Dear _____,

Your new patient appointment is scheduled for

_____ AT _____ AM/PM at our Mesquite / Greenville location.

You MUST bring all the following with you to this appointment. **Failure to do so will result in your appointment being rescheduled.**

- A valid, Texas, photo ID
- All insurance ID cards
- An up to date medication list
- Your specialist office visit copay/co-ins/deductible amount due
    - If you have any questions regarding your amount due, please give our office a call prior to your appointment.
- This New Patient Packet with all pages completed **except** for the signatures.
    - We will need to witness you sign them when you check in.
    - If for any reason you do not receive your paperwork, you must arrive at least 1 hour early.

Should you need to cancel or reschedule, we ask that you notify the office at least 1 business day in advance. Failure to do so, will result in a $25 fee. We do this to assure that every patient can be seen as soon as possible. Also, we will not allow more than 3 scheduled attempts as this prevents other patients from being seen.

As a reminder, this appointment is a **consultation only**. After evaluation, it is at the physician's discretion to accept you as a patient, prescribe medications, and/or offer treatment.

ADVANCED PAIN SOLUTIONS LOCATIONS

Mesquite (Main)

3865 Childress Avenue Suite A
Mesquite, TX 75150
972-681-7246

Greenville

3931 Joe Ramsey Boulevard Suite D
Greenville, TX 75401
972-681-7246

Kikkeri International, Inc.
dba Advanced Pain Solutions
Ph: (972) 681-7246
Fx: (972) 681-1079

Dear Patient,

We welcome you to Advanced Pain Solutions. You are important to us, and we want to make your visit to our office as comfortable as possible. At any time during your visit, should you not understand something, including how we gather information, please let the office manager know. We are here to serve you.

If this is your first visit to Advanced Pain Solutions, it will be necessary to obtain as much information as we can about your medical history. Our physician needs to know about your current medical problems, you allergic reactions to medications, what types of medications you have been taking, and what other physicians have been involved in your care.

During your first visit, the time it takes to work you into the system might be a little longer than on subsequent visits. We ask that you understand. If you do not understand, then ask questions, please. We will need your insurance information in order to correctly bill your insurance(s). Please ensure that the information is correct and up-to-date. You will be asked to complete a sheet upon which this information can be written. This will become part of your ***confidential*** chart at Advanced Pain Solutions and will not be released to anyone or any agency without your signed consent.

We hope you enjoy your visit with us, and we are looking forward to becoming your healthcare provider. If at any time you need help after hours, please call the number at the top of this letter.

Sincerely,

Dr. Kikkeri and Staff

Kikkeri International, Inc.
dba Advanced Pain Solutions

Acknowledgment of Privacy Practices

I have been given the opportunity to review this clinic'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 the Notice of Privacy Practices, a stack of which is kept in the patient waiting area on the clipboard for your perusal. If you would like a copy, please notify the receptionist and one will be given to you.

Patient Signature: _____ Date: _____

Printed Patient Name: _____

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PATIENT REGISTRATION SHEET

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred: ( )_____ Cell: ( )_____ Work: ( )_____

May we leave a message: Email_____

At home? ( ) Yes ( ) No On your cell? ( ) Yes ( ) No At work? ( ) Yes ( ) No

Sex: ( ) M ( ) F Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed

Social Security Number: _____ Date of Birth: _____

Are you employed: ( ) Full-Time ( ) Part-Time ( ) Retired ( ) Not Employed

Referred By: _____ Phone: _____

Family Physician: _____ Phone: _____

Patient's Spouse: _____ Work Phone: _____

Work Injury: ( ) Yes ( ) No Auto Accident: ( ) Yes ( ) No

If yes, date of the injury or auto accident: _____

Primary Insurance Information:

Insurance Carrier: _____

Policy/ID No: _____ Group No: _____

Subscriber: _____ Subscriber DOB: _____

Subscriber's employer: _____ Relation to patient: _____

Secondary Insurance Information:

Insurance Carrier: _____

Policy/ID No: _____ Group No: _____

Subscriber: _____ Subscriber DOB: _____

Subscriber's employer: _____ Relation to patient: _____

Pharmacy Information:

Pharmacy Name: _____ Address: _____

Telephone: ( ) _____ Fax: ( ) _____

Emergency Contact Information:

Name: _____ Relation to patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Home: ( )_____ Cell: ( )_____ Work: ( )_____

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PAIN MANAGEMENT HISTORY

Date: _____ **Age:** _____

Name: _____ **Date of Birth:** _____

Insurance Name: _____ **Date of Injury:** _____

Referring Doctor: _____ **Height:** _____ **Weight:** _____

Current Pain Problems:

1. Date of onset of pain: _____

2. Date of diagnosis: _____

3. Under what circumstances did the pain begin:

Work Accident _____ Home Accident _____ Auto Accident _____ After Surgery _____

4. Describe your pain briefly (include location of pain): _____

_____

The following words may help you:

