/ PAIN RATIO: (mark which item best describes the ratio between pain in your back/leg or neck/arm).

FOR BACK PAIN

__Back pain only/no leg pain

__Back pain worse than leg pain

__Back pain and leg pain are equal

__Leg pain worse than back pain

__Leg pain worse than back pain

FOR NECK PAIN

__Neck pain only/no arm pain

__Neck pain worse than arm pain

__Neck pain and arm pain equal

__Arm pain worse than neck pain

__Arm pain only/no neck pain

Please read through these words and choose which best describe your pain. Also mark the line which gives the intensity of that particular pain (only mark those that apply to your pain).

- Sharp/ ___Mild ___Moderate ___Severe ___Unbearable
- Shooting/___Mild ___Moderate ___Severe ___Unbearable
- Throbbing/ ___Mild ___Moderate ___Severe ___Unbearable
- Cramping/ ___Mild ___Moderate ___Severe ___Unbearable
- Stabbing/ ___Mild ___Moderate ___Severe ___Unbearable
- Gnawing/ ___Mild ___Moderate ___Severe ___Unbearable
- Hot-Burning/ ___Mild ___Moderate ___Severe ___Unbearable
- Aching/ ___Mild ___Moderate ___Severe ___Unbearable
- Heavy/ ___Mild ___Moderate ___Severe ___Unbearable
- Tender/ ___Mild ___Moderate ___Severe ___Unbearable
- Splitting/ ___Mild ___Moderate ___Severe ___Unbearable
- Tiring/-Exhausting/ ___Mild ___Moderate ___Severe ___Unbearable
- Sickening/ ___Mild ___Moderate ___Severe ___Unbearable
- Fearful/ ___Mild ___Moderate ___Severe ___Unbearable
- Punishing/ ___Mild ___Moderate ___Severe ___Unbearable

How much time during an average day (24 hours) are you in pain?

_____Few hour's _____Less than 1/3 of time ____Almost 50% of the time ____Almost 2/3 of the time

_____Almost 24 hours _____Anytime that I am not lying down _____ Pain is not present daily

Do you have any of the following problems related to your pain? (Only mark those that apply)

_____Numbness _____Tingling _____Pin and Needles _____Weakness

_____Problems with Bowel Movement _____Problems with your Bladder

Pain Intensity Scale: On a scale of 1 to 10, with "0" representing no pain, "1" representing a nuisance which would not interfere with daily activities. While "10" would be the most severe pain imaginable. Which of the numbers on the scale below would describe your pain? (Please CIRCLE the number on the scales below that rates your level of pain)

What is your pain like today?	Less Pain < 0-1-2-3-4-5-6-7-8-9-10 > More Pain
What is your least pain?	Less Pain < 0-1-2-3-4-5-6-7-8-9-10 > More Pain
What is your worst pain?	Less Pain < 0-1-2-3-4-5-6-7-8-9-10 > More Pain
Average pain (overall)?	Less Pain < 0-1-2-3-4-5-6-7-8-9-10 > More Pain

Factors that change your pain (Do any of the following make your pain change?).

