LONE STAR
ORTHOPAEDIC AND SPINE SPECIALISTS, PLLC
DEDICATED TO RESTORING ACTIVE LIFESTYLES
Burleson — Fort Worth — Mansfield
817.926.BONE (2663)

First and foremost, we want to express our appreciation to you for selecting our practice. We want all of your experiences with us to be positive.

We know that filling out these forms can be difficult, but please complete them carefully. Your accurate responses will give us a better understanding of you and your problem. This enables us to provide you with the best possible medical care. Thank you for your cooperation!

Please bring your insurance card, driver's license or other picture ID, and all copies of medical records pertaining to your appointment including MRIs, X-rays, and CT scans. We do prefer that you have these on a CD. Please bring copies of the reports with the imaging.

Please confirm prior to your appointment which location you are scheduled at as we have multiple locations.

Again, thank you for selecting Lone Star Orthopaedic and Spine Specialists. Please feel free to call if you have any questions prior to your appointment.

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New Patient Registration

Contact Information

Patient Name (Last, First, MI): _____ Today's Date: _____

Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-Mail: _____

Primary Care Physician: _____

How did you learn about our practice?

☐ Referred by a Physician: _____ ☐ Internet / Website ☐ Newspaper / Magazine

☐ Referred by a Patient: _____ ☐ Other: _____

Care Plan

Do you have any of the following: ☐ Advance Directive ☐ Designated Power of Attorney ☐ Other: _____

Demographic Information

Date of Birth: _____ Social Security #: ___-___-___ Gender: ☐ Male ☐ Female ☐ Other

Marital Status: ☐ Single ☐ Co-Habitating ☐ Married ☐ Divorced ☐ Widow / Widower ☐ Other

Ethnicity: _____ Preferred Language: _____

Employer or School: _____

Is todays visit: **Work Related** ☐ Yes ☐ No **3rd Party Liability** ☐ Yes ☐ No **Auto Accident** ☐ Yes ☐ No

Emergency Contact Information

Contact Name (Last, First, MI): _____ Phone #: _____

Address: _____
Street City State Zip Code

Preferred Pharmacy

Pharmacy Name: _____ Phone #: _____

Primary Insurance Information

Primary Insurance: _____ Phone #: _____

Insured's Name: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Date of Birth: _____ Insured's Social Security #: ___-___-___

Employer/Group Name: _____ Group #: _____

ID #: _____

Secondary Insurance Information

Secondary Insurance: _____ ID #: _____

Insured's Name: _____ Insured's Date of Birth: _____

Workers' Compensation Information

Insurance Company: _____ Phone #: _____ Date of Injury: _____

Adjuster's Name: _____ Phone #: _____ Claim #: _____

Patient Signature: _____ Date: _____

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Current Symptoms

Symptom Diagram

Please mark the areas where you are experiencing symptoms. Pay special attention to the Right and Left sides.