( )Aching ( )Throbbing ( )Stabbing ( )Shooting ( )Burning ( )Penetrating

( )Sharp ( )Numb ( )Tingling ( )Constant ( )Intermittent

5. Intensity of the pain: ( ) Mild ( ) Moderate ( ) Severe ( ) Excruciating

6. What makes the pain worse: _____

( )Sitting ( )Standing ( )Walking ( )Coughing ( )Bending over

( )Exercise ( )Lifting ( )Deep breathing ( )Lying on your back

9. What eases the pain? (Massage, rest, medication, etc.)

_____

10. If you take any pain medication, describe the effect: _____

I do not take pain medications. _____ It does not help. _____

11. How long does the pain relief last? (Hours) _____

12. How many times a day do you take it? _____

13. In the past two weeks, are you taking: more, same, or less pain medication?

14. Has the pain caused depression or other emotional problems? _____

If so, have you sought medical care? _____

15. Has the pain affected your ability to work? _____ For how long? _____

16. Does the pain interfere with your sleep? _____

17. Has the pain affected your ability to enjoy life, personal relationships, other? _____

_____

18. In the last 24 hours, how much relief have you had from treatment and medications?

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

19. In the last 24 hours how would you rate your worst pain?

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Excruciating Pain)

20. Describe any previous treatment for your pain:

Treatment	Location	Date	Response
Physical therapy			
Work Hardening			
Pain Program			
Injections/Nerve blocks			
Others (Surgery, TENS, Acupuncture, Chiropractor, Biofeedback)			

21. What is your current occupation or last job? _____
If not working currently, when did you work last? _____
22. What prevents you from returing to work? _____
23. Do you receive compensation or disability payments? _____
24. Do you have an application for compensation or disability payments? _____
25. Are you in active litigation because of pain or injury? _____
26. Do you enjoy your work? _____
27. Last grade completed? (High school, College, Master, Professional) _____
28. Are you left or right handed? _____

PAST MEDICAL HISTORY

1. Please circle any of the following illnesses, which you have or had in the past:

High Blood Pressure	Stomach Ulcer	Asthma
Angina	Gallbladder Disease	Tuberculosis
Heart Attack	Colon Disease	Gout
Heart Murmur	Heart Surgery	Cancer
Hepatitis	Rheumatoid Arthritis	Diabetes Mellitus
Osteoarthritis	Vascular Disease	Thyroid Disease
Kidney Disease	Anemia	Seizures
Glaucoma	Bleeding Disorders	Drug Abuse
Recent Weight Loss	Change in bladder or bowel habits	Bipolar Disorder
Depression	Chronic Pain Syndrome	Schizophrenia
Attention Deficit Disorder	Obsessive-Compulsive Disorder	Other _____

2. Please list all previous hospitalizations/surgeries:

Diagnosis/Reasons	**Date**

3. List any previous injuries:

_____
_____

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4. List medications you are taking now:

Medication (Name)	Dose (MG)	Frequency (Times a Day)	Medication (Name)	Dose (MG)	Frequency (Times a day)

5. List medications to which you are allergic:

Medication Type of reaction (rash, itching, swelling, etc.)

_____

_____

_____

FAMILY HISTORY

Circle condition and describe as follows:

(F-Father, M-Mother, B-Brother, S-Sister)

High blood pressure _____ Heart attack _____

Diabetes _____ Cancer _____

Bleeding disorder _____ Seizures _____

Neurological disorders _____ Chronic pain _____

Problems with anesthesia _____ Depression _____

Substance Abuse: Alcohol _____ Illegal Drugs _____ Prescription Drugs _____

SOCIAL HISTORY

1. Do you drink alcoholic beverages: ( )Yes ( )No

If yes, what type and on the average, how many per week: _____

2. Smoking habits: ( )Yes ( )No ( )Past

If yes, how much do you smoke and for how long: _____

3. History of substance abuse: ( )Yes ( )No

Which? (Circle all that apply): Alcohol Illegal Drugs Prescription Drugs

History of Drug Detoxification Program? ( )Yes ( )No

List substances: _____

History of preadolescent sexual abuse? ( )Yes ( )No

Advanced Pain Solutions Pain Diary

1. **FIRST** -Mark the drawings where you USUALLY feel pain.
Dull Aching XXXX
Burning OOOO
Stabbing ////
Sharp ----