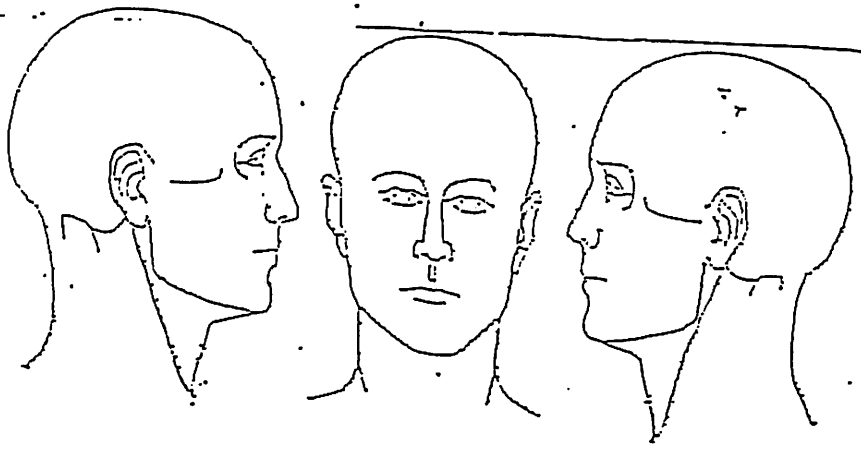
- Sitting/ __No Change __Somewhat Worse __Way Worse __Some Better __Pain Free
- Standing/ __No Change __Somewhat Worse __Way Worse __Some Better __Pain Free
- Walking/ __No Change __Somewhat Worse __Way Worse __Some Better __Pain Free
- Bending-Forward/ __No Change __Somewhat Worse __Way Worse __Some Better __Pain Free
- Bending Backward/ __No Change __Somewhat Worse __Way Worse __Some Better __Pain Free
- Bending to Same Side/ __No Change __Somewhat Worse __Way Worse __Some Better __Pain Free
- Bending to Opposite/ __No Change __Somewhat Worse __Way Worse __Some Better __Pain Free
- Lying Down-Resting/ __No Change __Somewhat Worse __Way Worse __Some Better __Pain Free
- Driving/ __No Change __Somewhat Worse __Way Worse __Some Better __Pain Free
- Lifting/ __No Change __Somewhat Worse __Way Worse __Some Better __Pain Free
- Coughing-Sneezing/ __No Change __Somewhat Worse __Way Worse __Some Better __Pain Free
- Cold Weather/ __No Change __Somewhat Worse __Way Worse __Some Better __Pain Free
- Damp Weather/ __No Change __Somewhat Worse __Way Worse __Some Better __Pain Free
- Sexual Activity/ __No Change __Somewhat Worse __Way Worse __Some Better __Pain Free
- Overhead Activity/ __No Change __Somewhat Worse __Way Worse __Some Better __Pain Free
- Other_____/ __No Change __Somewhat Worse __Way Worse __Some Better __Pain Free

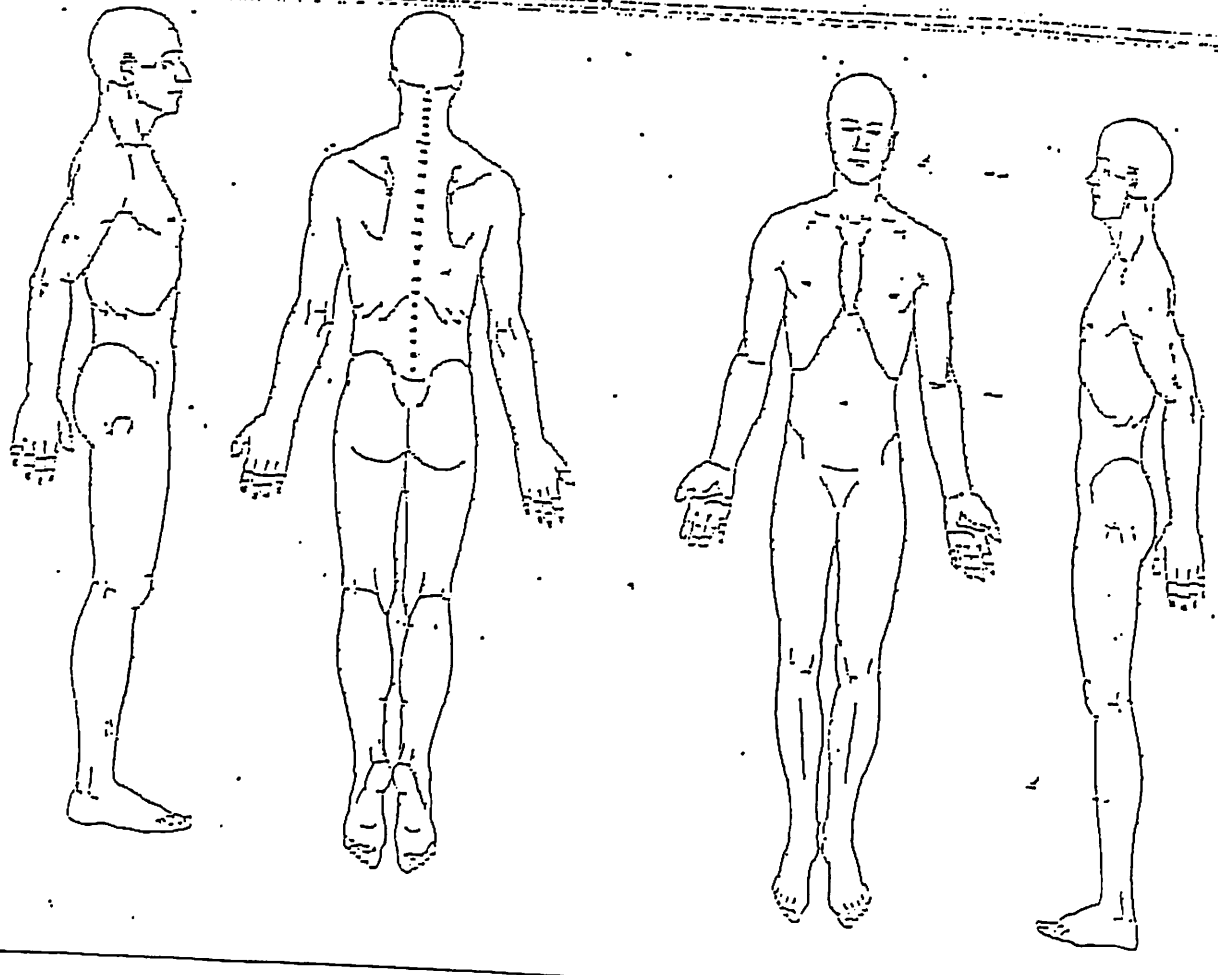
Are you able to perform any of the following without assistance?

