

How did you hear about **WOL+MED**? Who Referred You?

Please tell us why you chose **WOL+MED** for your work or auto injury. Who can we thank for your referral?

- I saw the **sign** on the building / next to the highway.
- I saw a **newspaper** ad in the Denton Record Chronicle.

- The **ER** sent me here.
 - ___ Denton Regional Medical Center
 - ___ Denton Presbyterian
 - ___ Lewisville Medical Center
 - ___ Other _____

- I saw an ad in the **Yellow Pages**.
 - ___ Yellow Book, Denton
 - ___ Yellow Book in another town (which town?) _____
 - ___ AT&T, Gainesville
 - ___ Verizon (IDEARC), Denton
 - ___ Verizon (IDEARC), Lewisville
 - ___ My Lonestar Pages, Denton
 - ___ My Lonestar Pages, Cooke County
 - ___ Other (Please Specify) _____

- A **Friend** Referred me (Please tell us who) _____
- A **Family Member** Referred me (Please tell us who) _____
- A **Co-Worker** Referred me (Please tell us who) _____
- A **Doctor** Referred me (Please Specify which Doctor) _____
- An **Attorney** Referred me (Please specify which Attorney) _____
- My **Employer** Referred me (Please specify which Employer) _____
- I saw the web site (www.wolmed.com) and decided to come here.

- I searched the internet and found **WOL+MED**.
(Which search engine did you use?)
 - ___ Google
 - ___ Yahoo
 - ___ MSN
 - ___ AOL
 - ___ Superpages.com (from Verizon)
 - ___ Yellow Book.com
 - ___ Other (Please Specify) _____

- I was already a patient here.
- Other (Please Specify) _____

X

X

PATIENT INFORMATION FORM(Please **PRINT** legibly and fill in **COMPLETELY**.)

Date _____ / _____ / _____

Last Name _____		(please give Driver's License to receptionist to copy)	
First Name _____ M.I. _____		Driver's License _____	
Address _____		Email address _____	
City _____ State _____ Zip _____		Home phone (_____) _____ - _____	
Employer/School _____		Work phone (_____) _____ - _____	
Employer Address _____		Cell # (_____) _____ - _____ Fax # (_____) _____ - _____	
City _____ State _____ Zip _____		Date of Birth _____ Age _____	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security # _____ - _____ - _____	
Person Responsible for payment <input type="checkbox"/> Self		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed	
or _____		<input type="checkbox"/> Divorced <input type="checkbox"/> Separated	
		Occupation _____	
		Student <input type="checkbox"/> Yes <input type="checkbox"/> No	

PLEASE FILL IN COMPLETELY

Spouse's or Significant Other's Name			
Spouse's or Significant Other's Employer	Occupation (check if student)	How Long Employed	Bus. Phone
Spouse's or Significant Other's Employer's Address	City and State	Zip	Bus. Phone
Spouse's or Significant Other's Address (if different)	City and State	Zip	Home Phone
Has any member of your family been here before? (Names and ages)			
Mother's Name	Street Address, City, State, and Zip		Home Phone
Mother's Employer and Location	Occupation		Bus. Phone
Father's Name	Street Address, City, State, and Zip		Home Phone
Father's Employer and Location	Occupation		Bus. Phone
In case of emergency please notify: (other than parents, spouse, or anyone living at your residence)			Home Phone
Relationship	Street Address, City, State, and Zip		Bus. Phone
Your Hobbies:			Have you been here before? Y N What year? 19__

HOW DID YOU HEAR ABOUT US?

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Saw sign | <input type="checkbox"/> Gainesville - SBC | <input type="checkbox"/> Internet/Web pages | <input type="checkbox"/> friend (name) _____ |
| <input type="checkbox"/> on building/parking lot | <input type="checkbox"/> Verizon - Denton | <input type="checkbox"/> Google, (www.adwords.com) | <input type="checkbox"/> relative (name) _____ |
| <input type="checkbox"/> bowling alley | <input type="checkbox"/> Verizon - Area Wide | <input type="checkbox"/> Yahoo, | <input type="checkbox"/> doctor (name) _____ |
| <input type="checkbox"/> newspaper | <input type="checkbox"/> Verizon - Gainesville | <input type="checkbox"/> MSN | <input type="checkbox"/> attorney (name) _____ |
| <input type="checkbox"/> emergency room | <input type="checkbox"/> Complimentary | <input type="checkbox"/> Direct Internet Access | <input type="checkbox"/> employer (name) _____ |
| <input type="checkbox"/> DRMC <input type="checkbox"/> DCH | | <input type="checkbox"/> Web site (www.wolmed.com) | <input type="checkbox"/> other (describe) _____ |
| <input type="checkbox"/> Yellow Book Denton | | <input type="checkbox"/> (www.superpages.com) | |