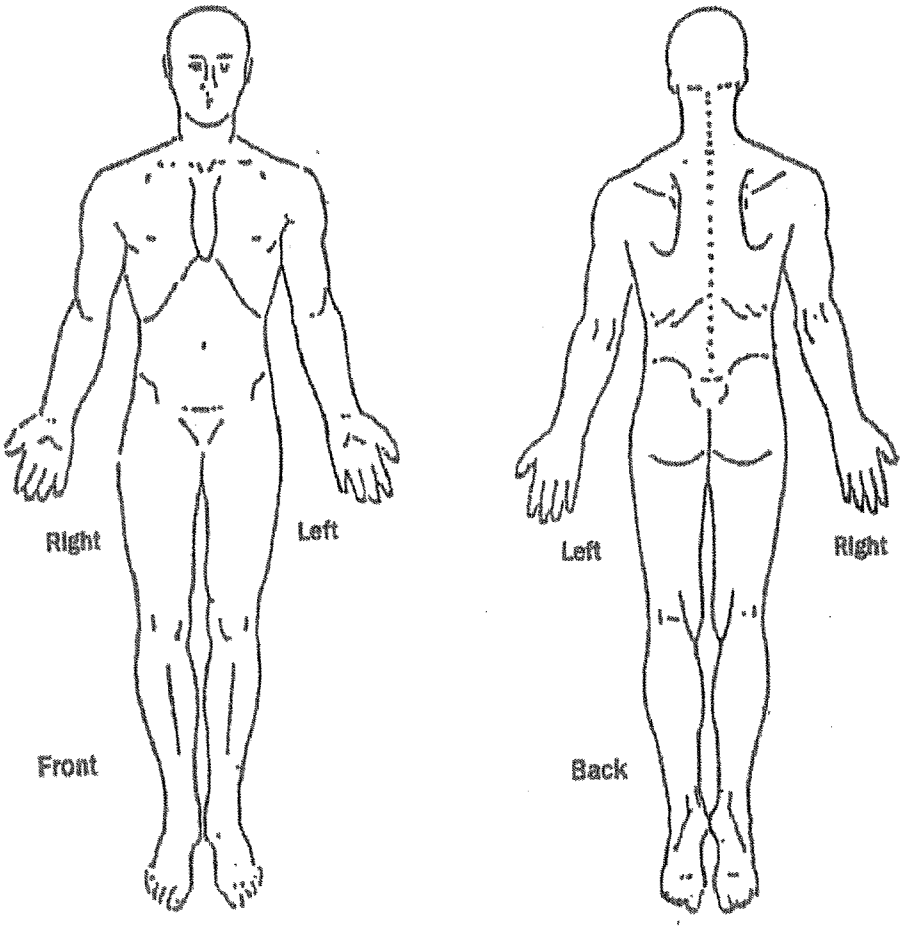
2. **SECOND** - CIRCLE <u>ONLY ONE</u> AREA THAT HURTS THE MOST

NAME: _____

DATE OF BIRTH: _____

DATE: _____

SIGNATURE: _____



<u>5 A's of Chronic Pain</u>

1. **ANALGESIA** - Do your pain medications reduce your pain?
   Yes or No
2. **ACTIVITY** - Do your pain medications improve your level of functioning?
   Yes or No
3. **ADVERSE EFFECTS** - Do your pain medications cause any significant or severe side effects?
   Yes or No
4. **ABERRANT BEHAVIORS** - Do your pain medications make you act strange, odd or peculiar?
   Yes or No
5. **AFFECT** - Do your pain medications make you feel depressed or agitated?
   Yes or No

3. **LOWEST** pain level in the past 2 weeks. (After you take your pain medicine)

   Least Pain 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 Worst Pain

4. **HIGHEST** pain level in the past 2 weeks. (Before you take your pain medicine)

   Least Pain 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 Worst Pain

5. Pain level **NOW**.

   Least Pain 0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 Worst Pain

6. **DO YOUR PAIN MEDICINES**:

   A. Help to relieve your pain? (Do you still need your pain medications?) Yes No

   B. Help you to be more active? (Can you do more after you take your pain medicine?) Yes No

   C. Cause nausea? (That it is so bad you want to change pain medicine?) Yes No

   D. Make you feel sleepy or sedated? Yes No

7. Do you need a prescription for **opioid induced constipation** (OIC)? Yes No

8. **PCP Name:** _____ **Date of last labs:** _____

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PATIENT AGREEMENT

In agreement of Advanced Pain Solutions accepting me as a new patient for those problems for which he agrees to see me, I agree to the following:

ASSIGNMENT OF BENEFITS: I hereby assign to Advanced Pain Solutions, all medical insurance benefits to which I may now be or in the future become entitled to, in relationship to medical services provided by Advanced Pain Solutions. I hereby authorize direct third-party (insurance) payment directly to Advanced Pain Solutions of benefits due to me for his services.

PAYMENT/DEFAULT: I understand and agree that payment is due at the time that medical services are rendered, unless other arrangements have been previously made. I understand that I am financially responsible for charges not paid for by a third-party (insurance). In case of my default of payment for bills related to my treatment by Advanced Pain Solutions, I hereby agree to pay for any and all collection and other charges, including attorneys' fees and court costs, resulting from collection efforts or litigation related to said bills.

