

CONSENT AND DISCLOSURE

(PLEASE READ BEFORE YOU SIGN)

PATIENT NAME: _____ DATE: _____

Authorization to Release Information: The undersigned hereby authorizes River Oaks Pain Management, to release information concerning examination, testing and treatment of the above patient, hereafter referred to as the patient, to any insurance company, attorney, other medical facility, other physician, requesting the same for the purpose of determining eligibility for payment of insurance benefits, for billing purposes, referral services or medical treatments.

Authorization to Obtain Information: The undersigned hereby authorizes River Oaks Pain Management to obtain information concerning examination, testing and treatment of the patient, from any insurance company, attorney, other physicians and other medical facilities.

State of Financial Responsibility: The undersigned agrees, whether he/she signed as an agent or a patient, that in consideration of services to be rendered to the patient, he/she hereby individually obligates himself to pay the account in accordance with the regular rates charged by the provider. Should the account be referred to collections, whether it is a collection agency or an attorney, the undersigned agrees to pay the collection expense and attorney fees equal to 32% of the outstanding balance due. Should protracted litigation result, the court may set an attorney fee in excess of 32% of the outstanding balance.

Consent for Treatment: The undersigned hereby consents to examination and treatment of the patient by the physicians at River Oaks Pain Management and to the performance of any surgical or diagnostic procedure deemed necessary under the circumstances.

Authorization to Pay Insurance Benefits and Guarantee of Payment: The undersigned hereby authorizes payment to River Oaks Pain Management for the treatment or diagnosis conducted, any benefits specified and otherwise payable to the patient, but not to exceed the customary charges. The undersigned understands that he / she is financially responsible to River Oaks Pain Management for charges not covered by this assignment of benefits.

Statement to Permit Payment of Medical Insurance Benefits to Physicians: The undersigned certifies that the information given by the patient in applying for payment under Titles V, XVII, and XIX of the Social Security Act is complete and correct. He / She authorizes any holder of medical or other information about the patient, to release to the Social Security Administration or its carriers any information needed for this or any related Medical / Medicaid Claim. He / She requests that payment of authorized benefits be made on the patient's behalf to River Oaks Pain Management or its designated representative. He/She hereby authorizes River Oaks Pain Management or its designated representative to obtain from the Social Security Administration, and the agency to release, any information to establish the patient's entitlement to Medicare / Medicaid benefits.

PATIENT'S SIGNATURE: _____ DATE: _____

PATIENT'S AGENT/GUARANTOR (Relationship) _____

WITNESS: _____



**River Oaks
Pain Management**

MEDICATION CONTRACT

I _____, understand that this contract is between myself and River Oaks Pain Management. It is designed to inform me fully of the manner in which my medications, especially narcotics, will be provided. It also outlines the criteria by which the Clinics team will determine whether or not to continue to prescribe my medications.

1. Pain medications, especially of a narcotic type, will be provided only after it is determined that reasonable alternatives for adequate pain control have been investigated / attempted.
2. I will agree to try other approaches or techniques as felt appropriate by the team that may assist me in taking the lowest effective dose possible.
3. My "pain medications" will be prescribed by one doctor and one doctor only and filled at one pharmacy. Any attempt, successful or not, to obtain additional medications without the permission of the Medication Clinic may result in discontinuation of medication therapy.
4. Medication will be given at fixed intervals, usually every two or four weeks, and only if I keep my Clinic appointments.
5. I may at times, be requested to submit to a drug screen to confirm that I am taking only those medications prescribed.
6. Medications will be continued as long as (a) there is associated pain relief of at least 30 to 50%, (b) my functional activity is commensurate with what would be expected, given my physical condition, and is enhanced by taking the medication, and (c) there is no evidence of physical tolerance, as suggested by the need for increasing medicine.
7. Evidence of hoarding or other mismanagement of my pain medication may result in discontinuation of Clinic services.
8. "Flare-ups" or exacerbations of my pain symptoms will be handled by other therapies, such as TENS, exercise, icing, heat relaxation, or non-habit forming preparations. Only when it is determined that there is a physiological basis for the flare-up, and additional medicine required, a brief increase "rescue dose" will be considered.
9. If it is determined that the situation may be out of control, I will agree to be hospitalized where medications and other therapies can be provided in a controlled fashion.
10. I understand there are risks with medications that will be given to me including: constipation, decreased appetite, confusion, loss of balance, breathing difficulty, physical dependence, psychological dependence, and tolerance. I am willing to take these risks.

I have read and understand each of the above statements. I realize that the Medication Clinic will assume the responsibility of assisting me in my therapy as long as I comply with the above.

Patient

Spouse/Family Member/Guardian

Witness

Date



**River Oaks
Pain Management**

AUTHORIZATION FOR RELEASE OF INFORMATION FROM ANOTHER FACILITY

TO:

(Facility)

(Address)

(City, State, Zip)

(Telephone)

(Fax)

I HEREBY AUTHORIZE YOU TO RELEASE COMPLETE MEDICAL RECORDS ON:

Patient's Name: _____

Social Security No: _____

Date of Birth: _____

Date of Initial Visit: _____

PLEASE MAIL RECORDS TO THE FOLLOWING ADDRESS :

River Oaks Pain Management
4120 SW Fwy., Suite 230
Houston, TX 77027
Tel: (713) 355-1500
Fax: (713) 629-1945

Patient's Signature

Date

Patient's Agent/Guardian Relationship to Patient

Date



**River Oaks
Pain Management**

ASSIGNMENT OF BENEFITS / LONG TERM SIGNATURE AUTHORIZATION

TO: Insurance Carrier

FROM: Your insured / Our Patient

Name: _____

Name: _____

Address: _____

Address: _____

City, State, Zip: _____

City, State, Zip _____

Date of Injury _____

Claim Number: _____

I hereby authorize payment to River Oaks Pain Management, of all benefits otherwise payable to me but not to exceed the total charges for the services rendered.

I hereby authorize River Oaks Pain Management to furnish my insurance company (companies) or its representatives any information necessary for services rendered.

I also authorize the release of any medical or other information necessary to process my claim by paper or via electronic claims submission.

This authorization also permits the release of information to this provider by HCFA, its intermediaries, or carriers on any unassigned Medicare claims.

I understand that I am financially responsible to River Oaks Pain Management, for all charges not covered by my insurance policy (policies).

I further permit copies of this authorization to be used in place of the original.

TERM OF AUTHORIZATION

From date executed (below) until December 31, 2035.

Patient Name

Signature

Insured Name (if different than patient)

Signature

Date



**River Oaks
Pain Management**

NON-COVERED SERVICES AUTHORIZATION & PAYMENT AGREEMENT

PATIENT: _____

ACCOUNT#: _____

PHYSICIAN: _____

SERVICE & CPT REQUESTED: _____

FEE: _____

SCHEDULED FOR : _____

SERVICE VERIFIED NON-COVERED: _____

DATE: _____

INSURANCE: _____

REP: _____

PLEASE READ AND SIGN:

- I understand the service listed above is deemed to be a “non-covered service” by my insurance plan.
- I am requesting that the service be performed.
- I will accept responsibility for the fee for the service.
- I understand that the services must be paid in full before the service is performed.

PATIENT'S SIGNATURE: _____

DATE: _____

WITNESS: _____

DATE: _____



**River Oaks
Pain Management**