Walk ___No ___Yes **Sit** ___No ___Yes **Stand** ___No ___Yes **Climb Stairs** ___No ___Yes

Dress Yourself ___Yes ___No **Drive Car** ___No ___Yes

Shade in problem areas!





EFFECT OF PAIN DURING ACTIVITIES

Please place a mark in the box which best describes the change in your daily activities after your pain/injury occurred. (Your desire to participate and actual participation in these activities)

- **Personal Activities/** __No Change __Decreased Some __Decreased A lot __Disappeared __Increased Somewhat __Increased A lot
- **Household Cleaning/** __No Change __Decreased Some __Decreased A lot __Disappeared __Increased Somewhat __Increased A lot
- **Family Activities/** __No Change __Decreased Some __Decreased A lot __Disappeared __Increased Somewhat __Increased A lot
- **Recreation & Hobbies/** __No Change __Decreased Some __Decreased A lot __Disappeared __Increased Somewhat __Increased A lot
- **Sexual Relations/** __No Change __Decreased Some __Decreased A lot __Disappeared __Increased Somewhat __Increased A lot
- **Physical Exercise/** __No Change __Decreased Some __Decreased A lot __Disappeared __Increased Somewhat __Increased A lot
- **Watching TV/** __No Change __Decreased Some __Decreased A lot __Disappeared __Increased Somewhat __Increased A lot

How often do you have to stop your activities and sit down or lie down to control your pain?

___Rarely-Not daily ___Approximately once per day ___Several times per day

___I spend almost all day lying or sitting to control my pain

What aspect of your pain, or which pain, is the most bothersome to you and why?

_____

MEDICAL HISTORY

Do you or have you ever suffered from any of the following?

	Yes / No		*Yes / No*
Chronic Headaches	___ ___	Sinus Problems	___ ___
Visual or Hearing Disturbance	___ ___	Pneumonia	___ ___
High Blood Pressure	___ ___	Asthma	___ ___
Heart Rhythm Disorders	___ ___	Emphysema	___ ___
Heart Attacks	___ ___	Other Lung Disease	___ ___
Other Heart Diseases	___ ___	Heartburn or Ulcers	___ ___
Diabetes	___ ___	Hepatitis	___ ___
Thyroid Problems	___ ___	Gallbladder Disease	___ ___