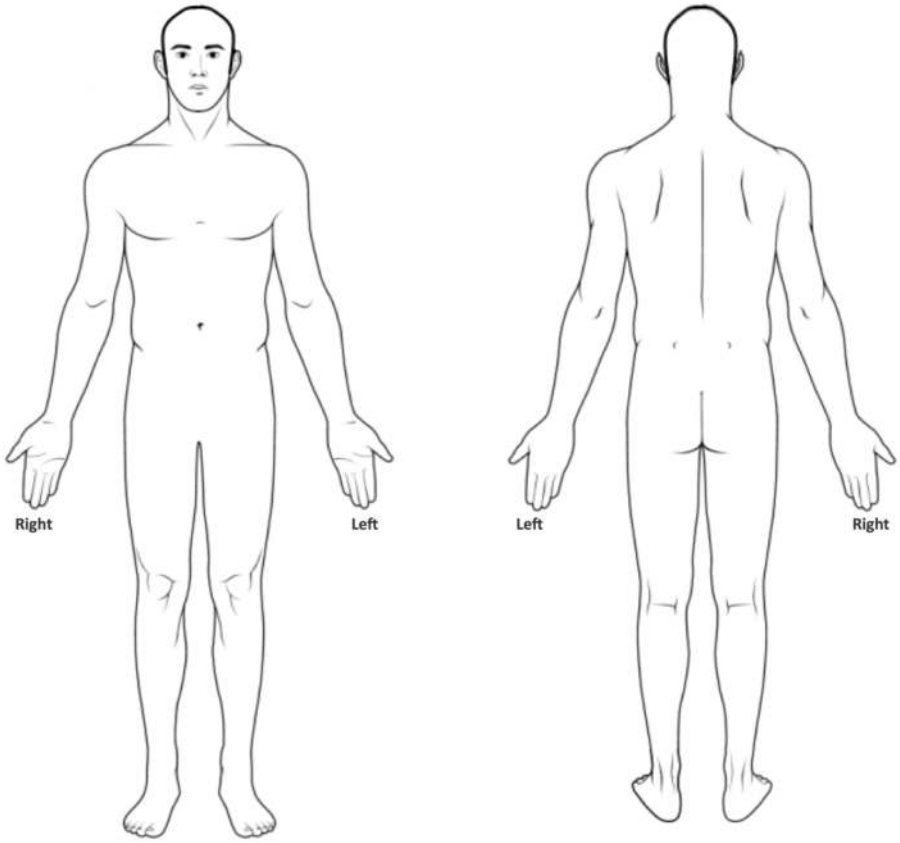
Ache
^^^^^^^^^^
^^^^^^^^^^
^^^^^^^^^^

Numbness
OOOOOO
OOOOOO
OOOOOO

Pins & Needles
= = = = = =
= = = = = =
= = = = = =

Burning
XXXXXXX
XXXXXXX
XXXXXXX

Stabbing
/ / / / / / / /
/ / / / / / / /
/ / / / / / / /



Symptom Severity

Please rate the severity of the pain you are experiencing **Today**:

	←No Pain									Worst Possible →
Neck pain:	0	1	2	3	4	5	6	7	8	9	10
Arm & Hand pain:	0	1	2	3	4	5	6	7	8	9	10
Middle-Back pain:	0	1	2	3	4	5	6	7	8	9	10
Low-Back pain:	0	1	2	3	4	5	6	7	8	9	10
Buttock & Leg pain:	0	1	2	3	4	5	6	7	8	9	10

Please check any additional symptoms :

- ☐ Numbness / Dull Sensation
- ☐ Pins & Needles / Burning Sensation
- ☐ Weakness
- ☐ Unable to control Bowel / Bladder
- ☐ Difficulty with Buttons / Zippers
- ☐ Pain that wakes you from sleep

Exacerbating & Alleviating Factors

How do each of the following activities affect your symptoms? (Please check all that apply)

Activity	Better	No Change	Worse
Prolonged Standing	☐	☐	☐
Prolonged Walking	☐	☐	☐
Rest	☐	☐	☐
Reclining	☐	☐	☐
Bending / Twisting	☐	☐	☐
Rising from a chair	☐	☐	☐
Coughing / Sneezing	☐	☐	☐
Climbing Stairs	☐	☐	☐

Do you have any other Neck or Spine issues NOT related to today's visit?

Previous Treatment

Previous Treatments

Please indicate any previous treatments you have had for this **CURRENT** neck / back pain:

Treatment	Better	No Change	Worse
Rest / Activity Modification	☐	☐	☐
Physical Therapy	☐	☐	☐
Chiropractic Care	☐	☐	☐
Spinal Injections	☐	☐	☐
Psychiatric Consultation	☐	☐	☐
Other:_____	☐	☐	☐

Have you had any **recent** tests for this performed for this **CURRENT** neck / back pain?

