ALAVIE
INTERVENTIONAL
PAIN MANAGEMENT

1001 Water Street, Ste E100
Kerrville, Texas 78028
Phone: (830) 896-2444 Fax: (406)302-0617
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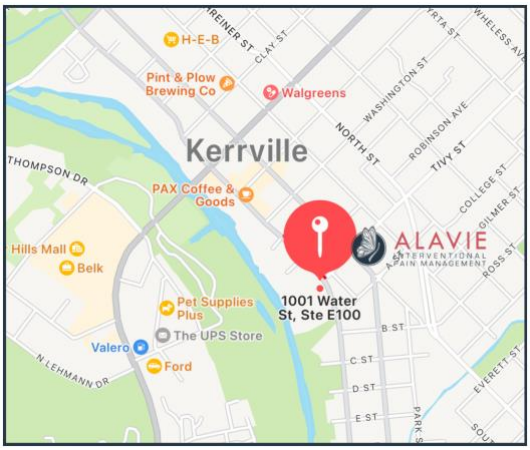
WELCOME TO ALAVIE INTERVENTIONAL PAIN MANAGEMENT

Dr. Samuelson is excited to expand his clinic to the Kerrville area! The goal of our clinic is to reduce your painful symptoms and improve your overall quality of life. Our passion is to provide the best, most comprehensive care for our patients and we look forward to serving you.



Since you are establishing care with Dr. Samuelson as a new patient, we ask that the following paperwork be completed and brought with you to your appointment on:

_____ at _____

Please also bring the following with you to your first appointment:

- Photo ID and Insurance card(s)
- List of current medications
- Please review, complete and sign our credit card office policy. We require a credit/debit/or HSA card be saved on file with our office. This policy offers you the convenience of knowing your balances will be paid on time. Your card information is stored securely and can be updated on request. Use your phone to scan the QR code to electronically review and sign our credit card on file policy. It can also be accessed on our website at alaviepain.com under the FORMS tab.

Please call us if you have any problems locating our office (830) 896-2444

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NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION

{Please Print}

Today's Date: ____/_____/_____

Patients Full Name: _____ DOB: ____/_____/_____

SSN: _____ Sex: ☐ Male ☐ Female

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other

Race: ☐ African/American ☐ Caucasian ☐ Hispanic ☐ Other_____

Ethnicity: ☐Non Hispanic/Latino ☐ Hispanic/Latino ☐ Refuse to report

Preferred Language: ☐ English ☐ Spanish ☐ Other_____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email address: _____

Patient Occupation: _____

Patient Employer: _____ Employer Phone No. (____)_____

Is this a Workers' Compensation Injury? ☐Yes ☐ No {if yes, please see front desk for additional form}

Is this visit related to an ongoing legal case? ☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____

Emergency Contact Phone #: _____ Relationship to patient: _____

REFERRAL INFORMATION

Referring Physician: _____

Primary Care Physician: _____

INSURANCE INFORMATION

Primary Insurance: _____	Secondary Insurance {if applicable}:_____
Policy Holder {if not patient}:_____	Policy Holder {if not patient}:_____
Patient's Relationship to Policy Holder:	Patient's Relationship to Policy Holder:
☐ Self ☐ Spouse ☐ Child	☐ Self ☐ Spouse ☐ Child
☐ Other _____	☐ Other _____
SSN: _____ DOB: _____	SSN: _____ DOB: _____
Policy #: _____	Policy #: _____
Group ID #: _____	Group ID #: _____

Please initial the statements below:

____ The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Alavie Interventional Pain Management {AIPM}. I understand fully that I am responsible for any amount not covered by the insurance, or any collection fees, or interest acquired. I also authorize AIPM or insurance company to release any information required to process my claims.

_____ Alavie Interventional Pain Management {AIPM} provides the opportunity for patients to communicate by email. By providing an electronic mail address to AIPM, you as the patient acknowledge that medical information may be contained in these communications. Email should never be used for emergency problems. AIPM cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by AIPM intentional misconduct.