PLEASE TURN OVER AND COMPLETE OTHER SIDE

PLEASE FILL IN COMPLETELY. PLEASE PRINT.

INSURANCE INFORMATION

If insurance information is incomplete, if deductible is not met, or if we cannot confirm insurance coverage, payment will be expected and due at time services are rendered. If your insurance company requires special forms to be filled out, it is your responsibility to complete all of the patient information and deliver the forms to us at the time services are rendered.

If you want us to bill your insurance, please...

- (1) let us photocopy your current insurance card and driver's license.
 - (2) give us your insurance claim form supplied by your insurance company (with the patient portion filled out and signed in both places requested).
- A. I assign the professional or medical expense benefit allowable and otherwise payable to me under my current insurance policy to **WOL + MED** as payment toward total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this assignment shall be considered as effective and valid as the original.
- B. I authorize the release of any information pertinent to my case to any insurance company, adjuster, my attorney, my employer (employer only for work related injuries), my managers, or other doctors involved in this case.
- C. I authorize release of all medical records from all other medical providers to **WOL + MED**.
FAX Medical Records to 775-599-3899 Denton
 972-572-9448 Dallas
- D. I understand that if I do not wish to file on my insurance or if any insurance (or any other third party) does not fully cover the charges incurred, I am fully responsible for paying the balance of my account.
- E. To: Texas Workers Comp Commission or any out of state Workers Compensation Commission.
Please release any and all information regarding my case to **Wol+Med Medical, P.A.**

Date ____/____/____

Signature of policy holder

Signature of claimant if other than policy holder

(For Office Use Only: When requesting medical records fax this form plus the patient information form)

COMPLETE HISTORY FORM (Please try to answer all questions on both sides. This information will be treated as confidential.)

Name _____ Today's Date ____/____/____
 Date of birth ____/____/____ Age _____

PAST HEALTH HISTORY Month & year of last yearly physical ____/____ Never
 Have you ever had any of the following conditions? Check "NOW" if you have problem NOW. Check "PAST" if you had problem in the PAST. Check "NEVER" if you have NEVER HAD this problem.

	Now	Past	Never		Now	Past	Never		Now	Past	Never
Anemia/blood disease				Tuberculosis				Kidney disease			
Thyroid trouble				Pneumonia				Back pain			
Diabetes				Stomach ulcers				Epileptic seizures			
Rheumatic fever				Liver disease				Alcohol or drugs			
High blood pressure				Jaundice				Auto injury			
Heart problems				Cancer				Work injury			

List medications you take regularly? _____

What drugs are you allergic to? _____

Have you had all your "shots" (immunizations)? Yes No

Name and address of previous family doctor: _____

Do you want to be notified when your yearly physical & blood tests are due? Yes No

Please list any SERIOUS illnesses, hospitalizations, cancers, or surgeries you have had.

Date	Illness or Operation	Doctor and/or Hospital	Mark X and enter Date if you have had.
			<input type="checkbox"/> 19__ X-rays of _____
			<input type="checkbox"/> 19__ Scan of _____
			<input type="checkbox"/> 19__ Colon tests
			<input type="checkbox"/> 19__ Breast x-rays
			<input type="checkbox"/> 19__ Heart tests
			<input type="checkbox"/> 19__ Pneumonia shot
			<input type="checkbox"/> 19__ Yearly physical
			<input type="checkbox"/> 19__ Yearly blood tests

FAMILY HEALTH ("Blood" relations only) Check "✓" if adopted.