RELEASE OF INFORMATION: I hereby consent Advanced Pain Solutions and his staff to release any and all of my protected health information or to deliver verbal reports that they deem useful for the following purposes:

- To carry out treatment, obtain payment for services rendered, or for healthcare operations (including delivering message related to my appoints, lab or other reports, or my medical status, to persons or answering machines, telephone number or e-mail address I may identify as a means of reaching me, including cellular, work or home telephone or facsimile numbers, or by e-mail.)
- To facilitate communication by telephone, fax, or e-mail with individuals identifying themselves as representing any state or federal government agencies regulating healthcare or any insurance company that may be responsible for payment of Advanced Pain Solutions' bills or of other benefits to me.
- To any individual accompanying me in the event that I undergo a surgical or other procedure.
- For research purposes and scientific papers, providing that I am not specifically identified.
- To previous and future physicians, facilities or other health care providers involved in my care, or to any attorneys I may from time to time designate as representing me.
- To me in the presence of any individual who accompanies me to clinic visits or other encounters with Advanced Pain Solutions and his staff, I specifically accept that it is my responsibility to exclude from such encounters individuals who I do not wish to be knowledgeable of my protected health information.

I understand that I have the right to review Advanced Pain Solutions' Notice of Privacy Practices and to revoke consents related to use of protected health information for which consent is required.

I understand that Advanced Pain Solutions has the right to refuse to treat me in the event that I do not sign this consent and I understand and agree that no physician-patient relationship will exist between Advanced Pain Solutions and me, unless and until, I sign this agreement without restriction.

I understand that I have the right to revoke this agreement at any time. This agreement shall remain valid and in full force and effect until such time as I may revoke it. My authorization for disclosures or other actions under the authority of this agreement undertaken prior to said revocation, shall survive said revocation. Additionally, I agree that if I revoke any part of this consent, my act of revocation of any part of this consent, will unilaterally from my side, terminate our physician-patient relationship. In the event of my revocation of any part of this consent, I further agree not to attempt to again be seen by Advanced Pain Solutions as a patient without re-signing or re-activating this consent in full, or in the event that this consent has been amended, revised, replaces, to whatever amended, revised or replaced consent that Advanced Pain Solutions requires at that time. Further, I hereby release and discharge Advanced Pain Solutions from any liability due to any prior act performed by Advanced Pain Solutions or his staff.

CONFIDENTIALITY OF MINORS: If I am under the age of 18 years old, I hereby authorize Advanced Pain Solutions to share all current or further information regarding my medical condition(s) with my parents or guardians.

LIMITATION OF PHYSICIAN-PATIENT RELATIONSHIP: I understand that Advanced Pain Solutions' clinic is sub-specialized in and restricted to those areas in which he is fellowship-trained: interventional pain management. In order to have access to his expertise within his sub-specialties, as limited above, I agree to hold Advanced Pain Solutions harmless for any and all failure to diagnose, treat or disclosure medical conditions, other conditions or facts that are not part of his clinic restriction, including but not limited to, all non-pain management conditions. I further agree that our physician-patient relationship is limited to management of only those problems that Advanced Pain Solutions from time to time agrees to treat, and specifically agree that Advanced Pain Solutions has the right to refuse, diagnose, or treat any additional problems that I may have or may develop in the future. For example, by way of illustration but not by way of limitation, Advanced Pain Solutions shall have no obligation to see me for or treat me for, a shoulder or neck pain which I develop the date following the date of this agreement or any time thereafter, unless he agrees to at the time of such occurrence.

LEGAL TESTIMONY: In the event that the patient or patient's parents, legal guardians, heirs, estate, assigns, or personal representatives makes a claim against a third party that results in any obligation for Advanced Pain Solutions to provide to or prepare testimony, whether as an expert or material witness, the patient agrees to compensate Advanced Pain Solutions for all time expended by Advanced Pain Solutions to prove or prepare testimony, including but not limited to time spent in traveling, at this usual and customary rate as an expert witness in force at the time of said testimony, and to reimburse Advanced Pain Solutions for all expenses incurred in the provision of said testimony, including but not limited to the cost of travel, and further agrees that payment for said testimony shall be presented paid. In the event of failure to re-pay, the patient agrees that payment shall be made out of any recovery from said claim as a first priority over all other claims, prior to disbursement of any said recovery to the patient.

Kikkeri International, Inc.
dba Advanced Pain Solutions

SEVERABILITY: This agreement shall be legally binding upon me, the patient, and parents or legal guardians thereof if a minor, their heirs, estate, assigns, including all minor children, and personal representatives, as it shall be interpreted according to the laws of The State of Texas. Any disputes arising under this agreement, including the interpretation thereof, shall be litigated in and venue shall be Dallas County, Texas. If any part, clause, provision or condition of this agreement is held to be void, invalid or inoperative such voiding, invalidity, or inoperativeness shall not affect any other part, clause, provision or condition thereof, but the remainder of this agreement shall be effective as though the void, invalid or inoperative part, clause or provision or condition has not been contained herein.