	Yes / No			Yes / No	
Pancreatitis	___	___	Muscle Disorders	___	___
Kidney Stones	___	___	Sickle Cell Anemia	___	___
Blood in urine or stool	___	___	Hemophilia	___	___
Urine/Stool Leak	___	___	Easy Bleeding	___	___
Frequent Constipation	___	___	Depression/Suicidal Thoughts	___	___
Seizures	___	___	Cancer	___	___ Type _____
Reactions to Anesthesia	___	___	Other _____		

SURGICAL HISTORY:

	Yes / No			Yes / No	
Tonsillectomy	___	___	Hysterectomy	___	___
Appendectomy	___	___	Bladder/ Kidney	___	___
Gallbladder	___	___	Other: _____		
Lung	___	___			
Heart	___	___			
Spine	___	___			

FAMILY HISTORY:

	Yes / No			Yes / No	
Heart Disease	___	___	Migraines	___	___
Hemophilia	___	___	Anesthetic Reactions	___	___
Other Bleeding Disorder	___	___	Muscular Disorder	___	___
Sickle Cell Anemia	___	___	Other: _____		

SOCIAL HISTORY

Do you, or have you ever used the following?

	Yes / No			Yes / No	
Smoke: _____ pk/yr	___	___	Marijuana	___	___
Alcohol	___	___	Cocaine	___	___

Other Street Drugs: _____

Please list if you are allergic to any medications along with your reaction:

_____

List all medications you are currently take (prescription and nonprescription).

	Medication	Dose	Frequency	Date Started	Time of Last Dose
1.)					
2.)					
3.)					
4.)					
5.)					

Previous hospitalizations without surgery (include year and doctors)

1.) _____
2.) _____
3.) _____

Previous surgeries (include year and the doctor's name)

1.) _____
2.) _____
3.) _____

REVIEW OF SYMPTOMS (PLEASE CIRCLE THE ONE'S THAT APPLY)

General: Recent weight changes, weakness, fatigue, fever

Skin: Rashes, lumps, color change

Respiratory: Asthma, wheezing, shortness of breath

Cardiac: Chest pain, palpitations, dyspnea, orthopnea, edema

Gastrointestinal: Heartburn, nausea, vomiting, bowel changes

Urinary: Polyuria, urgency, incontinence, loss of bladder control

Musculoskeletal: Muscle or join pain

Neurologic: Fainting, blackouts, weakness, paralysis, numbness, tingling

Hematologic: Anemia, easy bruising

Psychiatric: Nervousness, loss of appetite, depression, suicidal thoughts

	Sensory Light Touch R L	Pinprick R L	Motor	R L	Reflexes R L	Tenderness Midline	Facet R L	Para-spinal R L
C5			Deltoid					
5/6			Biceps	/5 /5				
5/6			B/R	/5 /5				
C6			Wrist Flex					
C7			Triceps	/5 /5				
			Wrist Ext					
C8			Grip					
T1			Hand intrinsic					

	Sensory Light Touch R L	Pinprick R L	Motor	R L	Reflexes R L	Tenderness Midline	Facet R L	Para-spinal R L
L1			Psoas					
L2			Adduction					
L3			Quadriceps					
L4			Ant. Tibialis		/5 /5			
L5			EHL		/5 /5			
S1			Gastroc/Soleus		/5 /5			
S2								
S3/4 /5			Anal Sphincter					

