SOUTH TEXAS ARTHRITIS CARE CENTER

5414 FREDERICKSBURG RD STE. 150 SAN ANTONIO, TX 78229 PHONE: (210) 615-9800, FAX: (210) 615-9801. www.happyjointmd.com

Dear Patient,

Thank you for choosing South Texas Arthritis Care Center for addressing your rheumatologic condition.

In order to better serve you, I have enclosed a New Patient History Form for you to fill out. Please fill this form out completely before your scheduled visit, as it may take some time to fill out. As a reminder, please bring the following documents filled out **completely** on your scheduled appointment (please do not mail):

1. Proof of Insurance
2. Office Policies-Please sign at the bottom and place you initials by each number
3. Patient Demographic Information Form
4. New Patient History Form
5. Authorization to Release Medical Records, signed. This enables us to obtain any records we need from your doctors.
6. Referral note or letter from the doctor who requested a rheumatology consultation, indicating the reason you were referred. If you have an **HMO**, please read yellow sheet.
7. Any information, such as medical records, lab work, x-rays, CT scan or MRI readings, that will be helpful for me to better evaluate your case.

Please arrive **30 minutes before your scheduled appointment** in order to be processed into our system. If you are not here at the requested time before your appointment, we may have to delay or reschedule your visit.

IMPORTANT:
Please confirm your appointment at least one day before. We will remind you of your appointment 2 days prior to your visit. **If we do not hear from you or cannot reach you, your appointment will be cancelled in order to accommodate other patients who need to be seen.**

Our office hours are: **7:40 am to 4:30 pm, Monday to Thursday**
7:30 am to 1:00 pm, Friday

We strive to make your experience at South Texas Arthritis Care Center a pleasurable one.
If you have any questions, please feel free to call. I'm looking forward to meeting you.

Sincerely,

Emily R. Pineda, MD

EMILY PINEDA

SOUTH TEXAS ARTHRITIS CARE CENTER

OFFICE POLICIES

Welcome to South Texas Arthritis Care Center. We appreciate the opportunity to work with you. In order to serve you better, we have implemented the following office policies. Please initial to signify that you have read, understood and will comply with the policies. Thank you.

Please initial by each number:

_____1. **PAYMENTS.** All applicable fees, deductibles, coinsurance or copays must be paid at the time of your appointment. We accept cash, checks, Visa, Mastercard or Discover. There will be a will be a $40.00 charge for all returned checks. Patients who present checks which are dishonored will be required to pay future amounts due with cash, money orders, or credit cards.

_____2. **CANCELLATIONS.** If you need to cancel and reschedule your appointment, please be sure to call us at least 24 hours before your scheduled appointment. You will be charged $35.00 for the visit for late cancellations or missed appointments, unless you had an emergency.

_____3. **HMO & PPO REFERRALS.** If your policy requires written authorization (referrals or precertification) from your primary care physician or PCP, we required that we have is authorization on file in our office before your scheduled appointment. It is your responsibility to make sure that your visit is pre-approved so that your insurance company will pay for your visit. Otherwise you will be responsible for the payment in full.

_____4. **OFFICE COURTESY.** Please do not bring any food or drinks into the clinic. Childcare is not provided for children. Please do not leave children unattended in the reception area.

_____5. **MEDICATION REFILL REQUEST.** We will only approve a medication refill request after business hours or on weekends if it is a true emergency; and there will be a charge for this service. Therefore, it is important for you to have your doctor write your prescriptions at the time of your visit.

_____6. **LAB TEST RESULTS.** Because of telephone limitations, we ask that you not call us to check on lab results. We will call you to report any significantly abnormal results.

_____7. **ANSWERING SERVICE.** A 24-hour answering service is available for emergency situations by calling our main number the 210 615-9800.

"I, the guarantor of payment and responsible party, agree to the above policies and agree to the terms regarding payment and payment responsibilities."