Relative	Names	Age	Sex	Health Problems	If dead, cause of death	Age	Has any relation had	Yes	No
Father			M				Tuberculosis		
Mother			F				Heart disease		
Brothers & Sisters							High blood pressure		
							Alcoholism		
							Kidney disease		
							Diabetes		
							Strokes		
Children							Epilepsy		
							Nervous breakdown		
							Allergies or Asthma		
							Anemia		
							Cancer		

Please turn page! Please fill out the back of this sheet!

Check "✓" any **SERIOUS** problems you have now or have had in the past. Check "**NOW**" if you have problem NOW. Check "**PAST**" if you had problem in the PAST. Check "**NEVER**" if you have NEVER HAD this problem.

now			past			never			now			past			never		
Always Tired						Chills						Always Hungry					
Need Complete Yearly Physical?						Very Thirsty						Difficulty Sleeping					
Need Yearly Blood Tests?						Night Sweats						Bleeding Tendency					
Loss of Appetite						Warm "Blooded"						Growths, Tumors, Lumps					
Loss of Weight						Cold "Blooded"						Number of Alcoholic Drinks/Day					
Want Weight Loss Program?						Skin Trouble						Use/used Marijuana/Drugs					
Fever						Fainting or Dizziness						Need AIDS Test?					
HEAD & NECK																	
Allergies						Ever had Allergy Tests?						Itchy Eyes					
Headaches						Need Allergy Tests?						Frequent Colds					
Eye Trouble						Nasal Congestion						Sore Throat					
Hearing Difficulty						Nose Bleeds						Lumps in Neck					
Earaches						Congested or Runny Nose						Neck Pain					
Sinus Trouble						Sore Tongue						Sneezing Spells					
RESPIRATORY																	
Cough						Wheezing						Cigarette smoking					
Cough up phlegm						Shortness of breath						Number per day					
Cough up blood						Date of last TB test						Date of last chest x-ray					
CARDIOVASCULAR																	
Shortness of breath walking						Racing/skipping heart beat						Pains in Legs Feet (circle)					
Shortness of breath at night						Heart murmur						Poor circulation in legs					
Chest pains or pressure						Date last electrocardiogram						Cold feet, leg cramps					
High blood pressure						Swelling of ankles						Phlebitis (inflammation of veins)					
DIGESTIVE																	
Difficulty swallowing						Abdominal pain						Bloody bowel movements					
Heartburn						Gas & Bloating						Black bowel movements					
Nausea						Constipation						Do you take laxatives?					
Vomiting						Diarrhea						Any foods cause indigestion?					
Vomiting blood						Belching						Anal tags or growths					
Lump in throat						Blood on toilet paper						Hemorrhoids					
URINARY																	
Need to urinate often						Genital growths or warts						Getting up at night to urinate					
Painful urination						Wetting pants or bed						Weak urine stream					
Blood in urine						Difficulty starting urine						Have to run to the bathroom					
BONE AND JOINTS																	
Pain, stiffness, joint swelling						Have you had broken bones?						Back pain Neck pain (circle)					
Loss of joint movement						Foot trouble (warts or corns)						Do you need physical therapy?					
NERVOUS SYSTEM																	
Forgetfulness						Abnormal sensations, numbness						Difficulty walking					
Nervousness						Loss of balance						Tremors, shaking					
Depression						Clumsiness						Muscle weakness					
Frequent thoughts of suicide						Spells of any kind						Sexual difficulties of any type					
Poor concentration						Worry too much						Hot flashes					
Crying spells						Family marital problems						Irritable, feel like screaming					
SKIN																	
Warts hands feet other						Tatoos						Ingrown toe nails					
Moles						Rashes						Corns on feet					
Skin growths						Spots or veins on face						Veins on legs					
WOMEN ONLY																	
Irregular menstruation						Have you passed menopause?						Number of pregnancies					
Painful menstruation						Abnormal discharge or itching						Number of miscarriages					
Very heavy periods						Do you take birth control pills?						Date of last menstrual period					
Bleeding between periods						Any trouble with breasts						Date of last yearly pap smear					
Are you pregnant?						Hysterectomy						Need wrinkle laser surgery					Yes No

What is your main problem today? _____

What other problems do you have not listed above? _____

Doctor's signature _____

WORKER'S COMPENSATION HISTORY

Fill in
if known →

TWCC # _____
CARRIER'S CLAIM # _____

Please print. Give complete answers to all questions.