Test	< 6 months ago	6-12 months ago
X-Rays	☐	☐
CT Scan	☐	☐
MRI	☐	☐
Myelogram	☐	☐
EMG / NCV (Nerve Studies)	☐	☐

Previous Spine Surgeries or Injections

If you have **ever** had any previous **surgery or injections on your Neck or Spine**, please provide the details below:

Date	Surgeon / Hospital	Procedure & Location (Specify Vertebral Levels)	Reason	Outcome
				☐ Better ☐ No Change ☐ Worse
				☐ Better ☐ No Change ☐ Worse
				☐ Better ☐ No Change ☐ Worse

Current Medications

Please list all medications you are taking, including Prescription, Over-the-counter, and Herbal Medications: ☐ None

Medication	Dose & How Often Taken	Doctor (If Prescription)

Allergies

Please list any allergies, including the reaction you experience: ☐ No Known Allergies

Medication	Reaction	Most recent exposure to this Medication

Drug Use

Do you use or have used illicit drugs? If yes please explain below: ☐ No History of Drug Use

Past Medical History

For each category, please indicate any conditions which you **currently have** or **have had in the past:**

No Medical Problems

☐ I do not have any current or previous medical conditions

Cardiovascular

☐ Hypertension ☐ Heart Attack ☐ Stroke ☐ TIA (Transient Ischemic Attack)
☐ Atrial Fibrillation ☐ Congestive Heart Failure

Pulmonary

☐ Asthma ☐ COPD ☐ Emphysema ☐ Tuberculosis
☐ Frequent Pneumonia ☐ Sleep Apnea ☐ Supplemental Oxygen Requirement

Gastrointestinal

☐ Gastric Reflux (GERD) ☐ Gastric Ulcer ☐ Hepatitis ☐ Cirrhosis
☐ Liver Disease ☐ Gall Stones ☐ Hernia ☐ IBS / Crohn's Disease / Ulcerative Colitis

Renal

☐ Kidney Stones ☐ Kidney Infection ☐ Renal Insufficiency ☐ Dialysis-Dependent

Genitourinary

☐ Enlarged Prostate (BPH) ☐ Sexual Difficulty ☐ Urinary Incontinence ☐ Menstrual Problems
☐ Frequent or Chronic Urinary Tract Infection (UTI)

Musculoskeletal

☐ Degenerative Arthritis ☐ Rheumatoid Arthritis ☐ Gout ☐ Fibromyalgia
☐ Osteoporosis / Osteopenia ☐ History of Hip Fracture ☐ Vertebral Fracture ☐ Scoliosis

Endocrine

☐ Diabetes ☐ Thyroid Disease ☐ Addison's Disease ☐ Polycystic Ovarian Syndrome (PCOS)

Neurologic / Psychologic

☐ Anxiety ☐ Depression ☐ Bipolar Disorder ☐ Schizophrenia
☐ Peripheral Neuropathy ☐ Carpal Tunnel Syndrome ☐ Alzheimer's Disease ☐ Parkinson's Disease
☐ Multiple Sclerosis ☐ Spinal Cord Injury ☐ Traumatic Brain Injury (TBI)

Hematologic

☐ Anemia ☐ Clotting Disorder ☐ Taking Anti-Coagulant Medications ("Blood Thinners")
☐ Deep Venous Thrombosis (DVT) ☐ Pulmonary Embolism (PE)
☐ History of Blood Transfusion ☐ Sickle-Cell Anemia

Immunologic

☐ Immune Disorder ☐ Long-term Steroid Therapy (e.g. Prednisone) ☐ Immuno-Suppressant Medication
☐ Organ Transplant ☐ Eczema ☐ Psoriasis ☐ Lupus
☐ Sjogen's Syndrome ☐ HIV/AIDS

Cancer

If you have been diagnosed with cancer, or have had cancer in the past, please select the appropriate bubble:

☐ Breast ☐ Lung ☐ Kidney ☐ Thyroid
☐ Prostate ☐ Bowel ☐ Skin ☐ Bone
☐ Leukemia ☐ Lymphoma ☐ Myeloma
☐ Other: _____

Please provide any additional details about type of cancer, when it was diagnosed (approximate year), any treatment (Including any Medications, Radiation, and/or Surgery), the name of your Oncologist, and the approximate date of your most recent Oncology follow-up appointment:

Past Medical History (Continued)

Additional Medical Problems

If you have any additional medical problems not listed, or need to provide any additional information, please check the bubble marked "yes", and provide details below:

