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	FOR NECK PAIN
__Back pain only/no leg pain	__Neck pain only/no arm pain
__Back pain worse than leg pain	__Neck pain worse than arm pain
__Back pain and leg pain are equal	__Neck pain and arm pain equal
__Leg pain worse than back pain	__Arm pain worse than neck pain
__Leg pain worse than back 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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INFORMED CONSENT AND PAIN MEDICINE AGREEMENT

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 physician. It is essential for the trust and confidence required for a proper patient-physician relationship and is intended to inform you of your 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 physician but also your 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 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 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 medications(s) include opioid/narcotic drug(s). I have discusses 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 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 judgement 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, and 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 the 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.

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THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCRIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATELY FROM THIS AGREEMENT. THIS INCLUDES THE USE OF MEDICATIONS FOR PURPOSES DIFFERENT THAN WHAT HAVE 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 physician at any time) and psychological evaluations if and when it is deemed necessary, and 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 authorized 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 judgement, 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 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 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 inform consent.

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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 physician immediately if I become pregnant.

_____**If I am pregnant or am uncertain, I WILL NOTIFY BY PHYSICIAN IMMEDIATELY.**

I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) to ensure complete safety of my unborn child(ren). With full knowledge of this, I consent to its use and hold my 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 physician. I understand that there are many strict federal and state laws, regulations and policies regarding the use and proscribing 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 or your physician who is managing your pain, or that physician's Physician Assistant or Nurse Practitioner, or another physician covering for your primary Pain Medicine Physician.

(Patient Shall Acknowledge All Provisions by Initialing)

_____ I am aware that all controlled substance prescriptions are now being monitor by the Texas State Board of Pharmacy and that information must be accessed by my Pain Medicine Physician every time a prescription is written, and by my pharmacist every time before my 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.

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_____ I agree to submit 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), treatment for chronic pain many be terminated. Also, a consult with, or referral to, an expert may be necessary, such as submitting to 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 in advance of 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) run out. My Pain Medicine Physician may limit the number of frequency of prescription refills.

_____ I understand that my medication(s) will be refilled regularly. I understand 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 provide 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 Management Physician** unless it is for an emergency **or** the medication(s) that is being prescribed by another physician is approved by my Pain Medicine Physician. Information that I have been receiving medication(s) prescribed by other physicians that has not been approved by my Pain Medicine Physician may lead to a discontinuation of medication(s) and treatment. All other health-related issues must be managed by my primary care physician and my other specialists.

_____ 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 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 my medication(s) to treat acute, post-surgical or chronic pain, then I will **disclose** this information to my Pain Medicine Physician at or before my next date of service, which must include, at the minimum, the name and contract 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 the dispensed the medication.

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 will alert my 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,** with the exception for those 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 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 **not to** share, sell, or otherwise permit others, including my family and friends, to have access to my 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.**

_____ 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 the discontinuance of medication.

_____ I recognized that my chronic pain represents a complex problem which may benefits 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 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.

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I certify and agree to the following *(patient Shall Acknowledge All Provisions by Initialing):*

_____ 1) I am **not currently using illegal drugs or abusing prescription medication**(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. 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 judgement.

_____ 2) 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.).

_____ 3) **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 an opportunity to lead a more productive and active life.

_____ 4) 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 medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.**

_____ 5) 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.

Patient Printed Name Physician Printed Name *(or Appropriate Authorized Assistant)*

Patient Signature Physician Signature *(or Appropriate Authorized Assistant)*

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: _____

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: _____

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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

Dr. Manjit S. Randhawa
Anesthesiology / Pain Management
Diplomat of American Board of Anesthesiology
Diplomat of American Academy of Pain Management
146 Hospital Drive, Suite # 205, Angleton, Texas 77515
☎ (979) 848-3068 / (979) 848-3081 / Fax (979) 849-1423

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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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: _____

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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.

Brazoria County Pain Center
Manjit S. Randhawa D.O. , P.A.

1980 E. Mulberry Street
Angleton, Texas 77515
Ph: 979 848-3068 Fax: 979 849-1423

Your Information.
Your Rights.
Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

► *See page 2 for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

► *See page 3 for more information on these choices and how to exercise them*

Our Uses and Disclosure

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

► *See page 3 and 4 for more information on these rights and how to exercise them*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you w with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by send ing a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/ privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instruction.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety*
In these cases we never share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising	• We may contact you for fundraising efforts, but you can tell us not to contact you again

Our Uses and Disclosure

How do we typically use or share your health information?
We typically use or share your health information in the following ways

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our Organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

Continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena

BCPC

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you.
The new notice will I be available upon request, in our office, and on our web site.

January 1st 2015

This Notice of Privacy Practices applies to the following organizations.

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this notice. All subsidiaries, business associates (ex. billing service, sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice.

We reserve the right to change this Notice

Privacy Officer: Rita Randhawa 979 848-3068 Ext 106 Email: rita@painbegone.net