_____ _____

Patient/Guardian Signature Date

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PAIN MANAGEMENT AGREEMENT

REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9, CHAPTER 170

The purpose of this agreement is to give you information about the use of any and all medication(s) (i.e., opioids, also called 'narcotics, painkillers', and other prescription medications, etc.) for chronic pain you will be taking for pain management and to assure that you and your physician comply with all state and federal regulations concerning the prescribing of controlled substances. You as a patient 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. The success of treatment depends on mutual trust and honesty in the physician/patient relationship and full agreement and understanding of the risks and benefits of using opioids to treat pain. **Therefore, medication(s) will only be provided so long as I follow the rules specified in this Agreement.**

I, _____, UNDERSTAND THAT COMPLIANCE WITH THE FOLLOWING GUIDELINES IS IMPORTANT IN CONTINUING PAIN TREATMENT WITH DR. SAMUELSON. 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:

****PLEASE INITIAL ON EACH LINE****

_____ I understand that there is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substances.

_____I am NOT pregnant. I will use appropriate contraception/birth control during my course of treatment. If I become pregnant, it is my responsibility to inform my physician immediately as certain drugs can be harmful to unborn children.

_____I understand that this Agreement is essential to the trust and confidence necessary in a provider/patient relationship and that my provider undertakes to treat me based on this Agreement.

_____I understand that if I break this Agreement, my provider will stop prescribing these pain control medicines.

_____I would also be amenable to seek psychiatric treatment, psychotherapy, and/or psychological treatment if my provider deems necessary.

_____ I will communicate fully with my provider about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain. 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 be required to follow up with my physician every month in order to have my medication refilled. **If I do not keep my follow up appointments, my medication refill may be denied.**

_____ I will not use any illegal controlled substances, including marijuana, cocaine, etc., nor will I misuse or self-prescribe/medicate with legal controlled substances. Use of alcohol will be limited to times when I am not driving or operating machinery and will be infrequent.

_____ I will not share my medication with anyone

_____ I will not attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other provider.

_____ I will safeguard my pain medication from loss, theft, or unintentional use by others, including youth. Lost or stolen medications will not be replaced.

____ I authorize the provider and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication.

_____ I agree that I will submit to urine and/or blood screens if requested by my provider to determine my compliance with my program of pain control medications.

_____ I understand that my provider will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program web site periodically throughout my treatment period.

_____ I will disclose to my physician all medication(s) that I take at any time, prescribed by any physician.

_____ I agree that I will use my medicine at a rate no greater that the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time. I understand I may be asked to bring all my medicines into the office for a random pill count. Failure to comply will lead to dismissal from the practice.

_____There are side effects with opioid therapy, which may include, but not exclusively, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, or the possibility of impaired cognitive (mental status) and/or motor ability. Overuse of opioids can cause decreased respiration (breathing).

_____ I agree to follow these guidelines that have been fully explained to me.

_____ I agree that refills of my prescriptions for pain medications will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends. **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.

_____All medication(s) must be obtained at **one pharmacy, when possible**. I will inform my physician if I need to change pharmacies. 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 will inform the clinic before any surgical/dental procedure so that the physician can better design my post-operative pain management care plan.

I agree to use the following pharmacy: _____

Location: _____

Phone number: _____

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.**

Patient Signature Date

Physician Signature Date

Dr. Christian G. Samuelson
Alavie Interventional Pain Management, PLLC • 12702 Toepperwein Road Suite 104 • Live Oak, TX 78233

LEGAL IRREVOCABLE ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND SUMMARY PLAN DOCUMENTS

Patient Name: _____Date:_____ Patient SS#:_____DOB: _____

In considering the amount of expenses to be incurred, I _____, the undersigned, have insurance and/or employee health care benefits coverage with _____(insurance co. information), and hereby irrevocably assign and convey directly to Christian G. Samuelson, M.D. at Alavie Interventional Pain Management, PLLC (hereafter "provider") all right, title and interest in all medical benefits payable and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider /practice. Said irrevocable assignment and transfer shall be for the purpose of granting the provider and practice an independent right of recovery against such responsible parties, but shall not be construed to be an obligation of the provider and practice to pursue any such right to recovery. I hereby authorize all responsible parties to pay directly to the provider and practice all benefits and amount due for services rendered by the physician.