Signature of Patient:_____ Date:_____

Printed Name: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have read the **South Texas Arthritis Care Center's** Notice of Privacy Practices.
(Print Name)

Signature of Patient:_____ Date:_____

PATIENT DEMOGRAPHIC INFORMATION

Title:_____ Name:_____ Suffix:____
(First) (M.I.) (Last)

SS#:_____-_____-_____ DOB:_____ Age:_____

Address_____
(No.) (Street) (Apt #)

_____
(City) (State) (Zip code)

Gender:

Marital Status
☐ Single ☐ Married
☐ Divorced ☐ Separated

Home phone:_____ Work phone:_____ Cell phone:_____

Emergency ontact:_____ Relationship:_____ Phone:_____

Primary Care Physician (PCP):_____ Referring Physician:_____

Address of PCP:_____ Phone no. of PCP:_____

INSURANCE INFORMATION
(Please list all insurances)

PRIMARY INSURANCE:_____ Phone no_____
Policy#_____ Grp#_____ Subscriber ID#_____ Effective Date _____
Policy Holder's Name_____ DOB_____
Insured Party SS#_____ Patient Relationship to Policy Holder_____
Plan Type: ☐ HMO ☐PPO ☐Medicare ☐ Medicaid ☐ Other_____
Referral required: ☐ Yes ☐ No Co-payment_____ Deductible_____
Requirements for referrals & other services_____

SECONDARY INSURANCE:_____ Phone no_____
Policy#_____ Grp#_____ SubscriberID#_____ Effective Date _____
Policy Holder's Name_____ DOB_____
Insured Party SS#_____ Patient Relationship to Policy Holder_____
Plan Type: ☐ HMO ☐PPO ☐Medicare ☐ Medicaid ☐ Other_____
Referral required: ☐ Yes ☐ No Co-payment_____ Deductible_____
Requirements for referrals & other services_____

TERTIARY INSURANCE:_____ Phone no_____
Policy#_____ Grp#_____ Subscriber ID#_____ Effective Date _____
Policy Holder's Name_____ DOB_____
Insured Party SS#_____ Patient Relationship to Policy Holder_____
Plan Type: ☐ HMO ☐PPO ☐Medicare ☐ Medicaid ☐ Other_____
Referral required: ☐ Yes ☐ No Co-payment_____ Deductible_____
Requirements for referrals & other services_____

By signing this statement, I hereby authorize the release of my medical information to my insurance carriers if requested. I also authorize my insurance companies to pay medical benefits to South Texas Arthritis Care Center for medical services rendered.

Signature of Patient or Responsible Party_____ **Date**_____

Patient HMO Referral Notice

It is the patient's responsibility to contact their primary care physician **(PCP)** to request a referral to be generated for services to be rendered at South Texas Arthritis Care Center.

You can either bring the referral with you or have your **PCP** fax the referral prior to appointment date to 210-615-9801. If we do not have the referral on the day of appointment, we will have to reschedule your appointment.

COMPLIANCE & DISCLOSURE UNDER TEXAS OCCUPATIONS CODE SECTION 102.006

Name of Patient: _____

Name of Clinic: Emily R Pineda, MD PA, dba South Texas Arthritis Care Center

COMPLIANCE & DISCLOSURE UNDER TEXAS OCCUPATIONS CODE - SECTION 102.006

In compliance with Section 102.006 of Texas Occupations Code my physician, clinic and or facility have or has disclosed to me at the time of initial contact:

(A) his, her or its affiliation with Hill Country Pharmacy, Ltd and
(B) That he, she or it will receive, directly or indirectly, remuneration for referring me.

I certify that I was informed that if a referral is necessary I would be informed of effective alternative resources reasonable and available at the time of my decision-making, and that it is my option to use one of the alternative resources. I was further informed that if I selected the use an alternative resource, neither my physician nor his or her staff would treat me differently if I choose an alternative provider or entity.

I understand that when and if I am referred to other entities, the referring physician does not have control of whether or not the provider is in or out of network or of the fees the referring provider charges. I understand that if this is a concern, I will ask the physician about the status of the referring provider.

I have read and fully understand this Disclosure Form. Therefore, I acknowledge I received such disclosure and notice and I agree to accept such referral if offered.

_____
Name of Patient

_____
Signature of Patient or Responsible Party

_____
Date

NEW PATIENT HISTORY FORM

Name: _____
Last First M.I.