☐ Yes, I have the following medical conditions:

Surgical History

For each category, please indicate any surgeries which you have had:

Head & Neck

☐ Eye Surgery ☐ Sinus Surgery ☐ Facial Reconstructive / Plastic surgery
☐ Oral Surgery ☐ Neck Surgery

Cardiothoracic

☐ Cardiac Bypass ☐ Cardiac Stent ☐ Angioplasty / Cardiac Catheterization
☐ Pacemaker / Defibrillator ☐ Cardiac Valve Surgery ☐ Lung Surgery ☐ Mastectomy

Abdominal

☐ Hernia Repair ☐ Appendectomy ☐ Gastric Bypass ☐ Cholecystectomy (Gallbladder)
☐ Esophageal Surgery ☐ Stomach / Bowel Surgery ☐ Organ Transplant ☐ Kidney Surgery

Pelvic

☐ C-Section ☐ Hysterectomy ☐ Bladder Suspension ☐ Prostate Surgery

Vascular

☐ Varicose Vein Surgery ☐ Aortic Aneurysm Repair ☐ Vascular Bypass ☐ Carotid Endarterectomy
☐ AV Fistula (Dialysis access)

Neurologic

☐ Brain Surgery ☐ Ventricular Shunt ☐ Cervical Spine Surgery ☐ Lumbar Spine Surgery
☐ Scoliosis Surgery ☐ Carpal Tunnel Release ☐ Ulnar Nerve Decompression

Orthopaedic

☐ Fracture Repair ☐ Knee Replacement ☐ Hip Replacement ☐ Shoulder Arthroplasty
☐ Arthroscopic Surgery

Other Surgeries

☐ If you have had any surgeries not present above, please list them here:

Hospitalization

Have you ever been hospitalized, for any reason?

☐ Never ☐ None besides those listed in Surgical History ☐ Yes

If you answered "Yes", please provide details including reason, approximate dates and length of hospital stay:

Family History

Please indicate any medical conditions affecting your family members:

Mother

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke
☐ Mental Illness ☐ Cancer ☐ Scoliosis ☐ Skeletal Dysplasia
☐ Genetic Abnormalities ☐ Other ☐ Unknown / Not Applicable

Father

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke
☐ Mental Illness ☐ Cancer ☐ Scoliosis ☐ Skeletal Dysplasia
☐ Genetic Abnormalities ☐ Other ☐ Unknown / Not Applicable

Siblings

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke
☐ Mental Illness ☐ Cancer ☐ Scoliosis ☐ Skeletal Dysplasia
☐ Genetic Abnormalities ☐ Other ☐ Unknown / Not Applicable

Children

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke
☐ Mental Illness ☐ Cancer ☐ Scoliosis ☐ Skeletal Dysplasia
☐ Genetic Abnormalities ☐ Other ☐ Unknown / Not Applicable

If you answered "Other" to any of the above, please provide explanation below:

_____

_____

Social History

Marital Status

☐ Single ☐ Co-Habitating ☐ Married ☐ Separated / Divorced
☐ Widow / Widower

Education

☐ Grammar School ☐ High School ☐ College ☐ Post-Graduate

Employment

What is your current *(or most recent)* Occupation?

_____

Please describe your Current Work Status:

☐ Working - Full Time ☐ Working - Part Time ☐ Seeking Employment ☐ Physically unable to work / Disabled
☐ Not working by choice (Retired - Homemaker - Student - etc.)

Habits

Tobacco & Nicotine Products

☐ Never used ☐ Current / Occasional User ☐ Former user – Quit Date (Approximate):_____

If you are *currently* using Tobacco or Nicotine products, please indicate the Type (select all that apply):

☐ Cigarettes ☐ Cigars ☐ Chewing Tobacco ☐ Nicotine Vaporizer / "e-Cigarette"
☐ Nicotine Gum / Patch

If you are *currently* using Tobacco or Nicotine products, please indicate how often:

☐ Daily ☐ At Least 1x per Week ☐ At Least 1x per Month ☐ Less than Once per Month

Alcohol

☐ Never ☐ Less than 1 drink per Week ☐ Weekly ☐ Daily

Do you have a History of Heavy Drinking or Alcoholism?