MEDICAL RECORDS OF OTHER PROVIDERS: I hereby authorize and direct all prior, current and future health care providers to provider Advanced Pain Solutions upon his request, any part or all, at his request, of their medical records, X-rays, reports or other information pertaining to my health care in their possession.

I hereby acknowledge that the accuracy of the information on the forms I have filled out is critical in providing appropriate medical care to me and that the likelihood of errors in diagnosis and treatment are significantly increased by inaccuracies or omissions on these forms. I hereby certify that the information I have given in the Patient Information packet is accurate and complete to the best of my knowledge and belief.

_____ _____

Patient Signature Date

_____

Printed Patient Name

_____ _____

Parent/Guardian Signature Date

_____ _____

Printed Parent/Guardian Name Relationship

FINANCIAL POLICY

Financial Policy: We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. If you have any questions regarding this policy, please feel free to discuss them with our office management. Unless either you or your healthcare coverage carrier have made other arrangements in advance, full payment is due at the time of service, and we reserve the right to charge for appointments missed, cancelled, or otherwise broken **without** 24 hours notice.

Your Insurance: We require payment of co-insurance, deductibles and co-pays at the time of the service. If you have any insurance coverage, we will prepare and file your claims for you. Please call our business office at (972) 681-7246 if you have any questions. In the event your health plan determines a service to be "non-covered", you will be responsible for the complete charge. Payment is due upon receipt of our statement. We will also bill your health insurance for all services provided by Advanced Pain Solutions while you were in the hospital. Any balance due is your legal responsibility and is due upon receipt of a statement from our office.

Financial Agreement and Assignment of Benefits: I hereby assign, transfer and covey to Advanced Pain Solutions, any and all benefits and all interest and right (including causes of action and the right to enforce payment) for services rendered under any insurance policies and any reimbursement or prepaid healthcare plan.

I acknowledge that any balance not covered or paid by such policy or plan is my legal responsibility. I further agree that this assignment **WILL NOT BE WITHDRAWN OR VOIDED** at any time until the account for this medical care is paid in full.

Minor Patients: For all services rendered to the minor patients, the parent or guardian of the patient is responsible for payment and **must** accompany the minor patient.

I have read, and understand, the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time.

Patient/Guardian Signature: _____ Date: _____

Printed **Patient** Name: _____

Witness Signature: _____ Date: _____

Kikkeri International, Inc.
dba Advanced Pain Solutions

Patient Authorization & Consent

Advanced Pain Solutions is committed to fulfilling all the requirements of the Health Insurance Portability & Accountability Act (HIPAA) of 2004.

Section A: ***Authorization***

This must be completed for all authorizations. The patient or the patient's representative must read and initial the following statements:

1. I authorize Advanced Pain Solutions to release any of my medical or insurance information necessary to process my medical claims and coordinate or manage my healthcare.

   Initials: _____

2. I understand that I may revoke this authorization any time by notifying Advanced Pain Solutions. But, if I revoke this authorization, my revocation will not have an effect on any actions Advanced Pain Solutions took before they received my revocation.

   Initials: _____

   You may revoke this authorization by signing a Revocation Authorization form and returning it to Advanced Pain Solutions. To request a Revocation Authorization form, you may ask the receptionist or contact our office at (972)681-7246.

3. Advanced Pain Solutions will not base condition for treatment or payment for healthcare services on your completing and signing this authorization.

   Initials: _____

   For additional information regarding disclosures of uses of my health information, I acknowledge I may obtain a copy of Advanced Pain Solutions Notice of Privacy Practice at any time from the receptionist or by contacting the above business office.

Section B: ***Consent***

In the event that a family member or caregiver attends my office visit and is in the exam room at the time of the evaluation and/or treatment, I give Advanced Pain Solutions and its physicians, physician assistants, nurse practitioners or employees my permission to discuss freely my condition, treatment, diagnosis, or insurance/payment issues with that person.

Initials: _____

May we leave a message on your home phone? Yes/No If so, what is the number? _____
May we leave a message on your cell phone? Yes/No If so, what is the number? _____
May we leave a message on your work phone? Yes/No If so, what is the number? _____

We address our patients by name in our office and reception area. If you do not wish for us to do this, please note here.

_____

With whom may we discuss or release information about your care, treatment, or diagnosis?

_____ Relation to patient: _____

_____ Relation to patient: _____

Printed Name: _____ Signature: _____ Date: _____

Kikkeri International, Inc.
dba Advanced Pain Solutions

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Patient Name: _____ Date(s) of Service: *ALL*

Patient Date of Birth: _____ Social Security Number: _____

I, the undersigned, authorize the release of/or request access to the information specified below from the medical record(s) of the above-named patient.