REFLEX

	R	L
Quadricep Femeralis	1+	1+
Achilles	1+	1+

RESPONSE TO SLR

	R	L
Back Pain	Negative	Negative
Sciatic Tension	Negative	Negative

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The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following Scale: 0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1.	How often do you feel that your pain is "out of control?"	0 1 2 3 4	
2.	How often do you have mood swings?	0 1 2 3 4	
3.	How often do you do things that you later regret?	0 1 2 3 4	
4.	How often has your family been supportive and encouraging?	0 1 2 3 4	
5.	How often have others told you that you have a bad temper?	0 1 2 3 4	
6.	Compared with other people, how often have you been in a car accident?	0 1 2 3 4	
7.	How often do you smoke a cigarette within an hour after you wake up?	0 1 2 3 4	
8.	How often have you felt a need for higher doses of medication to treat your pain?	0 1 2 3 4	
9.	How often do you take more medication than you are supposed to?	0 1 2 3 4	
10.	How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	0 1 2 3 4	
11.	How often have any of your close friends had a problem with alcohol or drugs?	0 1 2 3 4	
12.	How often have others suggested that you have a drug or alcohol problems?	0 1 2 3 4	
13.	How often have you attended an AA or NA meeting?	0 1 2 3 4	
14.	How often have you had a problem getting along with the doctors who prescribed your medicines?	0 1 2 3 4	
15.	How often have you taken medication other than the way that it was prescribed?	0 1 2 3 4	
16.	How often have you been seen by a psychiatrist or a mental health counselor?	0 1 2 3 4	
17.	How often have you been treated for an alcohol or drug problem?	0 1 2 3 4	
18.	How often have your medications been lost or stolen?	0 1 2 3 4	
19.	How often have others expressed concern over your use of medication?	0 1 2 3 4	
20.	How often have you felt a craving for medication?	0 1 2 3 4	
21.	How often has more than one doctor prescribed pain medication for you at the same time?	0 1 2 3 4	
22.	How often have you been asked to give a urine screen for substance abuse?	0 1 2 3 4	
23.	How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0 1 2 3 4	
24.	How often, in your lifetime, have you had legal problems or been arrested?	0 1 2 3 4	

Patient Name: _____ Date: _____

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PATIENT RESPONSIBILITY AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications (i.e., narcotics, tranquilizers, and barbiturates) are very useful but have a high potential for misuse and are therefore, closely controlled by local, state, and federal governments. They are intended to relieve pain, thus improving function and/or ability to work. Because my physician is prescribing controlled substance medications to help manage my pain, I agree by *initialing* to the following conditions:

1. ____ I am responsible for the controlled substance medication prescribed to me. If my prescription is **lost, misplaced, or stolen, or if I "run out early",** I understand that it WILL NOT be replaced until due.
2. ____ Refills of controlled substance medications:
    a.) Will be made only during regular office hours Monday thru Friday. All refill requests done after 11:00am on Friday WILL NOT be address until the following Monday. Refills WILL NOT be made at night, on the weekends, or during holiday.
    b.) All controlled medications are to be refilled at the time of your appointment. We WILL NOT refill any controlled medications by phone.
    c.) I must give my pharmacy 2-3 HOURS AFTER I check out from my appointment to have my prescriptions called in and ready at the pharmacy.
3. ____ It may be deemed necessary by my doctor that I see a medication-use specialist at any time while I am receiving controlled substance medications. I understand that if I do not attend such an appointment, my medication may be discontinued or may not be refilled beyond a tapering dose to completion. I understand that if the specialist feels that I am at risk of psychological dependence (addiction); my medications will no longer be refilled.
4. ____ **I agree to comply with random urine drug screen testing, documenting the proper use of my medications as well as confirming compliance.**
    a.) Urine specimen must be collected on the day of office visit.
    b.) Urine specimen which is ordered in an independent laboratory **"must"** be completed within three days of office visit for us to get the lab results.
    c.) I understand that driving a motor vehicle may not be allowed while taking controlled substance medications and that it is my responsibility to comply with the laws of the state while taking prescribed medications.
5. ____ I understand that if I violate any of the above conditions, my prescriptions for controlled substance medications may be **terminated immediately.** If the violation involves obtaining controlled substance medications from another individual, or the concomitant use of non-

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prescribed illicit (illegal) drugs, I may also be reported to all my physicians, medical facilities, and appropriate authorities.