Address: _____ Age: _____ Date of Birth: _____
Street Apt. # Sex: ☐ F ☐ M Birthplace: _____

_____ Phone:Home: _____-_____-_____
City State Zip Work: _____-_____-_____
Email address: _____ Pharmacy#: _____-_____-_____ Cell: _____-_____-_____

Referred here by: (check one): ☐Self ☐Family ☐Friend ☐Doctor ☐Other Health Professional

Name of person making referral: _____

Name of physician providing your primary medical care(PCP): _____

Address of Primary care provider (PCP): _____ Phone of PCP: _____

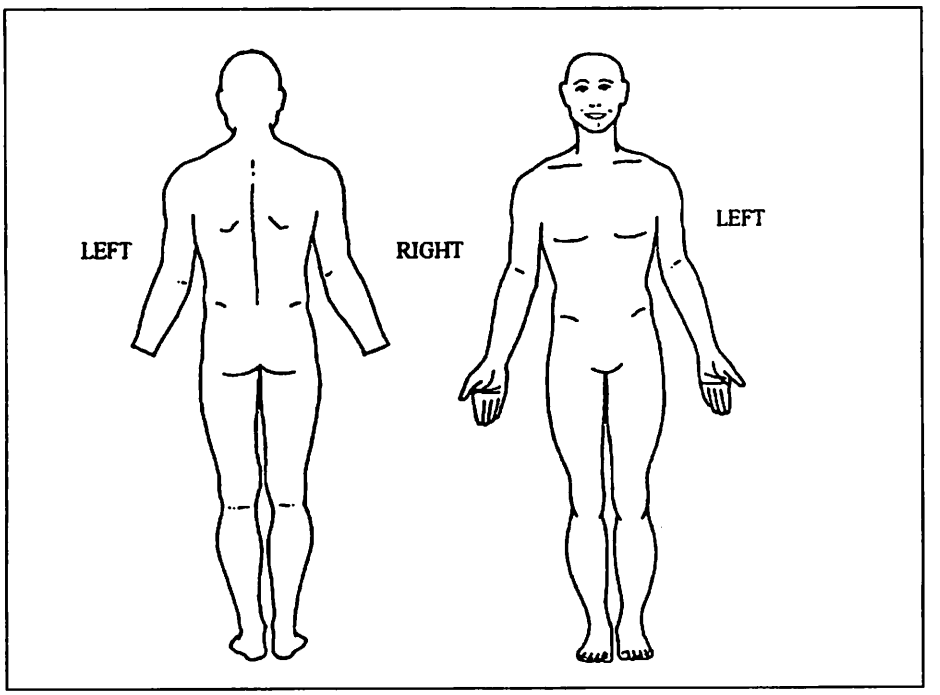
Other Physicians you are seeing and their Specialties: _____

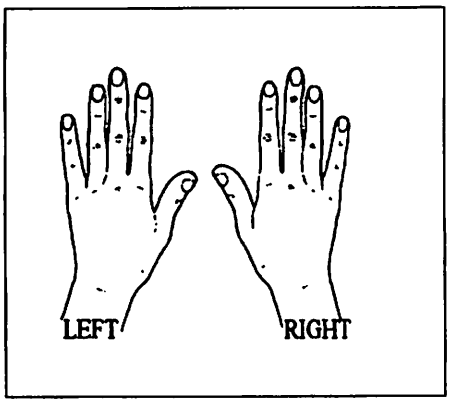
_____

Reason you were referred: _____

_____

Please shade all the locations of your pain over the past week:





PATIENT: _____, DATE OF BIRTH: _____ APPOINTMENT DATE: _____

What joint or muscle group causes the most pain?_____

Describe quality of pain (e.g. aching, burning, sharp, dull):_____

How long has your pain been present?_____

Does the pain occur on and off or continuously?_____

Time of day your pain is worse? ❑ Morning ❑ End of day

Is your symptom associated with joint stiffness in the morning? ❑Yes ❑ No. How long?_____minutes_____hours

What makes you pain worse?_____

_____

What relieves/improves your pain?_____

_____

What worsens your pain? ❑ Mild Activity ❑ Inactivity ❑Overactivity ❑Rest ❑ Work.