PATIENT INFORMATION IS NEEDED FOR:

(✓) Continuing Medical Care	( ) Military	( ) Social Security/Disability
(✓) Insurance	( ) Personal Use	( ) Other: _____
(✓) Legal Purposes	( ) School	_____

INFORMATION TO BE RELEASED OR ACCESSED:

(✓) History & Physical	(✓) Consultation Report	(✓) Emergency Room Record
(✓) Operative Reports	(✓) Discharge/Death Summary	(✓) Face Sheet
(✓) Lab/Pathology Reports	(✓) X-Ray Reports/Images	(✓) External Prescription History

( ) Other: _____

The above information may be released to:

Kikkeri International, PA dba Advanced Pain Solutions	(972) 681-7246	(972) 681-1079
(Doctor, Hospital, Attorney, Insurance, Self, etc.)	Phone	Fax

3865 Childress Avenue, Suite A	Mesquite	Texas	75150
Street Address	City	State	Zip Code

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used to disclose pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodefiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand that I may be charged a retrieval or processing fee for copies of my medical records according to Texas Hospital Licensing Law.

This authorization will expire upon discharge unless I revoke the authorization prior to that time or unless otherwise specified.

Patient/Guardian Signature: _____ Date: _____

If guardian, relationship to patient: _____ **Printed Name**: _____

Kikkeri International, PA
dba Advanced Pain Solutions

INFORMED CONSENT AND PAIN MEDICINE AGREEMENT
AS REQUIRED BY THE TEXAS MEDICAL BOARD
REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9, CHAPTER 170
5th Edition: Developed by the Texas Pain Society, January 2021 (www.texaspain.org)

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 (medication) therapy to be used, so that you may make an informed decision whether or not to take the drug(s) 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. It is essential for the trust and confidence required for a proper patient-physician relationship and is intended to inform you of your physician's expectations that are necessary for patient compliance. For the purpose of this agreement the use of the word "physician" is defined to include not only your physician but also your physician's authorized associates, physician assistants, nurse practitioners, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat your condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician (name listed on last page) to treat my condition of chronic pain, which is a state of pain that persists beyond the usual course of an acute disease or healing of an injury. 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 a part of the treatment of my chronic pain.

It has been explained to me that these medication(s) include opioid/narcotic drug(s). I have discussed with my Pain Medicine Physician the risks and benefits of the use of controlled substances for the treatment of chronic pain, including an explanation of the following: (a) diagnosis; (b) treatment plan; (c) anticipated therapeutic results, including realistic expectations for sustained pain relief, improved functioning and possibilities for lack of pain relief; (d) therapies in addition to or instead of drug therapy, including physical therapy or psychological techniques; (e) potential side effects and how to manage them; (f) adverse effects, including the potential for dependence, addiction, tolerance, and withdrawal; and (g) potential complications and impairment of judgment and motor skills. 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 accidental overdose, injury and death are also possibilities as a result of taking these medication(s).
I understand that concurrently consuming sedating substances like alcohol, or taking additional types of sedating controlled medications, such as benzodiazepines, along with opioids increases my chance for accidental overdose, injury, and death. If in the unusual situation it is medically indicated for me to receive multiple types of controlled substances, I understand that I will require close supervision of medical specialists to maximize my safety. I agree to follow their direction on the proper use of these medications. Deviation from using medications as directed is grounds for discontinuation of pain therapy.

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 (urine, blood, saliva or any other testing indicated and deemed necessary by my physician at any time) 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 or absence of authorized substances may result in my being discharged from my Pain Medicine Physician's care.

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 will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction times might still be slowed. Such activities include but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself.

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 functional 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 may 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.

For female patients only:

_____To the best of my knowledge **I am NOT pregnant.**

_____If I am not pregnant, I will take appropriate precautions to avoid pregnancy 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.**

I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) 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, or baby.

PAIN MEDICINE AGREEMENT:

I UNDERSTAND AND AGREE TO THE FOLLOWING:

That this pain medicine agreement relates to my use of any and all medication(s) called dangerous drugs and/or controlled substances (i.e., opioids, also called narcotics or painkillers, and other prescription medications) for chronic pain prescribed by my physician. I understand that there are many strict 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.**

The term "Pain Medicine Physician" below means your primary Pain Medicine Physician or your physician who is managing your pain, or that physician's Physician Assistant or Nurse Practitioner, or another physician covering for your primary Pain Medicine Physician.

My Pain Medicine Physician may at any time choose to discontinue 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.

(Patient Shall Acknowledge All Provisions by Initialing)

_____ I am aware that all controlled substance prescriptions are now being monitored by the Texas State Board of Pharmacy and that information must be accessed by my Pain Medicine Physician every time a prescription is written, and by my pharmacist every time before my prescription is dispensed.