☐ Never ☐ In the Past ☐ Current

Review of Systems

For each category, please indicate all problems which you **currently have**:

Constitutional

☐ None ☐ Fever ☐ Chills ☐ Night Sweats
☐ Recent Unexplained weight Loss (More than 10 Pounds) ☐ Recent Unexplained weight Gain (More than 10 Pounds)

General

☐ None ☐ Muscle Weakness ☐ Difficulty Standing ☐ Difficulty Walking

Head, Eyes, Ears, Nose, & Throat

☐ None ☐ Sinusitis ☐ Congestion ☐ Dentures
☐ Vision Problems ☐ Eye Glasses ☐ Hoarseness ☐ Difficulty Swallowing

Cardiovascular

☐ None ☐ Chest Pain ☐ Shortness of Breath ☐ Ankle / Feet Swelling
☐ Palpitations

Respiratory

☐ None ☐ Cough ☐ Wheezing

Gastrointestinal

☐ None ☐ Constipation ☐ Heartburn ☐ Dark / Bloody Stools
☐ Nausea ☐ Vomiting

Musculoskeletal

☐ None ☐ Neck ☐ Back ☐ Shoulder
☐ Wrist / Hand ☐ Hip ☐ Knee ☐ Ankle / Foot

Integumentary

☐ None ☐ Rash ☐ Itching ☐ Open sores
☐ Poor healing ☐ Acne ☐ Skin infection

Neurology

☐ None ☐ Memory Loss ☐ Confusion ☐ Dizziness
☐ Vertigo ☐ Tremor ☐ Frequent Headache ☐ Balance Problems

Psychiatric

☐ None ☐ Sleep disturbances ☐ Feelings of hopelessness

Genitourinary

☐ None ☐ Urinary incontinence ☐ Pain with Urination ☐ Frequent Urination
☐ Incomplete voiding

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PRACTICE POLICIES

Financial Obligations

I agree that in return for the services provided by Lone Star Orthopaedic and Spine Specialists I will pay my account at the time service is rendered, or will make financial arrangements satisfactory to Lone Star Orthopaedic and Spine Specialists for payment. If my insurance company or health plan designates co-payments and/or deductibles, I agree to pay them to Lone Star Orthopaedic and Spine Specialists. All co-payments and past due balances are due and payable at the time of service. I understand and agree that if my account is delinquent, a collection agency may be authorized to recover the unpaid amount.

Patient Initials:_____

HMO Referrals

If your insurance has designated a primary care physician (PCP), a prior authorization from your PCP is required to see a specialist. It is your responsibility to work with your PCP and insurance carrier to obtain this authorization prior to your office visit with Lone Star Orthopaedic and Spine Specialists. If authorization is not provided, either by you the Patient, or through your Insurance Carrier or PCP, you will be asked to re-schedule your appointment until the authorization is available, or pay for the visit at the time of service and file with your insurance carrier for reimbursement.

Patient Initials:_____

Self-Pay Accounts

Patients without an insurance plan at the time of service, and/or patients who are covered by insurance carrier with whom the practice does not participate, are individually obligated to pay the full charges at the time of service

Patient Initials:_____

Non-Participating Insurance Accounts

Services provided to Patients who are insured by carriers with which the practice does not participate are considered “out-of-network.” It is the financial obligation of the patient with non-participating insurance carriers to pay the co-pay and/or visit in full at the time of service.

Patient Initials:_____

If You Require Surgery

If you require surgery, your surgeon and supporting staff will work with you to select a date that will accommodate both schedules. Our staff will review any anticipated financial responsibilities you may have. Keep in mind that these are estimates only, and are subject to change once the surgery has been billed and insurance has paid. You may be asked to make a pre-payment to cover the amount of your deductible/percentage for surgical care. This payment will be due before surgery is performed.

Please feel free to talk to our staff about a payment plan if you have a special financial situation. Our office will work with you to ensure that you receive the highest quality of care. Lone Star Orthopaedic & Spine Specialists will require that all balances being placed on a payment schedule be paid in full within 6 months – as such, payment plans are structured on a 6-month time frame.