Injured Employee's Name Last First Middle			Date of Birth / /	Age	Date of injury / /	Social Security Number - -
3. Employee's Mailing Address (Street or P.O. Box)					Employer's Name	
City	State	Zip Code	Phone No. Home ()		Employer's Mailing Address (Street or P. O. Box)	
			Business ()		City	State Zip Code
Supervisor's Name			Phone #		Worker's Comp Insurance Carrier	
Occupation					Date of Hire: / / Time of Accident: Rate of Pay: \$ ____ per Hour # Hours worked/week:	

ACCIDENT INFORMATION

Give all the details of how your accident occurred.

Have you reported this injury to your employer?	Yes	No
Did you get checked by any other doctor?	Yes	No
Did you bring x-ray reports?	Yes	No
After the accident, did you return to work?	Yes	No
Have you ever injured this same area before?	Yes	No
Do any other diseases or accidents affect your work performance?	Yes	No
When working, do you have to favor any part of your body?	Yes	No
Have you had a worker's compensation claim before?	Yes	No
Before the injury, were you able to work as well as others your age?	Yes	No
Are your work activities restricted as a result of this accident?	Yes	No

If an attorney is retained, give full name and address: _____ Phone _____

In what exact area did you feel pain immediately after the accident? _____

If you returned to work, what was the date? Month _____ Day _____ Year _____

If you were checked by another doctor, give full name and address: _____

What was the doctor's diagnosis? _____

What therapy, if any, did you receive? _____

Which x-rays did you get? none neck back other x-rays _____

Note: If you have another treating physician, you will need to fill out a change of treating doctor's form (TWCC 53) before treatment can be started.

Do you have any other work injuries that you are being treated for? Yes No

If you have other conditions that affect your work performance, explain them: _____

Since this injury, are your symptoms: The same? Better? Worse?

HEALTH SURVEY

Check any **SERIOUS** problems you have now or have had in the past. Check **"NOW"** if you have problem NOW. Check **"PAST"** if you had problem in the PAST. Check **"NEVER"** if you have NEVER HAD this problem.

Gastrointestinal				now past never				now past never				now past never											
Poor appetite				Vomiting food				Abdominal pain				Difficult chewing				Vomiting blood				Trouble controlling bowels			

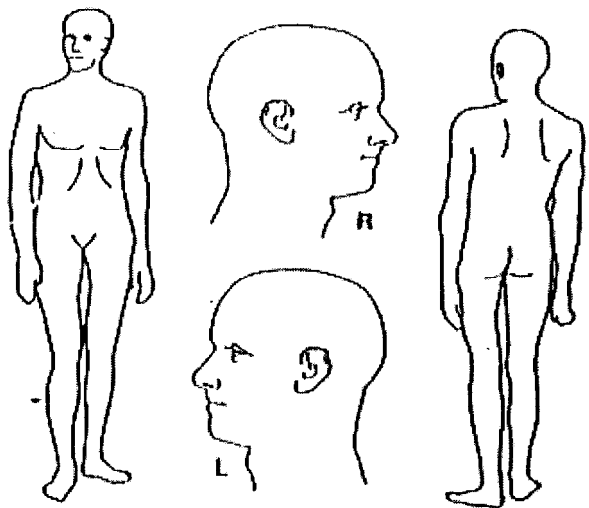
Nervous System				now past never				now past never				now past never											
Numbness				Loss of feeling				Muscle jerking				Numbness, tingling, or weakness of feet & legs				Paralysis				Convulsions			
Numbness, tingling, or weakness of hands				Dizziness				Forgetfulness					Fainting				Confusion						
				Headaches				Depression															

Cardiovascular				now past never				now past never				now past never			
Chest pain				Difficult breathing				Coughing blood							

Eye, Ear, Nose, & Throat				now past never				now past never				now past never											
Visual problems				Nose pain				Sore gums				Ear pain				Nose bleeding				Dental problems			
Ear noises				Nose discharge				Sore mouth				Hearing loss				Difficult breathing thru nose				Sore throat			
Ear discharge																							