_____ I will not consume alcohol or use any illegal substances (such as marijuana, heroin, cocaine, methamphetamines, etc.) while being prescribed dangerous and controlled substances for the treatment of chronic pain.

_____ I agree to submit to laboratory tests for drug levels upon request, including 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 alcohol or illegal substance(s), 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.

_____ 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. My Pain Medicine Physician may limit the number and frequency of prescription refills.

_____ 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. But if my medications were stolen and I provide my Pain Medicine Physician with a copy of the police report, my Pain Medicine Physician after carefully reviewing my situation, may issue an early refill.**

_____ My Pain Medicine Physician will manage all of my chronic pain symptoms. **Only my Pain Medicine Physician may prescribe Dangerous Drugs and Controlled Substances for the treatment of chronic pain**. I will receive controlled substance medication(s) **only from ONE Pain Medicine Physician,** unless it is for an emergency **or** the medication(s) that is being prescribed by another physician is approved by my Pain Medicine Physician. Information that I have been receiving medication(s) prescribed by other physicians that has not been approved by my Pain Medicine Physician may lead to a discontinuation of medication(s) and treatment. All other health related issues must be managed by my primary care physician and my other specialists.

_____ I agree that I **will inform any physician** who may treat me for any other medical problem(s) that I am enrolled in a pain medicine program and have signed this Pain Medicine Agreement.

_____ I hereby give my Pain Medicine Physician **permission to** discuss all diagnostic and treatment details with my other physician(s) and my pharmacist(s) regarding my use of medications prescribed by my other physician(s). I give my Pain Medicine Physician permission to obtain any and all medical records necessary to diagnose and treat my painful conditions.

_____ I will use the medication(s) **exactly as directed by my Pain Medicine Physician. Any unauthorized increase** in the dose of medication(s) may cause the discontinuation of my pain treatment(s).

_____ If anyone other than my Pain Medicine Physician prescribes me medication(s) to treat acute, post- surgical or chronic pain, then I will **disclose** this information to my Pain Medicine Physician at or before my next date of service, which must include, at a minimum, the name and contact information for the person who issued the prescription, the date of the prescription, the name and quantity of the drug prescribed, and the pharmacy that dispensed the medication.

_____ I will alert my physician if I receive a prescription for Naloxone or any opioid antagonist which are designed to reverse the effects of an accidental or intentional overdose of pain medication.

_____ All medication(s) must be obtained at **one pharmacy designated by me**, with exception for those circumstances for which I have no control or responsibility, that prevent me from obtaining prescribed medications at my designated pharmacy. Should the need arise to change pharmacies, my Pain Medicine Physician must be informed at or before my next date of service regarding the circumstances and the identity of the pharmacy. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my Pain Medicine Physician to release my medical records to my pharmacist as needed.

_____ My progress will be periodically reviewed and, if the medication(s) are not improving my function and quality of life, the **medication(s) may be discontinued**.

_____ I must **keep all follow-up appointments** as recommended by my Pain Medicine Physician or my treatment may be discontinued.

_____ I agree **not to** share, sell or otherwise permit others, including my family and friends, to have access to my medications.

_____ I will **not use any cannabidiol (CBD) products unless one of my physicians has prescribed me Epidiolex, and I will immediately provide you with that physician's name and lab work so that I can make sure it is not causing problems with my current medications. I understand that the use of over-the-counter CBD products increases my risk of failing a urine drug test because of the presence of illegal substances present in many over-the-counter CBD products.**

_____ I agree to be seen in **in-person office visits** because in Texas it is illegal to use Telehealth for the treatment of chronic pain with controlled substances.

_____ If it appears to my Pain Medicine Physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then **my Pain Medicine Physician may try alternative medication(s) or may taper me off all medication(s)**. I will not hold my Pain Medicine Physician liable for problems caused by the discontinuance of medication(s).

_____ I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, interventional pain medicine (e.g. steroid injections, nerve ablations, implants to relieve pain, etc.) 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 medicine program** recommended by my Pain Medicine Physician to achieve increased function and improved quality of life.

_____ I understand many prescription medications for chronic pain produce serious side effects including drowsiness, dizziness, and confusion. Alcohol will enhance all of these side effects and I will discontinue it before starting these medications.

I certify and agree to the following (*Patient Shall Acknowledge All Provisions by Initialing*):

_____ 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** to me 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.**

_____ 5) If I become a patient in this clinic and receive controlled substances to control my pain, this Pain Medicine Agreement supersedes any other pain management agreement that I may have signed in the past.

