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ACKNOWLEDGEMENT/CONSENT

____ (initial) **RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, (print patient name) _____, have read a copy of Balcones Pain Consultants Notice of Privacy Practices. (This document is available in our waiting room or balconespain.com).

____ (initial) **CANCELLATION POLICY**

If the patient cannot adhere to a scheduled appointment, it is the patient's responsibility to call the office to cancel within 24 hours of the scheduled appointment. Balcones Pain Consultants reserves the right to charge the patient a **\$50.00 fee if the patient does not cancel an office visit and a \$100 fee if the patient does not cancel an injection/procedure** without the adequate notification.

____ (initial) **RELEASE OF MEDICAL INFORMATION**

I do/do not (circle one) authorize Balcones Pain Consultants and its designated representatives to release medical information to my spouse, parent, or guardian.

____ (initial) **CONTACT PERMISSION**

In the event that Balcones Pain Consultants needs to contact you (patient) regarding an appointment, lab result, medication, or any other reason, it is permissible to:

Check all that apply:

- Leave a message on an answering machine.
- Speak with spouse/significant other. (please list name) _____
- Speak with other family members. (please list names) _____

____ (initial) **CONSENT TO TREATMENT**

I consent to the performance of those diagnostic procedures, examinations, and rendering of treatment by the medical provider and their designated medical office staff as it deemed necessary in the medical provider's judgment.

____ (initial) **AUTHORIZATION/ASSIGNMENT/FIANCIAL RESPONSIBILITY**

I authorize the release of any medical information necessary to process an insurance claim on my behalf. I understand that I am financially responsible for all charges and that I am responsible for obtaining any referrals required by my insurance carrier. I request that my medical insurance carrier make any payment directly to Balcones Pain Consultants for services rendered to me. As a courtesy, my charges will be filed with my insurance carrier; however, I will be billed if the claim is denied or is not paid in a timely manner. **Should my account become a collection problem, additional charges may be incurred. Any co-payments/co-insurance amount, plus any deductible is due when services are rendered.** There is a **\$30.00 service fee on all returned checks in addition to the amount of the check.** If this happens checks must be redeemed with certified funds (credit card or cash) at or before the next visit.

____ (initial) This is notification that Dr. Matthew McCarty has a partial ownership interest in Stonegate Surgery Center and Austin Surgical Hospital and Dr. McCarty will receive remuneration for patients treated at those entities.

My signature below indicates that I have read and am in agreement with all statements that I have initialed above.

Signature of Patient (or guardian)

Date



URINE DRUG SCREENING

Patient Information and Consent

As part of your pain management treatment plan you have been prescribed, or are being considered for treatment with opioid, or narcotic, pain relievers. You may also have been prescribed other controlled substances such as muscle relaxers, sleeping aids, anti-neuropathics, or anxiolytics. As discussed in your medication agreement, these types of medications have potential for serious side effects, and also have potential for misuse, abuse, and diversion.

In order to protect your right, as a patient with chronic pain, to obtain these medications for legitimate medical use, our practice uses a Urine Drug Screening (UDS) process. This UDS will screen for your compliance of taking the prescribed medications, and will also screen for illegal substances and non-prescribed substances. All results will remain a part of your medical record with our office, and will be used to guide your treatment.

The Urine Drug Screens also serve to protect our medical practice from individuals seeking medications for other than legitimate medical use, and allows us to focus our energy and attention towards treating our patients with chronic pain.

All patients who are prescribed these medications will be asked to undergo both scheduled and unscheduled Urine Drug Screens as part of this process, without exception, and without regard to age, race, sex, past medical history, or current diagnosis. We do not want this process to appear punitive or negative, and appreciate your participation in protecting your rights as a chronic pain patient, and our rights as a chronic pain medical practice.