Patient Initials:_____

Returned Checks

All returned checks will be assessed a $35.00 fee.

Patient Initials:_____

Signature:_____ Date: _____

Patient or Authorized Party Signature

Electronic signature: This Agreement may be executed and delivered by electronic means and upon such delivery the electronic signature will be deemed to have the same effect as if the original signature.

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Practice Consent Form

Consent to Treat

I consent to necessary medical treatment as recommended by my physician. I understand that insurance may not cover all recommended medical services, such as preventative health exams, immunizations, screening test, detailed phone consultations, copies of medical records, or preparation of reports, forms, and summaries.

Patient Initials:_____

Privacy Notification

As permitted by the Health Insurance Portability and Accountability Act (HIPAA), I understand that my protected health information may be used and disclosed by the physician, office staff, and others outside of this office who are involved in my care and treatment for the purpose of providing health care services.

I acknowledge that I have been provided an opportunity to review the Notice of Privacy Practices which explains how my medical information will be used and disclosed. I understand that I am entitled to a copy of this document.

Patient Initials:_____

Release of Information

I authorize Gurpreet S. Bajaj, M.D., Barnard Barragan, M.D., Von L. Evans, M.D., Alfredo L. Marti, M.D., Dalton M. Ryba, D.P.M., John A. Thomas, M.D., Christopher Werner, D.P.M., and Jeffrey J. Ratusznik, M.D. to discuss information with the following:

____ Family Members

____ Coaching/Training Staff at my school. School Name: _____

_____I restrict release of information to only the following:

Name:_____Relation: _____

Name:_____Relation: _____

Patient Initials:_____

Medical Record Authorization

I authorize Lone Star Orthopaedic and Spine Specialists to obtain outside medical records including but not limited to Primary Care Physicians, Hospitals, Imaging Centers, and Pharmacies:

Patient Initials:_____

I have read and fully understand the above consent for treatment, financial responsibility, release of medical records information, and insurance authorization. These authorizations shall remain until written notice is given by me revoking said authorization.

Patient Signature: _____ **Date:** _____

Electronic Signature: This Agreement may be executed and delivered by electronic means and upon such delivery the electronic signature will be deemed to have the same effect as if the original signature.

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Informed Consent and Pain Management Agreement
As Required by the Texas Medical Board
Reference: Texas Administrative Code, Title 22, Part 9, Chapter 170

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 therapy to be used, so that you may make the informed decision whether or not to take the drug after knowing the risk 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 of withhold your consent/permission to use the drug(s) recommended to you by me, as your physician. For the purpose of this agreement the use of the word "physician" is defined to include not only my physician but also my physician's authorized associates, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat my condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician (name at bottom of agreement) to treat my condition which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent for my physician to administer or write prescription(s) for dangerous and/or controlled drugs (medications) as an element in the treatment of my chronic pain.

It has been explained to me that these medication(s) include opioid/narcotic drug(s), which can be harmful if taken without supervision. I further understand that these medications(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. 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 death is also a possibility as a result from taking these medication(s).

THE SPECIFIC MEDICATION(S) THAT MY PHYSICIAN PLANS TO PRESCIBE WILL BE DESCRIBED AND DOCUMENTED SEPARATE 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 SOMETHIMES 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

 Intial_____

hereby give permission to perform the test or my refusal may lead to termination of treatment. The presence of unauthorized substances may result in my being discharged from your care.

For **Female** patients only:

To the best of my knowledge **I am not pregnant.**

If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment. I accept that it **MY responsibility** to inform my physician immediately if I become pregnant.

If I am pregnant or uncertain, I WILL NOTIFY MY PHYSICIAN IMMEDIATELY. All of the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics to assure complete safety to 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/baby.

I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUGS USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING; constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention(inability to urinate), orthostatic hypotension(low blood pressure), arrhythmias(irregular heartbeat), insomnia, depression, impairment of reasoning and judgment, respiratory depression(slow or no breathing),impotence, tolerance to medication(s),physical and emotional dependence or even addiction, and death. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.