_____

Name and contact information for pharmacy

_____ _____

Patient Printed Name | Physician Printed Name *(or Appropriately Authorized Assistant)*

_____ _____

Patient Signature | Physician Signature *(or Appropriately Authorized Assistant)*

Kikkeri International, PA
dba Advanced Pain Solutions

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Kikkeri International, Inc.
dba Advanced Pain Solutions

Medication Guidelines

In order to treat your pain effectively, certain medications may be used that are controlled substances. These are usually potent analgesic (pain killers) that must be used carefully, as prescribed by your doctor. These guidelines are designed to improve communication between physician-patient and maintain strict accountability as required by state law but most of all, provide you with a safe and efficient medication program.

Initials: _____ 1. Pain medications are designed to reduce your pain to manageable levels, not to eliminate the pain completely. In some situations, this may not be possible.

Initials: _____ 2. Sometimes it may take several days or weeks for the medication to achieve its goal. During this time we strongly suggest you take the medication as prescribed.

Initials: _____ 3. If you believe that your medication is not effective or develop side effects, make an appointment to be seen. You must bring the medications with you at the time of your visit. **If you fail to do so, we will not be able to prescribe alternatives.**

Initials: _____ 4. Side effects of pain medications include but are not limited to sleepiness, confusion, drowsiness, impaired reflexes, nausea, vomiting, constipation, impaired breathing, and itching. You should not operate any motor vehicle or any heavy machinery when you start any pain medication, change the dosage or feel sleepy, drowsy, or impaired.

Initials: _____ 5. Medication changes or adjustments will not be done over the phone. You need to be seen in the office, so your concerns can be addressed properly.

Initials: _____ 6. Prescribed medications must be taken strictly as ordered, not only for safety reasons but to maintain the physician-patient relationship. **Failure to do so may result in termination of prescription privileges.**

Initials: _____ 7. Patients on medication management will need to be seen in the office at least once per month for refills and adjustments.

Initials: _____ 8. You will not be allowed to refill your medication up to (three) 3 days prior. It is your responsibility to ensure proper refills of your medication.

Initials: _____ 9. **ADVANCED PAIN SOLUTIONS DOES NOT REFILL MEDICATIONS OVER THE PHONE FROM YOUR PHARMACY.**

Initials: _____ 10. **PLEASE CALL YOUR PHARMACY AND HAVE THEM FAX A REFILL REQUEST IN ORDER FOR US TO REFILL A MEDICATION. SOME MEDICATOINS CANNOT BE REFILLED THIS WAY. AN OFFICE VISIT IS REQUIRED.**

Initials: _____ 11. Please note that Advanced Pain Solutions **DOES NOT** replace lost or stolen medications.

Initials: _____ 12. Advanced Pain Solutions prescribes medication specific to pain management. Other types of medications (blood pressure, diabetes, etc.) must be managed by your referring doctor.

Patient Signature: _____ Printed Name: _____

Witness Signature: _____ Date: _____

Kikkeri International, Inc.
dba Advanced Pain Solutions

Consent for Treatment by Nurse Practitioners and Physician Assistants

Nurse practitioners (NP) and physician assistants (PA) are healthcare professionals licensed to practice medicine with physician supervision. NPs and PAs conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel on preventive healthcare, and assist in surgery. NPs and PAs are trained in intensive education programs accredited for the nurse practitioner or physician assistant. Upon graduation they are required to take a national certification exam to receive their state licensure.

I understand that the nurse practitioner or the physician assistant and the physician work together as a team to provide my medical care.

This agreement will remain in effect until otherwise stated by me.

Patient/Parent/Guardian Signature: _____

Printed Name: _____ Date: _____

Witness Signature: _____ Date: _____

ADVANCED
PAIN SOLUTIONS

Every Patient Must Have a Primary Care Physician (Medical Home)

All patients that are under the care of Advanced Pain Solutions are required to have a primary care physician (Medical Home). Chronic opioid therapy is high risk and must be integrated with your other medical conditions. Patients are required to have a well examination and obtain lab work at least once per year. The required annual lab work is as follows:

Complete Blood Count, CBC
Comprehensive Metabolic Panel, CMP
Complete Urinalysis
Testosterone level, for males
EKG is required for patients on methadone
Vitamin D and Cortisol levels are recommended

If you have not seen your primary care physician for your annual examination and completed the required laboratory work, the following will occur (unless other arrangements have been approved by your provider).

- You will be reminded of our policies and procedures and given 2 months time to comply
- If you have not gotten your annual examination and laboratory work after 2 months, your appointments will be changed to every 2 weeks. Prescription refills will also be changed to every 2 weeks.

If you have not performed annual examination and laboratory work after another 2 months, you will be weaned off your pain medication (unless other arrangements have been approved by your provider).

Please ask for a copy of your annual examination and labs and ask your provider to fax these records to 972-681-1079.

_____ _____

PRINTED NAME DATE OF BIRTH

_____ _____

PATIENT SIGNATURE DATE