If your work makes your pain worse, what type of work do you do?_____

What type of activity at work makes your pain worse? _____

_____

Previous treatment for this problem (include physical therapy, specific surgery, injections and names of medication tried)

and mention if it helped or not:_____

_____

_____

Please list practitioners/doctors you have seen for this problem:_____

_____

_____

If there is anything else you would like to add regarding the problem you came to our office today, please write below:

_____

_____

_____

_____

_____

_____

_____

PATIENT: _____, DATE OF BIRTH: _____ APPOINTMENT DATE: _____

SYSTEMS REVIEW

As you review the following list, please check any of those problems, which have significantly affected you.

Date of last Tuberculosis Test _____ Date of last bone densitometry _____ Date of last chest x-ray _____

Are you receiving disability? ❑Yes ❑No Are you applying for disability? ❑Yes ❑No

Do you have a medical related lawsuit pending? ❑Yes ❑No

Constitutional

❑ Recent weight gain
amount _____
❑ Recent weight loss
amount _____
❑ Fatigue
❑ Weakness
❑ Fever

Eyes

❑ Pain
❑ Redness
❑ Loss of vision
❑ Double or blurred vision
❑ Dryness
❑ Feels like something in eye
❑ Pain with light exposure

Ears–Nose–Mouth–Throat

❑ Loss of hearing
❑ Nosebleeds
❑ Dryness in nose
❑ Sores in mouth
❑ Dryness of mouth
❑ Frequent sore throats
❑ Hoarseness
❑ Difficulty in swallowing
❑ Jaw pain when chewing food

Cardiovascular

❑ Heart murmurs
❑ Pain in chest when taking deep breath

Respiratory

❑ Swollen legs or feet
❑ Coughing of blood
❑ Wheezing (asthma)

Gastrointestinal

❑ Nausea
❑ Stomach pain relieved by food or milk
❑ Increasing constipation
❑ Persistent diarrhea
❑ Heartburn

Genitourinary

❑ Difficult urination
❑ Pain or burning on urination
❑ Blood in urine
❑ Vaginal dryness
❑ Rash/ulcers
❑ Sexual difficulties
❑ Prostate trouble

For Women Only:

Age when periods began:_____
Periods regular? ❑ Yes ❑ No
How many days apart? _____
Date of last period? ____/____/____

Musculoskeletal

❑ Joint pain
❑ Muscle weakness
❑ Muscle tenderness
❑ Joint swelling

List joints affected in the last 6 mos.

_____
_____
_____
_____
_____

Skin

❑ Redness
❑ Rash
❑ Hives
❑ Sun sensitive (sun allergy)
❑ Tightness
❑ Nodules/bumps
❑ Hair loss
❑ Color changes of hands or feet in the cold

Neurologic

❑ Headaches
❑ Muscle spasm
❑ Sensitivity or pain of hands and/or feet
❑ Memory loss
❑ Night sweats

Psychiatric

❑ Excessive worries
❑ Anxiety
❑ Depression
❑ Difficulty falling asleep
❑ Difficulty staying asleep

Endocrine

❑ Excessive sweating
❑ Excessive thirst
❑ Cold intolerance
❑ Heat intolerance

Hematologic/Lymphatic

❑ Swollen glands
❑ Tender glands
❑ Anemia
❑ Bleeding tendency
❑ Blood clot
❑ Transfusion/when _____

Allergic/Immunologic

❑ Frequent sneezing
❑ Increased susceptibility to infection

PAST MEDICAL HISTORY
Do you now or ever had: (check if yes)

❑ Cancer,type:_____ ❑ Heart:_____ ❑ Asthma
❑ Goiter ❑ Leukemia ❑ Stroke
❑ Cataracts ❑ Diabetes ❑ Epilepsy
❑ Nervous breakdown ❑ Stomach ulcers ❑ Rheumatic fever
❑ Migraine headaches ❑ Jaundice ❑ Bowel Inflammation
❑ Kidney disease ❑ Pneumonia ❑ Psoriasis
❑ ↑Blood Pressure ❑ HIV/AIDS ❑ Anemia
❑ Emphysema ❑ Glaucoma ❑ Tuberculosis
❑ Reflux (GERD) ❑ Arthritis-type unknown ❑ Hypothyroidism
❑ Fibromyalgia ❑ Rheumatoid arthritis ❑ Lupus
❑ Osteoarthritis ❑ Gout ❑ Osteoporosis
❑ Cholesterol problem ❑ Depression