The alternative method of treatment, the possible risks involved, and the possibility of complications has been explained to me, and I still desire to receive medication(s) for the treatment of my chronic pain.

The goal of this treatment is to help me gain control of my chronic pain in order to live a more productive and active 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) on a regular basis is to reduce(but probably not eliminate) my pain so that I can enjoy and improved quality of life. I realize that the treatment for some will require prolonged or continuous use of the 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 medication(s) at any time and that I will notify my physician of any discontinued use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

I understand that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of medications to treat chronic

Intial_____

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 and treatment, risks of non-treatment and the drug therapy, medical treatment or diagnostic procedure(s), and I believe that I have sufficient information to give this informed consent.

PAIN MANAGEMENT AGREEMENT:

I UNDERSTAND AND AGREE TO THE FOLLOWING:
That this pain management agreement relates to my use of any and all medication(s) (i.e. opioids, also called 'narcotics, painkillers', and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). **Therefore, medication(s) will only be provided as long as I follow the rules specified in the Agreement.**

My physician may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any criminal behavior:

- My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the medication(s) may be discontinued.
- I will disclose to my physician all medication(s) that I take at any time, prescribed by any physician.
- I will use medication(s) exactly as prescribed by my physician.
- I will agree not to share, sell or otherwise permit others, including my family and friends, to have access to these medications.
- I will not allow or assist in the misuse/diversion of my medication; nor will I give or sell them to anyone else.
- All medication(s) must be obtained at one pharmacy, when possible. Should the need arise to change pharmacies, my physician must be informed. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my physician to release my medical records to my pharmacist as needed.
- I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money. If either are lost or stolen, they will NOT BE REPLACED.
- 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) prior to the time of my next scheduled refill, even if my prescription(s) run out.
- I will receive medication(s) only from ONE physician unless it is an emergency or the medication(s) that is being prescribed by another physician is approved by my physician. Information that I have been receiving

Intial_____

medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.

- If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then my physician may try alternative medication(s) or may taper me off all medication(s). I will not hold my physician liable for problems caused by discontinuance of medication(s).
- I agree to submit to urine and/or blood screens to detect the use of non-prescribed and prescribed medication(s) at any time with or without prior warning. If I test positive for illegal substance(s), such as marijuana, speed, cocaine, etc., treatment for chronic pain may be terminated. Also, a consult with, or referral to, an expert may be necessary: such as submitting to a psychiatric of psychological evaluation by a qualified physician such as an addictionologist or a physician who specializes in detoxification and rehabilitation and/or cognitive behavioral therapy/psychotherapy.
- I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, 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 management program recommended by my physician to achieve increased function and improved quality of life.
- I agree that I shall inform any doctor who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.
- I hereby give my physician permission to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).

I must take the medication(s) as instructed by my physician. Any unauthorized increase in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.

- I must keep all follow-up appointments as recommended by my physician or my treatment may be discontinued.

I certify and agree to the following:

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 judgment.
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 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,

Intial_____

and active life.

4. I will review the side effects of the medication(s) that may be used in the treatment of my chronic pain. I fully understand that explanations regarding the benefits and the risk of these medication(s) and I agree to the use of these medication(s) in the treatment of chronic pain.

Patient Signature Date

Pharmacy Name Phone Number

Pharmacy Address (or Cross Streets)

Physician Signature (or Authorized Representative) Date

Electronic Signature: This Agreement may be executed and delivered by electronic means and upon such delivery the electronic signature will be deemed to have the same effect as if the original signature.