Musculoskeletal				now past never			
Low back pain							
Upper back pain							
Pain between shoulders							
Neck pain							
Shoulder pain							
Arm pain							
Knee pain							
Leg pain							
Swollen joints							
Painful joints							
Stiff joints							
Sore muscles							
Weak muscles							
Walking problems							
Need help walking							
Ruptures							
Broken bones							

Mark areas of pain resulting from this accident on figures.
 Aching Numbness Pins & Needles Burning Stabbing
 XXX 000 === ▲▲▲ ///

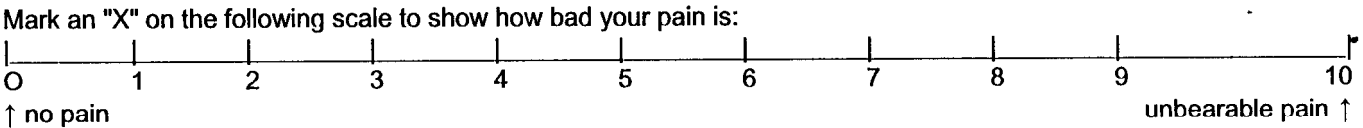


Genitourinary				now past never			
Trouble controlling bladder							
Bladder trouble							
Excessive urination							
Discolored urine							

Female now past never

Breast pain			
-------------	--	--	--

Are you pregnant? Yes No
 (If "yes", we cannot do x-rays.)



What are your main problems today? _____

Patient's signature _____ Date _____

WOL MED FINANCIAL POLICY

X

X

A. NO INSURANCE

If you do not have health insurance, payment by cash, check, or credit card is required at the time of service.

B. BILLING HEALTH INSURANCE

1. If you have health insurance, we will file the claims for you if:
 - a. you allow us to photocopy your insurance card and driver's license.
 - b. you have completed and signed both sides of the patient information form
2. You will need to pay your copay or coinsurance at the time of services.
3. If your insurance company reduces our charges, you are responsible for the remainder after insurance payment is credited to your account. You are also responsible for payment of all "non-covered" services as indicated by your insurance company. If your insurance pays only a part of the bill, you are responsible for the remainder.

C. MEDICARE

1. We are a Medicare participating physician. We accept assignment on Medicare claims filed.
2. You are responsible for your annual deductible (currently \$110.00). You have to pay the first \$110.00 of allowable charges for the current year.
3. Medicare will pay our office 80% of the "allowable" charge (An "allowable charge" is the charge set by Medicare). By law, Medicare rules that we must collect 20% coinsurance from our Medicare patients.
4. Since Medicare pays 100% of the allowable charges on laboratory work, all blood tests are "free" to Medicare patients.

D. STATEMENTS

1. You will receive a statement once a month on outstanding balances. Payment is due within two weeks after receiving a statement. **It is your responsibility to notify us if your address changes.**

E. DELINQUENT ACCOUNTS

We do turn delinquent accounts over to an independent collection agency. We want to work with you to avoid this last effort to clear your account, so please notify our office of any changes of address or employment. Your best protection is to pay your copay and to pay for non-covered services at each visit so that you are never faced with an accumulation of multiple visits.

F. WORKER'S COMPENSATION

1. There is no charge to you for a verified worker's compensation injury.
2. You must bring us a photocopy of a "First Report of Injury" signed by your supervisor or have your supervisor telephone us to verify your coverage.
3. If your injury is not covered by worker's compensation, you will be responsible for payment for services.

If you have any questions, problems, or changes, please notify us. We are here to help you.

I agree to the above financial policy.

Date _____/_____/_____

Signature

**WOL  MED
BACK AND NECK PAIN CENTER**

Advance Directive:

Wol+Med Back and Neck Pain Center recognizes each individual's right to choose medical intervention. This document is to serve as your written will and intent for receiving medical intervention including CPR and appropriate resuscitation in the event of a medical emergency.

While in a cognizant and coherent mental state, I _____
Execute my right to choose or deny medical intervention/resuscitation by placing a mark in one of the following:

_____ Yes, while in Wol+Med Back and Neck Pain Center, I choose to receive resuscitation and medical intervention in the event of a medical emergency. I fully understand that this intervention will potentially keep me alive with disregard to quality of life.