Other medical problems:_____

_____

SOCIAL HISTORY

Do you smoke? ❑ No. Never
❑ Past.. How long ago?_____
❑ Yes. Packs per day: _____

Do you drink alcohol? ❑ Yes ❑ No. # per week _____
Has anyone ever told you to cut back on alcohol?_____
Do you use drugs for non-medical reasons?_____
If yes, please list:_____
Do you exercise regularly?_____Type_____

Marital Status: ❑Never Married ❑Married ❑ Divorced
❑ Separated ❑ Widowed

# of pregnancies:_____ # of children_____

# of miscarriages:_____ At what month of pregnancy?_____

Occupation:_____

Employer:_____

If retired, Former Occupation: _____

Spouse's occupation:_____

Previous Operations

Type	*Year*	*Reason*
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? ❑ No ❑ Yes Describe:_____
Any other serious injuries? ❑ No ❑ Yes Describe:_____

PRESENT MEDICATIONS (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc.)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped? A Lot	Some	Not At All
1.			❑	❑	❑
2.			❑	❑	❑
3.			❑	❑	❑
4.			❑	❑	❑
5.			❑	❑	❑
6.			❑	❑	❑
7.			❑	❑	❑
8.			❑	❑	❑
9.			❑	❑	❑
10.			❑	❑	❑

ALLERGIES to medication:_____
What was your reaction?_____

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Health of children: _____

_____

Do you know of any blood relative who has or had: (check and give relationship)

- ❑ Cancer _____
- ❑ Leukemia _____
- ❑ Stroke _____
- ❑ Colitis _____
- ❑ Arthritis(unknown type) _____
- ❑ Heart disease _____
- ❑ High blood pressure _____
- ❑ Bleeding tendency _____
- ❑ Alcoholism _____
- ❑ Osteoarthritis _____
- ❑ Rheumatoid arthritis _____
- ❑ Rheumatic fever _____
- ❑ Epilepsy _____
- ❑ Asthma _____
- ❑ Psoriasis _____
- ❑ Lupus _____
- ❑ Gout _____
- ❑ Tuberculosis _____
- ❑ Diabetes _____
- ❑ Goiter _____
- ❑ Underactive thyroid _____
- ❑ Osteoporosis _____
- ❑ Ankylosing Spondylitis _____

❑ Other significant Family History (please list)_____

PAST MEDICATIONS Please review this list of "arthritis" medications. As accurately as possible, try to remember which medications you have taken, ***how long*** you were taking the medication, the ***results*** of taking the medication and list any ***reactions*** you may have had. Record your comments in the spaces provided.

Drug names/Dosage	**Length of time**	**Please check: Helped? A Lot**	**Some**	**Not At All**	**Reactions**
Non-Steroidal Anti-Inflammatory Drugs-NSAIDs		❑	❑	❑	
Circle any you have taken in the past Ansaid (flurbiprofen) Arthrotec (diclofenac + misoprostil) Aspirin (including coated aspirin) Celebrex (celecoxib) Clinoril (sulindac) Daypro (oxaprozin) Disalcid (salsalate) Dolobid (diflunisal) Feldene (piroxicam) Indocin (indomethacin) Lodine (etodolac) Meclomen (meclofenamate) Motrin/Rufen (ibuprofen) Nalfon (fenoprofen) Naprosyn (naproxen) Oruvail (ketoprofen) Tolectin (tolmetin) Trilisate (choline magnesium trisalicylate) Vioxx (rofecoxib) Voltaren (diclofenac)					
Pain Relievers					
Acetaminophen (Tylenol)		❑	❑	❑	
Codeine (Vicodin, Tylenol 3)		❑	❑	❑	
Propoxyphene (Darvon/Darvocet)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Disease Modifying Antirheumatic Drugs (DMARDS)					
Auranofin, gold pills (Ridaura)		❑	❑	❑	
Gold shots (Myochrysine or Solganol)		❑	❑	❑	
Hydroxychloroquine (Plaquenil)		❑	❑	❑	
Penicillamine (Cuprimine or Depen)		❑	❑	❑	
Methotrexate (Rheumatrex)		❑	❑	❑	
Azathioprine (Imuran)		❑	❑	❑	
Sulfasalazine (Azulfidine)		❑	❑	❑	
Quinacrine (Atabrine)		❑	❑	❑	
Cyclophosphamide (Cytoxan)		❑	❑	❑	