I understand that if the provider and practice is not paid in full by proceeds for any benefits, then this assignment does not release my obligation and liability to the provider and practice for payment and all services and items provided to me or by my insurance company or employee health benefit plan, then I agree to pay provider and practice for all charges in excess of the benefits paid. All payments will be made to provider and practice at 12702 Toepperwein Road, Suite 104, Live Oak, TX 78233.

I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the provider to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider and practice any and all summary plan documents, insurance policy and/or settlement information upon written request from such provider and practice in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named provider to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chosen action, or the right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named provider and practice and to the extent permissible under law to claim such benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such provider and practice in any attempts by such provider and practice to pursue such claim, chosen action or right against any insurers and/or employee health care plan, including, if necessary, bring suit with such provider and practice against any insurers and/or employee health care plan in my name but at such provider and practice's expense.

This lifetime assignment of benefits will remain in effect until revoked by me in writing. A photocopy of this assignment of benefits is to be considered as valid as the original.

The terms and consequences of these irrevocable assignments and financial responsibilities have been fully explained to me to my understanding and I have signed this document freely and without inducement other than the retention of services by the physician.

_____ _____
Name of Insured / Patient (Please Print) **Date**

_____
Signature of Insured / Patient

***If patient is under 18 years of age:*

_____ _____
Name of Guardian (Please Print) **Date**

_____
Signature of Guardian

_____ _____
Signature of Witness **Date**

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

The Notice of Privacy Practices (the Notice) contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

The law requires that we obtain your signature acknowledging that we have provided you with this Notice. Please review it carefully and if you have any questions, it is your right and obligation to ask so we can have a further discussion prior to signing this document. Our office has copies of the Notice which are available upon request. You can also read the Notice by visiting our website at alaviepain.com and clicking "Forms".

I acknowledge receiving Alavie Interventional Pain Management, PLLC's Notice of Privacy Practices and agree to its terms.

_____ _____
Patient/Legal Guardian Signature Date

_____
Printed Name

_____ _____
Christian G. Samuelson, M.D. Date

I authorize Alavie Interventional Pain Management to disclose or provide protected health information about me to the individual(s) listed below:

Name: _____ Phone: _____

Relationship: _____ ☐All information ☐Appointment ☐Financial ☐Health

Name: _____ Phone: _____

Relationship: _____ ☐All information ☐Appointment ☐Financial ☐Health

Name: _____ Phone: _____

Relationship: _____ ☐All information ☐Appointment ☐Financial ☐Health

_____ _____
Patient/Legal Guardian Signature Date

PATIENT FINANCIAL RESPONSIBILITIES

Thank you for choosing Alavie Interventional Pain Management for your pain management needs. Our financial policy outlines our practice guidelines and have been established to assist in providing the highest quality medical care while also allowing you to receive all the benefits offered to you by your health plan. We ask that you read and follow these guidelines, which are necessary to facilitate your care. Your signature verifies that you understand and agree to comply with our policies.

Insurance: Insurance cards should be available upon request at all visits. If you have a change of address, telephone number, employer, insurance plan or coverage, please notify the receptionist. We file claims as a courtesy to our patients and are only responsible for filing claims to contracted insurance companies and the member. It is your responsibility to know and understand your coverage and benefits. Any dispute for unpaid charges from the insurance company will be billed to the patient/member.

- HMO plans or other managed care policies - You are responsible for obtaining any referral required by your insurance. If a referral is not on file prior to your visit, your appointment will be canceled or rescheduled until one is obtained. Depending on the particular plan, please verify the number of visits permitted. **You will be financially responsible for any visits not authorized.**

- Contract – Your insurance policy is a contract between you, your employer (if applicable) and the insurance company. We are not a party to that contract. It is important that you understand the provisions of your policy, as we cannot guarantee payment of claims.

No insurance: If you are not covered by insurance at the time of service, you will be responsible for all charges incurred at the time of service. We accept cash and all major credit cards.

No-Show Policy: We require 24-hour notice for appointment cancellations.

- Patients will receive one courtesy missed appointment per calendar year.
- After the 2nd and subsequent missed appointments, a No-Show Fee of **$50 per missed clinic visit** and **$150 per missed procedure visit** will be assessed to your account and must be paid before any future appointments can be scheduled. Unpaid/accrued fees that affect regular appointments may interfere with the physicians' ability to provide you with your scheduled pain medications. This fee is not billable to your insurance company and is the sole responsibility of the patient.
- 3 No Shows will result in termination from the practice. *Unpaid/accrued fees can also result in termination from the practice.*

Copays/Coinsurance & Deductible– All copays, coinsurance & deductibles are due at the time of service.