_____ No, while in Wol+Med Back and Neck Pain Center, I choose not to receive resuscitation and medical intervention including CPR in the event of a medical emergency. I fully understand the medical consequences resulting from this decision including regards to quality of life and ultimately death.

I have executed my rights and intent for the above.

Signature

Date

Witness

Date

**Acknowledgement of Review of
Notice of Privacy Practices**

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority

Notice of Our Privacy Practices

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.

Effective: 4/14/2003 (must be on or after the date of first printing or publication)

Under Federal Law, how might your protected health information need to be used/ disclosed by our office for treatment, payment, or health care operation purposes?

Generally, your protected information may be used or disclosed by our clinic for treatment, payment, or specific health care operations. These three words or phrases are defined by Federal Law, 45 CFR s 164.501 and other regulations as follows:

Treatment. *Treatment means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.*

Payment. *The activities undertaken by us to obtain or provide reimbursement for the provision of health care. Such activities include without limit determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims; billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health care data processing; and review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges.*

Other Health Care Operations. 45 CFR s 164.501 and .520(b)(1)(iii) outline several other purposes for which our practice may use or disclose protected information. For example, our practice may use or disclose protected information for the purposes of (1) conducting training programs in which student, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, (2) providing appointment reminders to patients, (3) providing treatment alternatives or other health-related benefits and services that may be of interest to patients, and (4) contacting patients to raise funds.

Disclosures to the Patient by Fax and E-mail

Periodically, patients request that our clinic transmit protected information to them by means of fax or email, or leave a message on voice mail regarding such information. While we may request specific written authorization from you prior to disclosing protected information through such means, you hereby agree (1) that by providing us with a fax number, email address, or phone number which includes voice mail, you are hereby consenting to disclosures through such means, and (2) in the even that you receive protected information from us via such means AND you do not wish to receive any more communications in these or other fashions, you agree that you will immediately instruct us in writing not to continue disclosing your protected information through such means.

Under Federal Law, how might your protected health information need to be used/ disclosed in ways that don't require written consent or authorization?

Under certain circumstances, law may require or permit our practice to make use of or to disclose your protected information without your consent or authorization. Such circumstances include:

- a) Uses and disclosures required by law.
- b) Uses and disclosures for public health activities.
- c) Disclosures about victims of abuse, neglect, or domestic violence.
- d) Uses and disclosures for health oversight activities.
- e) Disclosures for judicial and administrative proceedings.
- f) Disclosures for law enforcement purposes.
- g) Uses and disclosures about decedents.
- h) Uses and disclosures for cadaveric organ, eye or tissue donation purposes.
- i) Uses and disclosures for research purposes.
- j) Uses and disclosures to avert a serious threat to health or safety.

- k) Uses and disclosures for specialized government functions.
- l) Disclosures for workers' compensation.

What happens if other law is more restrictive than Federal Law?

In the event other law becomes more restrictive than Federal Law with respect to uses and disclosures of your protected information, our practice will include descriptions of the more stringent requirements in this privacy notice.

All other uses/ Disclosures require your written authorization

All other uses and disclosures besides those listed herein and those which require an opportunity to agree or object (see CFR 164.512) will only be made with your written authorization. Once such authorization is granted, you may revoke it at any time as provided by and subject to 45 CFR 164.508(b)(5).

Your Rights and How to Exercise Those Rights

Under Federal Law, you have the following rights. To exercise your rights, you will need to send a written request to the attention of the Privacy Officer of our clinic.

- You have the right to request restrictions on certain uses and disclosures of protected health information as provided by s 164.552(a). Please note however that under Federal Law, our clinic is not required to agree to a requested restriction.
- You have the right to receive confidential communications of protected health information as provided by and subject to 45 CFR s 164.522(b).
- You have the right to inspect and copy protected health information as provided by and subject to 45 CFR s 164.524.
- You have the right to receive an accounting of disclosures as provided by and subject to 45 CFR s 164.526.
- You have the right to receive an accounting of disclosures of protected health information as provided by and subject to 45 CFR s 164.528
- You have the right to obtain a copy of this privacy notice.