PAST MEDICATIONS (continued)

ARTHRITIS CARE CENTER

Disease Modifying Antirheumatic Drugs (DMARDS)					
Leflunamide (Arava)		❑	❑	❑	
Mycophenolate mofetil (Cellcept)		❑	❑	❑	
Etanercept (Enbrel)		❑	❑	❑	
Infliximab (Remicade)		❑	❑	❑	
Adalimumab (Humira)		❑	❑	❑	
Rituximab (Rituxan)		❑	❑	❑	
Abetacept (Orencia)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Osteoporosis Medications					
Estrogen (Premarin, etc.)		❑	❑	❑	
Alendronate (Fosamax)		❑	❑	❑	
Etidronate (Didronel)		❑	❑	❑	
Raloxifene (Evista)		❑	❑	❑	
Risedronate (Actonel)		❑	❑	❑	
Calcitonin injection or nasal (Miacalcin, Calcimar)		❑	❑	❑	
Ibandronate (Boniva)		❑	❑	❑	
Parathyroid hormone (Forteo)		❑	❑	❑	
Other:		❑	❑	❑	
Gout Medications					
Probenecid (Benemid)		❑	❑	❑	
Colchicine		❑	❑	❑	
Allopurinol (Zyloprim/Lopurin)		❑	❑	❑	
Other:		❑	❑	❑	
Other:		❑	❑	❑	
Others					
Tamoxifen (Nolvadex)		❑	❑	❑	
Tiludronate (Skelid)		❑	❑	❑	
Cortisone/Prednisone		❑	❑	❑	
Hyalgan/Synvisc/Supartz/Euflexxa injections		❑	❑	❑	
Herbal or Nutritional Supplements		❑	❑	❑	
Please list supplements:					

Have you participated in any clinical trials for new medications? ❑ Yes ❑ No

If yes, list: _____

_____

_____

_____

_____

PATIENT: _____, DATE OF BIRTH: _____APPOINTMENT DATE: _____

HEALTH ASSESSMENT QUESTIONNAIRE

PLEASE ANSWER THESE QUESTIONS WITHIN A WEEK OR ON THE DAY OF YOUR VISIT.
This questionnaire is designed to help us assess how your illness affects your ability to function in daily life.
Thank you.

1. How much pain have you had because of your condition OVER THE PAST WEEK?

NO PAIN O O O O O O O O O O O O O O O O O O O O O PAIN

AS PAIN 0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10 BAD AS CAN BE

2. Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing:

VERY WELL O O O O O O O O O O O O O O O O O O O O O VERY POORLY

0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

3. How much of a problem has unusual fatigue or tiredness been for you OVER THE PAST WEEK?

NO FATIGUE O O O O O O O O O O O O O O O O O O O O O

FATIGUE 0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10 MAJOR PROBLEM

4. Please check (√) the ONE best answer for your abilities at this time (MD-HAQ):

OVER THE LAST WEEK, were you able to:	Without **ANY** Difficulty	With **SOME** DIfficulty	With **MUCH** Difficulty	**UNABLE** To Do
a. Dress yourself, including tying shoelaces and doing buttons?	0	1	2	3
b. Get in and out of bed?	0	1	2	3
c. Lift a full cup or glass to your mouth?	0	1	2	3
d. Walk outdoors on flat ground?	0	1	2	3
e. Wash and dry your entire body?	0	1	2	3
f. Bend down to pick up clothing from the floor?	0	1	2	3
g. Turn regular faucets on and off?	0	1	2	3
h. Get in and out of the car, bus, train, or airplane?	0	1	2	3
i. Walk 2 miles or three kilometers, if you wish?	0	1	2	3
j. Participate in recreational activities and sports as you would like, if you wish?	0	1	2	3
k. Get a good night's sleep?	0	1.1	2.2	3.3
l. Deal with feelings of anxiety or being nervous?	0	1.1	2.2	3.3
m. Deal with feelings of depression or feeling blue?	0	1.1	2.2	3.3