6. ____ I understand that the main treatment goal is reduce pain and improve any ability to function and/or work. In consideration of this goal, and the fact that I am being given health habits; exercise, weight control, and avoidance of the use of tobacco and alcohol, I must also comply with the treatment plan as prescribed by my physician. I understand that a successful outcome to my treatment will only be achieved by following a healthy lifestyle.
7. ____ I understand that the long-term advantages and disadvantages of chronic opioid use have yet to be scientifically determined and my treatment may change at any time. I understand, accept, and agree that there may be unknown risks associated with the long-term use of controlled substances and that my physician will advise me of any advances in this field and will make treatment changes as needed.
8. ____ I understand that the use of marijuana is not prescribed or recommended by this clinic. The use of marijuana involves risks to your health which may not be fully understood. Marijuana use is associated with abuse potential and risks of dependency. Marijuana use in chronic pain patients receiving opioid analgesics or other controlled substances can put patients at increased risk for adverse outcome. Especially, in the setting that requires complete attention, alertness, and mental history of serious mental disorders such as schizophrenia, psychosis, and bipolar disorder. I understand that driving a motor vehicle may not be allowed while using marijuana along with taking controlled substance medications and it is my responsibility to comply with the laws of the state.

I have been fully informed by Dr. Randhawa and his staff regarding physiological dependence (addiction) of controlled substance medications. I know that some individuals may develop tolerance to the medication, necessitating a dose increase to achieve that desired effect, and that there is a risk of becoming physically dependent on the medication. I must do so slowly and under the medical supervision or I may have withdrawal symptoms. I have read this contract and the same has been explained to me by Dr. Randhawa. In addition, I fully understand the consequences of violating this agreement.

I have read this information and the same has been explained to me by Dr. Randhawa and/or his staff, and all questions have been answered. I understand that this information and the instructions I have received are for my safety and the safety of others. I understand that failure to comply could result in injury to me and to others. I agree to abide by the terms and conditions of this agreement and to indemnify and release Brazoria County Pain Center and its owners and employees from any and all claims and damages from my failure to comply with the instructions I have received.

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

Physician Assistant/Registered Nurse Practitioner Consent

Brazoria County Pain Center

This facility has a Physician Assistant and a Registered Nurse Practitioner on staff to assist in the delivery of general medical care.

They're not a doctor, but are graduates of a certified training program and are licensed by the state board. Under the supervision of a physician, a Physician Assistant and a Registered Nurse Practitioner can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. "Supervision" does not require the constant physical presence of the supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

The Physician Assistant and Nurse Practitioner may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostics
- Formulating a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting at surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

I have read the above, and hereby consent to the services of a Physician Assistant and a Registered Nurse Practitioner for my health care needs. I understand that at any time I can refuse to see the Physician Assistant and Registered Nurse Practitioner and request to see a physician. However, you as the patient have the right to deny this consent. By denying this consent understands that if for any reason Dr. Manjit Randhawa is out of the clinic, or doesn't have any available appointments. You will not be able to receive any treatment by the Physician Assistant or Nurse Practitioner. This will include office visits and or medication refills.

(Print) Name: _____ Date: _____

Signature: _____

Acknowledgement of Receipt of Privacy Practices (HIPAA)

Patient Name: _____ Date of Birth: _____

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. This office has implemented an office policy to keep patient information confidential. Under the requirements of HIPAA we are not allowed to give medical information to anyone without the patient's consent. You may designate below if you want someone other than yourself to have access to your private health information.

I authorize Dr. Manjit S. Randhawa's office to release my medical and/or billing information to the following individuals(s):

1.) _____ Relation to Patient: _____
2.) _____ Relation to Patient: _____
3.) _____ Relation to Patient: _____

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Signature: _____ Date: _____

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FINANCIAL AGREEMENT

I, _____ acknowledge that if my insurance does not cover the services rendered after filing the claim, then I am responsible for the balance.

If a claim is denied due to insurance carrier stating injury is not covered because of an auto accident, or pre-existing condition I will be responsible for the charges.

In this case all services rendered thereafter will have to be paid at the time of office visit. Patient can then file with their own carrier.

_____ _____

Responsible Party Date

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Authorization to Disclose Health Information

Signature of this form is a written consent that allows us to forward your medical records. This consent will only take place if Dr. Randhawa refers you out to see another specialist.