Duties of Our Clinic

Our clinic is required by law to maintain the privacy of your protected information and to provide you with notice of our legal duties and privacy practices concerning your protected information. Our clinic is required to abide by the terms of this privacy notice currently in effect. Our clinic reserves the right to change the terms of the notice and to make new notice provisions effective for all protected information that our clinic maintains. The revised notice will be made available at the front desk of our clinic for your inspection or copying.

Complaints

Our clinic welcomes any suggestions for amending our privacy practices. If you believe that your privacy rights have been violated, you may file a complaint with the Privacy Officer of our clinic and to the Secretary of Health and Human Services. To file a complaint with our Clinic's Privacy Officer, simply request and complete a copy of our privacy complaint form and submit it to our Privacy Officer. No individual may be retaliated against for filing such a complaint.

Contact Information or Further Information

For more information, call our main office number and ask to speak with our Privacy Officer.

CONTROLLED and PAIN MEDICATIONS AGREEMENT (File on top of flow sheet.)

The following agreement relates to my use of medications prescribed for pain control by

Wol+Med Clinics

I understand that taking medications in excess of or in addition to those prescribed may create a risk of harm to me, including but not limited to physical injury, addictive behavior, and a lessened effectiveness of the prescribed medication. I understand that the rules stated below are for my benefit.

I recognize that there are federal, state, and individual physician and/or clinic policies regarding the use of controlled substances or addictive medications. The Texas Intractable Pain Treatment Act, the Texas State Board of Medical Examiners, and the Texas State Board of Pharmacy all have specific requirements for the use of controlled substances and addictive medications for the treatment of chronic, intractable pain. I understand that the Physician and/or facility identified above is under no obligation to provide me with these classes of medications. I further understand that I will be provided with controlled substances and addictive medications while actively participating in this program only if I adhere to the following requirements:

1. I will use the substances only in the amount, and as prescribed and as directed by Wol+Med.
2. All controlled substances, prescription medications, or addictive medications will be prescribed only by Wol+Med. I will not use any controlled substances, prescription medications or addictive medications under any circumstances without obtaining the express permission of Wol+Med. Information that I have been receiving these substances from any other source or from "doctor shopping" may lead to a discontinuation of medications and treatment and/or discharge from this practice.
3. I agree to submit to urine and blood screens to detect the use of substances not prescribed through Wol+Med at the request of Physician.
4. I recognize that chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, and behavioral medicine strategies. I also recognize that active participation in the management of my pain is extremely important. I agree to actively participate in all aspects of the pain management program as directed by Physician to secure increased functioning and improved coping with my condition.
5. I will use only one pharmacy (name = _____) for controlled substances. I authorize Physician and/or the facility identified above to provide my pharmacist with a copy of this agreement.
6. I agree to notify Physician promptly of any other physician or other health care provider that provides me with treatment outside the scope of this program.

7. I AGREE THAT FAILURE TO FOLLOW THE ABOVE REQUIREMENTS MAY RESULT IN A DISCONTINUATION OF MEDICATIONS AND TREATMENT.

I further understand that Physician and/or the facility identified above is not responsible for medicines or treatments prescribed by other health care providers. I understand that if it appears to the physician identified above that there is no improvement in my daily function or quality of life from the medication, I may be required to gradually taper my medication as prescribed and directed by the physician. I will not hold Physician, the facility identified above or any of its employees and/or agents liable for problems caused by discontinuation of medications.

PLEASE NOTE:

1. The physician will not refill the prescription before it is due.
2. If the medication is taken in a manner other than that prescribed, the physician reserves the right to refuse to refill the prescription.
3. Medications which are lost, stolen, etc., will not be refilled early.
4. Should the patient fail to fulfill any of the above listed obligations, the doctor reserves the right not to refill the prescription.
5. Controlled or addictive medications will not be refilled after office hours, on Sundays, or on holidays.
It is the responsibility of the patient to keep up with their medication and the amount remaining. The office should be notified at least three days in advance before a refill is due so the patient can be scheduled for an office visit prior to the time of running out of medication. "Emergency" narcotic or addictive medication requests are directed to the local emergency room.
6. No controlled medications will be called into the pharmacy, you must make appointment.

Patient's signature

_____/_____/_____
Date

Witness

Name _____

Fear Avoidance Beliefs Questionnaire (Physical Activity)

Here are some of the things other patients have told us about their pain. For each statement please mark the number from 0-6 to indicate how much physical activities such as bending, lifting, walking or driving affect or would affect your back pain.