Printed name of patient or person
legally responsible for patient

Date/Time

Signature of patient or person
legally responsible for patient

Signature of Witness



Name _____ Referring Physician _____

Date of Birth _____ Age _____ Date _____

A. CHIEF COMPLAINT (Reason for Visit) _____

1. Please rate your **Present** Pain Level (0 = no pain 10 =worst pain)

1 2 3 4 5 6 7 8 9 10

2. Please rate your **Average** Pain level (0 = no pain 10 = worst pain)

1 2 3 4 5 6 7 8 9 10

3. Please rate your ability to Perform activities of daily living: such as hygiene, household chores, transportation etc.
(0 = not able 10 = very able)

1 2 3 4 5 6 7 8 9 10

4. What is the exact location of your pain? _____

5. When did you first have this pain? _____

6. Please describe your pain. (Circle all that apply)

* Sharp	* Numbness	* Constant
* Dull	* Tingling	* Cramping
* Aching	* Radiating	* Burning
* Pressure	* Stabbing	* Other _____

7. How often do you have this pain? _____

8. What makes your pain worse? _____

9. Previous diagnoses for this pain? _____

10. Previous treatment for this pain? _____

11. Do you have numbness, tingling or weakness in the arms or legs? _____

12. Have you had any changes in bowel or bladder function? _____

B. PAST MEDICAL HISTORY (please check all that apply):

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Vascular Problems	<input type="checkbox"/> Shingles	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Low Thyroid	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Lupus	<input type="checkbox"/> Stroke	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Asthma
<input type="checkbox"/> Emphysema	<input type="checkbox"/> AIDS	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Osteoarthritis (regular)	

C. PAST SURGICAL HISTORY:

Surgery	Details	Date & Hospital
Back Surgery		
Breast		
Gall Bladder		
Hernia Repair		
Hysterectomy/Ovaries		
Tonsillectomy		
Stomach/Ulcer		
Other		

Hospitalizations other than surgery (include dates & hospitals) _____

All current physicians _____

D. CURRENT MEDICATIONS (Include over the counter & herbal products):

Name	Dose & Frequency	Condition Being Treated	Duration

E. ALLERGIES TO MEDICATION (List all medications & reactions): _____

F. SOCIAL HISTORY:

*Tobacco Use: No / Yes (Circle) Packs per Day _____ # of Years _____
*Alcohol Use: No / Yes (Circle) Drinks per Week _____ # of Years _____
*Recreational Drug Use: No / Yes (Circle) Drugs Used _____
*Diet: (Circle) Vegetarian Lactose-Free Caffeine-Free Diabetic Regular Other _____
*Marital Status: (Circle) Married Single Divorced Widow/Widower
*Occupation: _____

G. FAMILY HISTORY (Include age of family member):

History	Father	Mother	Brother/Sister	Other Relatives
Cancer				
Diabetes				
Heart Disease				
Hypertension				
Other				

H. RADIOLOGY:

Have you had an X-ray or MRI? _____
When? _____ Where? _____

I. PRIOR PAIN MANAGEMENT HISTORY:

Have you been treated for pain management before? Y N

J. WORK STATUS:

Are you currently working? Y N If not, when did you stop?
Who took you off work? _____
What are your current work restrictions, if any? _____

K. PSYCHOLOGICAL TREATMENT:

Have you ever had psychiatric, psychological, or social work treatments/evaluations for any diagnosis/problem, including your current pain? Y N

- a. If yes, for what diagnosis or problem were you treated? _____
- b. When were you treated? _____
- c. Therapist's name? _____

Have you considered suicide? Y N Date: _____
Have you ever attempted suicide? Y N Date: _____

L. REVIEW OF SYSTEMS:

General

Y N Weight Gain
Y N Weight Loss
Y N Dry Mouth
Y N Fatigue
Y N Fever

Skin

Y N Itching
Y N New Lesions
Y N Rash

HEENT

Y N Blurred Vision
Y N Headache
Y N Nasal Congestion
Y N Sinus Pain
Y N Sore Throat

Neck

Y N Neck Pain
Y N Neck Stiffness

Respiratory/Lung

Y N Cough
Y N Snoring
Y N Wheezing

Cardiovascular

Y N Chest Pain
Y N Palpitations
Y N Shortness of Breath

Gastrointestinal

Y N Abdominal Pain
Y N Bloody Stool
Y N Constipation
Y N Diarrhea
Y N Nausea
Y N Vomiting

Genitourinary

Y N Flank Pain
Y N Frequency

Genitourinary (Cont.)