FOR OFFICE USE ONLY

1. PAIN (0-10)
2. PTGL (0-10)
3. FTG (0-10)

1=0.3 16=5.3
2=0.7 17=5.7
3=1.0 18=6.0
4=1.3 19=6.3
5=1.7 20=6.1
6=2.0 21=7.0
7=2.3 22=7.3
8=2.7 23=7.7
9=3.0 24=8.0
10=3.3 25=8.3
11=3.7 26=8.7
12=4.0 27=9.0
13=4.3 28=9.3
14=4.7 29=9.7
15=5.0 30=10

4. MD-HAQ: a-j (0-10)
5. PSY: k-j (0-9.9)

PATIENT: _____, DATE OF BIRTH: _____ APPOINTMENT DATE: _____

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT

South Texas Arthritis Care Center
5414 Fredericksburg Rd. Ste. 150
San Antonio, Texas 78229

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 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. 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 medical supervision. I further understand that these medication(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 PRESCRIBE 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 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 and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the tests 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 is **MY responsibility** to inform my physician immediately if I become pregnant.

If I am pregnant or am 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 methods of treatment, the possible risks involved, and the possibilities of complications have 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 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 an improved quality of life. I realize that the treatment for some will 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 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 pain is controversial because of the uncertainty regarding the extent to which they provide long-term benefit. 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) 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 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 so long as I follow the rules specified in this 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 the medication(s) **exactly as directed by my physician**.
- I 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, where 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 may 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 for an emergency **or** the medication(s) that is being prescribed by another physician is approved by my physician. Information that I have been receiving 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 the 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 and 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 or 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, 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.**

_____

Patients Signature

_____

Physician Signature (or Appropriately Authorized Assistant)

_____

Pharmacy Name

_____

Pharmacy Phone Number

SOUTH TEXAS
ARTHRITIS CARE CENTER

Emily R. Pineda, MD, F.A.C.R.
Diplomat, Subspecialty of Rheumatology
Fellow Member, American College of Rheumatology

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San Antonio, TX 78229
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www.southtexasarthritis.com

Authorization to Release Medical Information to a 3rd Party

Date: _____

Patient Name: _____

Patient DOB: _____

To Whom It May Concern:

I _____, am providing this letter as authorization to South Texas Arthritis Care Center to:

☐ Release information about my medical condition

☐ Discuss information about my medical condition

☐ Both

to the following person(s) _____. At the time of release, two forms of ID must be provided (i.e. Social Security Card and a valid picture ID at the time of release). If you have any questions or concerns, you may contact me by phone, fax or email: _____.

Thank you,

_____
Patient signature

SOUTH TEXAS
ARTHRITIS CARE CENTER

Emily R. Pineda, M.D.
5414 Fredericksburg Rd. Ste 150
San Antonio, TX 78229
Phone: 210-615-9800
Fax: 210-615-9801

CONFIDENTIAL
Authorization to Release Medical Information

To: _____ Phone: _____

Date: _____ Fax: _____

Patient Name _____ DOB _____
(Last name) (First name) (M.I.)

Address _____

I authorize you to furnish **South Texas Arthritis Care Center** my medical records below. The purpose of this disclosure is for continuity of patient care:

Medical Records from _____ to _____

Laboratory results from _____ to _____

X-ray results from _____ to _____

Other _____

_____

I understand that the information released is for the specific purpose stated above. Any other use of this information without written consent of the patient is prohibited. This consent will expire 90 days after the date of my signature unless otherwise specified.

_____ _____
Signature of Patient or Legal Representative Date