Patient Name: _____ Date of Birth: _____

1. I authorize the use of disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure.

Brazoria County Pain Center
1980 E. Mulberry St.
Angleton, TX 77515

3. The type and amount of information to be disclosed is as follows:
    - Problem List
    - Medication List
    - List of Allergies
    - History and Physical
    - Progress Notes
    - Lab Results
    - X-ray and Diagnostic Reports
    - Entire Record

4. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

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5. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written vocation to this office staff. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under the policy.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. You do not have to sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524.

_____ _____

Signature of Patient or Legal Representative Date

_____

If Signed by Legal Representative/
Relationship to Patient

Brazoria County Pain Center
Dr. Manjit S. Randhawa
Anesthesiology / Pain Management
Diplomat of American Board of Anesthesiology
Diplomat of American Academy of Pain Management
1980 E. Mulberry St, Angleton, Texas 77515
☎ (979) 848-3068 / Fax (979) 849-1423

I acknowledge that a $35.00 no show fee will be billed to me if I fail to call the office to cancel or reschedule an appointment before my scheduled appointment time.

An appointment will not be scheduled for me until the no show fee is paid in full. I can pay that fee in the office or over the phone.

Signature: _____

Date: _____

Brazoria County Pain Center
Dr. Manjit S. Randhawa
Anesthesiology / Pain Management
Diplomat of American Board of Anesthesiology
Diplomat of American Academy of Pain Management
1980 E. Mulberry St, Angleton, Texas 77515
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Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____

Date of Birth: _____

I have received and understand the practice's Notice of Privacy Practices. The notice provides in detail the uses and disclosures of my protected health/information. I understand my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Signature: _____

Date: _____

Relationship to patient (if signed by a personal representative of patient):

_____

Brazoria County Pain Center
Manjit Singh Randhawa D.O., P.A.
Patient Billing Policy
Credit Card on File Policy

Thank you for choosing Brazoria County Pain Center for your medical needs. We are committed to providing you with exceptional medical care, as well as, making our medical billing processes as convenient and efficient as possible. We have added credit card on file (CCOF) program as a convenient method for paying for the portion of your services you owe after your health plan pays its portion of your claim (co-payments will still be collected at the time of service).

Effective August 15th, 2018, Brazoria County Pain Center office will require all patients keep an active credit card on file with us. The credit card will be kept in a secure system by Instamed, our payment processor. We will bill your insurance company **first** and once they have processed your claim, **one** of the following process will be in place based on your selection:

- Once your insurance company has processed your claims, **NO** statement will be sent to you and we will charge your credit card on file. You will need to select the option of 'No Statement with cc' in credit card authorization form.
- Once your insurance company has processed your claims, we **will send you an itemized statement** for any items on which you have a balance. You will have **thirty days** from the date of the statement to pay the balance in full (by cash, check, credit card, health savings account). If the bill has not been paid within **thirty days** of the billing statement date, we will charge your credit card on file. You will need to select the option of 'Statement with CC' in credit card authorization form.
- Once your insurance company has processed your claims, you can choose to have **Payment Plan** for the balance due. To be eligible for Payment Plan, your total outstanding balance should be **above $100.** Payment plan can be of minimum $25 per month to a maximum of 12 months. You will continue to receive itemized statement every month for the period of entire payment plan. You will need to select the option of 'Payment Plan' in credit card authorization form.

If the credit card we have on file for you changes, please notify us **IMMEDIATELY**, by calling the billing office at 979-848-3068. It is not uncommon for people to change or cancel their credit cards for various reasons, including when a credit card expires. That is quite understandable. If we run your credit card and it is denied for any reason, we reserve the right to charge an **additional $25 declined card fee** if we are not able to run a new credit card within **7 days**. We will contact you or leave you a phone message on the phone number you provided for us, asking you to give us a call with the new number right away. We will enter the new credit card number into your file, and that will become your new card on-file, subject to the same financial policy as the card you gave us in-person when you were in our office.

On failure to update new credit card information and payment of declined cards within 15 biz days, any unpaid balances will be turned over to collection agency. Additionally, any existing payment plan arrangements and saving credit card on file authorization will be canceled with immediate effect and account will be **turned over to collection agency**.