Y N Painful Urination
Y N Urgency

Male (Only)

Y N Impotence
Y N Testicular Pain

Musculoskeletal

Y N Leg Cramps
Y N Back Pain
Y N Calf Pain
Y N Decreased ROM
Y N Joint Pain
Y N Joint Redness
Y N Joint Stiffness
Y N Joint Swelling
Y N Muscle Atrophy
Y N Muscle Cramps
Y N Muscle Pain
Y N Muscle Weakness
Y N Swelling of Extremities

Neurologic

Y N Dizziness
Y N Paresthesias
Y N Unusual Sensation
Y N Weakness

Psychiatric

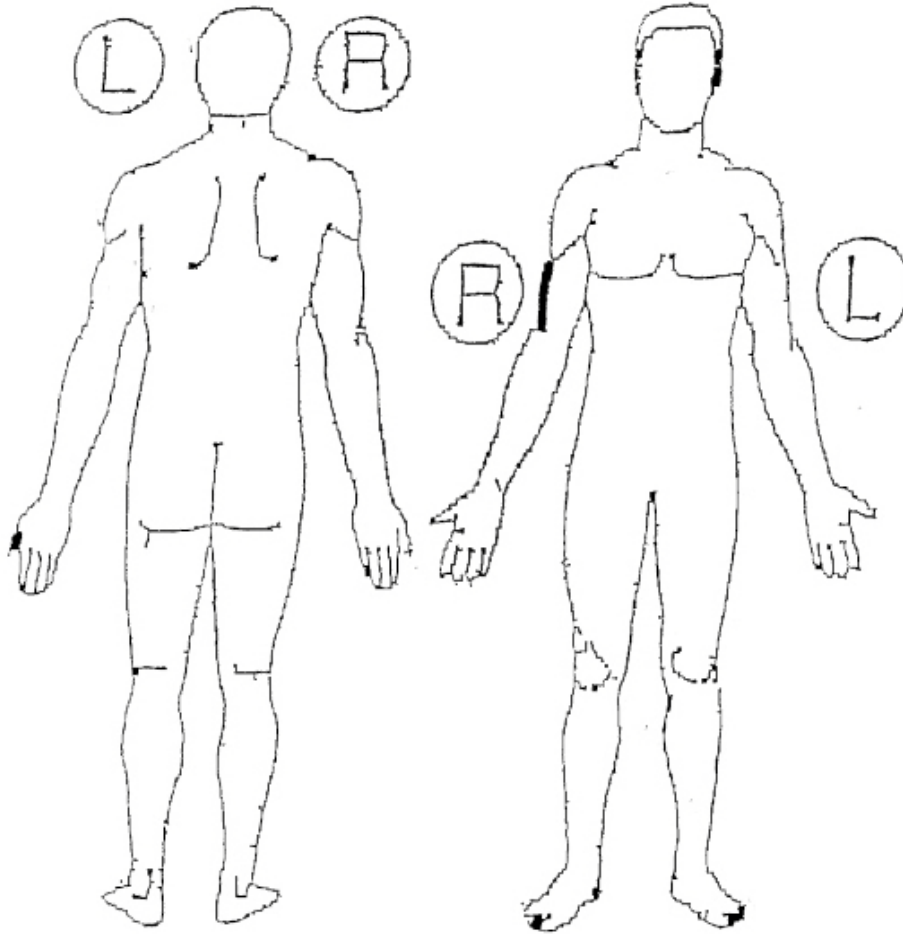
Y N Anxiety
Y N Depression
Y N Mood Changes
Y N Insomnia
Y N Suicidal Ideation
Y N Suicidal Planning
Y N Previous Suicide Attempts

Endocrine

Y N Cold Intolerance
Y N Heat Intolerance
Y N Libido Change
Y N Thyroid Problems

PAIN DIAGRAM

Please shade the areas on the diagrams where your pain is located.



Additional Comments: _____

Race/Ethnicity (please circle one):

- American Indian or Alaska Native
- Asian
- Black or African American
- More than one race
- Native Hawaiian
- Other Pacific Islander
- Refuse to report
- White

Ethnicity (please circle one):

- Hispanic or Latino
- Non-Hispanic or Latino
- Refuse to report

Marital Status (please circle one):

- Single
- Married
- Divorced
- Widowed
- Separated
- Refuse to report

Employment (please circle one):

- Full-time
- Part-time
- Not employed
- Self employed
- Retired
- Military Duty

If employed, employers name and address: _____

Student (please circle one):

- Full time
- Part time
- Not a student

Preferred Language (please circle one):

- English
- Spanish
- Other: _____