	Completely Disagree			Unsure		Completely Agree	
My pain was caused by physical activity	0	1	2	3	4	5	6
*Physical activity makes my pain worse	0	1	2	3	4	5	6
*Physical activity might harm my back	0	1	2	3	4	5	6
*I should not do physical activities which (might) make my pain worse	0	1	2	3	4	5	6
*I cannot do physical activities which (might) make my pain worse	0	1	2	3	4	5	6

FABQ(PA) Score: _____ Greater than 19 Less than 12 (For * questions only)

Fear Avoidance Beliefs Questionnaire (Work)

The following statements are about how your normal work affects or would affect your back.

	Completely Disagree			Unsure		Completely Agree	
*My pain was caused by my work or by an accident at work	0	1	2	3	4	5	6
*My work aggravated my pain	0	1	2	3	4	5	6
I have a claim for compensation for my pain	0	1	2	3	4	5	6
*My work is too heavy for me	0	1	2	3	4	5	6
*My work makes or would make my pain worse	0	1	2	3	4	5	6
*My work might harm my back	0	1	2	3	4	5	6
* I should not do my regular work with my present pain	0	1	2	3	4	5	6
I cannot do my normal work with my present pain	0	1	2	3	4	5	6
I cannot do my normal work until my pain is treated	0	1	2	3	4	5	6
*I do not think that I will be back to my normal work within 3 months	0	1	2	3	4	5	6
I do not think that I will ever be able to go back to work	0	1	2	3	4	5	6

FABQ(W) Score: _____ Greater than 34 Less than 19 (For * questions only)

Date _____ Scorer: _____
(Signature)

MEDICAL RECORDS REQUEST

1st Request 2nd Request! 3rd Request!!!!

- Denton Regional Presbyterian Denton Denton Imaging Lewisville Gainesville
- Fax 384-4718 Fax 898-7280 Fax 566-1841 Fax 972-420-1593 Fax 940- 612-8369
- Phone 384-3535 Phone 898-7056 Phone 387-1500 Phone 972-420-1072 Phone 940-665-1751 ext. 405

Hospital _____ Date Requested ____/____/____
 Doctor _____ Date Received ____/____/____
 Address _____
 City, State _____ Zip _____
 Area Code/phone number ____/____/____ Fax ____/____/____

YOU ARE HEREBY AUTHORIZED TO RELEASE TO:

**Ed Wolski, MD, FAAFP, DAAPM
2436 I 35E South, Suite 336
Denton, Texas 76205**

**Phone 940-484-7000
Fax 775-599-3899**

Any information, including the diagnosis and records of any treatment or examination rendered me and/or members of my family during the period listed below.

(Please Print in Big Capital Letters.)

Name of Patient	Date of Birth	Dates Treated
1. _____	____/____/____	____/____/____
2. _____	____/____/____	____/____/____

The reason for wanting these records released is continued care transferring doctors
 Please send by mail fax to 775-599-3899 (Please mail this request form back with records.)

Date Needed ____/____/____ ASAP!!! Patient signature _____

TO BE COMPLETED BY PHYSICIAN

Please indicate below what records are needed.

- History and Physical
- Discharge summary
- Radiology Reports
- ER x-ray reports
- CAT scans, MRIs
- Other scans
- Lab reports
- Pathology reports
- Consultation reports
- Operative report
- ER records
- Problem/Medication sheet
- Insurance and billing information
- Other

Telephone x-ray (scan) report (Check N if normal.)
 C Spine N _____
 LS Spine N _____
 T Spine N _____
 Other _____

Staff Use (Initial each step.)
 _____ 1. Telephone for verbal report and record above.
 _____ 2. Ask for faxed report (send to 940-383-1079).
 _____ 3. Ask for mailed report if fax not available or medical records too extensive.
 _____ 4. **File this form** in x-ray section of chart.
 _____ 5. File duplicate (bottom copy) in medical records tickler file.
 _____ 6. When faxed reports are received, remove duplicate from tickler file.
 _____ 7. Request x-rays and medical records every 2 weeks until reports are received.