If there is a problem with your bill/claim and it is brought to our attention after your credit card payment processes, we will investigate it and if we owe you the money, we will refund it to the **same card** in a timely manner. We understand that there are legitimate reasons that you may not have a credit card. If this is the case, you are welcome to leave an HSA (Health Savings Account), or Flex Plan Card on File. You may also pay for the visit with cash or a personal check.

How your Credit Card Information is Stored

We place a high priority on keeping your personal and financial information secure. Under HIPAA, we are under strict rules and guidelines in terms of protecting the privacy of protected health information. Under the Payment Card Industry Data Security Standard (PCI DSS), our payment processor, Instamed, is required to comply with very strict standards to safeguard your credit card information. Brazoria County Pain Center as a merchant of Instamed is also required to maintain PCI compliance. When you come to our office our staff will enter your information into our secure e-payments portal. All communications (between SSSC, e-payments, the acquiring bank and the issuing bank) are encrypted end to end with a 1024-bit RSA public/private key pair assuring server authenticity and invulnerability to man-in-the-middle attacks. Our system runs in secure mode using SSL (Secure Sockets Layer) which encrypts all communication data. For more information on Instamed please visit, https://www.instamed.com/.

Credit Card On File (CCOF) Authorization Form

By signing below, I agree to all of Brazoria County Pain Center (BCPC) Credit Card on File Policy and I authorize BCPC office to keep my signature and a valid credit/debit card number securely on-file in my account. I allow BCPC office to automatically charge my credit card for any outstanding balances. These may include: self-pay rates, co-insurance, deductibles, co-payments, insurance denials for ANY reason (including no referral on file); and missed or cancelled appointments. If the credit card that I give today changes, expires, or is denied for any reason, then I agree to immediately give BCPC office a new, valid credit card which I will allow them to key-in over the phone. Even though BCPC office is not swiping this card in person, I agree that the new card will still be subject to the financial policy listed herewith and may be used with the same authorization as the original card which I presented in person.

I understand that I am responsible for payment for all medical services provided to me by Brazoria County Pain Center. I understand that my insurance may deny or delay payment for these services or only partially pay them, and I agree to allow BCPC office to charge my credit card on file for the balance if that happens. I understand that this form is valid until I cancel this authorization through written notice to Brazoria County Pain Center office.

_____ _____

Signature of Patient / Credit Card Holder (or Legal Guardian) Date

_____ _____

Print Name of Person Signing Above Relationship to Patient

_____

Email Address (where receipts will be sent)*

*Email address is MUST in order to receive receipts. Print Clearly.

Brazoria County Pain Center
Manjit Singh Randhawa D.O., P.A.
Credit Card Information Form

_____
Patient Name (Last, First)

_____
Cardholder Name (Last, First)

_____
Cardholder Billing Address

_____
City State Zip

_____ _____/_____
Cardholder Phone Number Expiration Date

Card Type: ☐ MasterCard ☐ Visa ☐ Discover ☐ American Express

_____
Credit Card Number

By signing below, I hereby authorize my credit card to be charged for the services rendered by the above named medical provider. I agree that my credit card may be kept on file and charged as stated below**.

Please choose ONLY 1 of the options below:

☐ No Statement with Credit Card- Please charge my card for any balance due. I understand that my card on file will be charged automatically, and that I will NOT receive any statements.

OR

☐ Statement with Credit Card- Please send a monthly statement. I will settle my outstanding amount due and send/mail in payment promptly each and every month for the balance due. However, I realize that if I fail to pay the balance in full each month, and there ever becomes an outstanding balance over 30 days, by having credit card on file, I'm authorizing any balance that is overdue to be automatically charged.

OR

☐ Payment Plan- I understand that my credit card will be charged every month automatically for the below mentioned monthly amount towards the total outstanding balance mentioned below.

_____ _____ _____
Total outstanding balance Monthly Amount No. of months to be charged

Cardholder Signature_____ Date_____

Witness Signature_____ Date_____

**On failure to update new credit card information and payment of declined cards within 15 biz days, any unpaid balances will be turned over to collection agency. Additionally, any existing payment plan arrangements and saving credit card on file authorization will be canceled with immediate effect and account will be turned over to collection agency.