Intial_____

- Complaints may be directed to the following State Agency:

OFFICE OF THE OMBUDSMAN
P.O. BOX 13247
AUSTIN, TX 78711-3247
1-877-787-8999

- Web site for the Medicare Beneficiary Ombudsman: www.medicare.gov or 1-800-633-7227 or www.cms.hhs.gov/center/ombudsman

NOTICE TO PATIENTS: Physician Financial Ownership

We are required by Federal law to notify you that physicians hold financial interest or ownership in the following facilities: Baylor Surgicare at Fort Worth, Baylor Surgical Hospital, Gulfstream Surgery Center, Medical City Surgery Center, Texas Health Huguley Surgery Center, USMD Hospital Fort Worth, Precision Reading LLC. We are required by 42 C.F.R. § 416.50 to disclose this financial interest or ownership in writing and in advance of the date of the procedure. A list of physicians who have a financial interest in one of these facilities are listed below:

1. Dr. Gurpreet Bajaj
2. Dr. Barnard Barragan
3. Dr. Von Evans
4. Dr. Alfredo Marti
5. Dr. Jeffrey Ratusznik
6. Dr. Dalton Ryba
7. Dr. John Thomas
8. Dr. Christopher Werner

NOTICE TO PATIENTS: Policy for Advanced Directives

Please note that our Facility's policy on Advanced Directives is that Life sustaining efforts will be initiated and maintained on all patients. If you would like information on developing Advanced Directives, the following website can assist you and includes a description of the State's health and safety laws, and upon request, we will provide you with official State advance directive forms:

http://www.uslivingwillregistry.com/forms.shtm

NOTICE TO PATIENTS: Patient Statement of Responsibilities

1. I will provide accurate information about present and past illnesses, hospitalizations, medications, allergies and "NPO" status.
2. I will make every attempt to understand the implications of my procedure, including risks of refusing treatment, and I will ask for clarification when needed.
3. I will arrive at the scheduled time or notify facility of inability to do so.
4. I will follow all discharge instructions.
5. I will be respectful of the rights of other patients and staff.
6. I will be respectful of others' property.
7. I will immediately inform my physician of change in condition or adverse reaction.
8. I will be responsible for assuring that the financial obligations of my health care are fulfilled as promptly as possible.

LONE STAR
ORTHOPAEDIC AND SPINE SPECIALISTS, PLLC
DEDICATED TO RESTORING ACTIVE LIFESTYLES
Burleson — Fort Worth — Mansfield
817.926.BONE (2663)

_____ _____

Patient Name Date forms given

This is to confirm that I have received the following forms from my physician to review prior to arriving for my procedure. I also understand that I may contact Lone Star Orthopaedic & Spine Specialists, PLLC in case I have any questions regarding any of these forms.

Patient Statement of Responsibilities

Policy for Advanced Directives

Physician Financial Ownership

Patient Bill of Rights/Complaint Resolution

_____ _____

Signature of Patient or Legal Guardian Date

LONE STAR
ORTHOPAEDIC AND SPINE SPECIALISTS, PLLC
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Burleson — Fort Worth — Mansfield
817.926.BONE (2663)

Bone Health & Osteoporosis Clinic

Last Name: _____ First Name: _____

DOB: _____ / _____ / _____ ☐Male ☐Female

Please Circle Your Answers

Yes☐ No☐ 1. Are you over the age of 50?

Yes☐ No☐ 2. Have you ever broken a bone?

Age	Bone Involved	Circumstance

Yes☐ No☐ 3. Did a parent or sibling have a hip or vertebral (spine) fracture after the age of 50?

Yes☐ No☐ 4. Do you currently smoke, vape, or use chewing tobacco?
If No, Are you a former smoker? □ No □Yes, Quit Date:_____

Yes☐ No☐ 5. Have you ever had a weight loss procedure or gastric bypass?

Yes☐ No☐ 6. Have you taken any of these medications (3mo or more)? (Check all that apply)
□ Prednisone □ Methylprednisolone □ Dexamethasone
□ Methotrexate □ Chemotherapy

Yes☐ No☐ 7. Have you ever(or has it been suggested) taken a medication for your bones?
(Check all that apply)
□ Fosamax □ Boniva □ Actonel □ Reclast □ Evista
□ Prolia □ Forteo □ Calcitonin □ Strontium □ Boron

Yes☐ No☐ 8. Have you had a bone mineral density test(DXA) within the past 2 years?
If yes, when_____ Where_____

Office use only: □ Reviewed- Appt. not needed Name: _____
□ Schedule