Dismissal from Practice- Aside from clinical reasons, there are a few financial reasons why a patient may be dismissed from the practice. Failure to keep scheduled appointments, being verbally or physically abusive to staff or disruptive to other patients, failure to meet financial obligations, inability to pay co-pays and repeated cancellations are a few of those reasons.

Account Billing Questions & Refunds – Questions or concerns regarding your account or insurance claim can be directed to our billing department. If your account has a credit balance we will issue a refund once all outstanding claims on your account have processed.

My signature below represents that I have read and have a full understanding of Alavie Interventional Pain Management's financial policy. I may also request a copy of the signed policy for my own records.

_____ _____

Name of Patient/Responsible Party (Please Print) **Date**

_____

Signature of Patient/Responsible Party

Patient Intake Form

{Please Print}

Today's Date: _____/_____/_____

Patients Full Name: _____ DOB: _____/_____/_____

Reason for visit: ☐ Follow-Up ☐ Injection ☐ Post-Procedure Visit

Location of pain: _____

Frequency of Pain: ☐ Continuous ☐ Frequent ☐ Occasional

Quality of Pain:

☐Sharp	☐Aching	☐Dull
☐Tingling	☐Hot-burning	☐Tight
☐Numb	☐Stabbing	☐Pounding
☐Throbbing	☐Sickening	☐Cramping
☐Exhausting	☐Gnawing	☐Shooting
☐Heavy	☐Tender	☐Splitting

Radiation: ☐ Yes ☐ No If yes, where? _____

Worsening Factors: _____

Strategies used besides medication: _____

Pain level currently {out of 10}: _____

Average pain: _____ Maximum pain: _____ Minimum pain: _____

Pain relieved by taking medications:

☐ 0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

After starting medication, have your activities: ☐Improved ☐ Remained the same ☐ Decreased

Current function level: ☐ 1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐8 ☐10

Quality of sleep: ☐ Good ☐ Fair ☐ Poor Hours of sleep per night? _____

# of times waking up during the night?: _____

Word describing mood: ☐ Good ☐ Fair ☐ Poor

Are you taking your meds as directed? ☐ Yes ☐ No

Do you feel as though your medications provide you with significant benefit? ☐ Yes ☐ No

Are you having any negative side effects from your current medications? ☐ Yes ☐ No

Do you realize that by taking these meds you increase risk of death? ☐ Yes ☐ No

Comments/Questions for the doctor? _____

Current Symptoms

Constitutional

Fever	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Hot Flashes	☐ Yes	☐ No
Night Sweats	☐ Yes	☐ No
Weight Loss	☐ Yes	☐ No

Cardiovascular

Chest Pain	☐ Yes	☐ No
Limb Swelling	☐ Yes	☐ No
Limb pain with walking	☐ Yes	☐ No
Varicose veins	☐ Yes	☐ No

Respiratory

Trouble breathing	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Mucus production	☐ Yes	☐ No
Sleep Apnea	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Respiratory Infections	☐ Yes	☐ No

GI

Abdominal pain	☐ Yes	☐ No
Nausea/vomiting	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No

Musculoskeletal

Muscle Pain	☐ Yes	☐ No
Cramping	☐ Yes	☐ No
Muscle Twitch	☐ Yes	☐ No
Neck Pain	☐ Yes	☐ No
Back Pain	☐ Yes	☐ No
Joint Pain	☐ Yes	☐ No
Joint Swelling	☐ Yes	☐ No
Joint Stiffness	☐ Yes	☐ No

Neurologic

Seizures	☐ Yes	☐ No
Black Outs	☐ Yes	☐ No
Problems with Memory	☐ Yes	☐ No
Problems with Concentration	☐ Yes	☐ No
Headache	☐ Yes	☐ No
Numbness	☐ Yes	☐ No
Weakness	☐ Yes	☐ No
Tremors	☐ Yes	☐ No

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible by filling in the circle. There are no right or wrong answers.

Print Name: _____	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○

Print Name: _____	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○