PMPA

PHYSICAL MEDICINE & PAIN ASSOCIATES

GETTING PEOPLE ACTIVE AGAIN

Christine Vidouria, D.O.

Board Certified Pain Management/Board Certified Rehabilitation Medicine/Fellowship Trained Interventional Pain Management

Name _____ DOB _____ SSN _____

Address _____ City _____

State _____ Zip Code _____ Telephone _____ Alternate # _____

Driver's License Number _____ Marital Status (circle) M S W D

Employer _____ Occupation _____

Work Phone # _____ Sex (circle) M / F Ethnicity /Race _____

Preferred Language _____ Emergency Contact _____

Phone Number _____ Relationship _____

INSURANCE INFORMATION

Primary Insurance _____ ID # _____ Group # _____

Policy Holder's Name _____ Relationship _____

SSN of Policy Holder if Different from above _____ DOB _____

Secondary Insurance _____ ID# _____ Group# _____

Referred by _____ Phone# _____

PrimaryDr _____ .Phone# _____

Medicare Assignment for Covered Services

I certify that the information given in applying for payment is correct and request payment of authorized benefits be made on my behalf.

Assignment of Insurance Benefits

I hereby authorize payment to Dr. Christine Vidouria for Medical Services. I represent that I have insurance coverage and do hereby authorize Dr. Christine Vidouria to release and obtain all information necessary to secure payment of said benefits. If my insurance fails to pay Dr, Christine Vidouria for any reason I agree to pay all unpaid balances

I have read and understood the medical products disclosure, Medicare assignments, and assignments of insurance benefits and agree to all terms stated.

PMPA

PHYSICAL MEDICINE & PAIN ASSOCIATES

GETTING PEOPLE ACTIVE AGAIN

Christine Vidouria, D.O.

Board Certified Pain Management/Board Certified Rehabilitation Medicine/Fellowship Trained Interventional Pain Management

In the next few weeks our office will be introducing a patient portal. You will be able to log in and view your records, request your medication , send us a message, and send a REQUEST to change or cancel your appointment. In the space below please provide the best email we can send a link with your username and temporary password.

Name _____

DOB_____

Email_____

PMPA

PHYSICAL MEDICINE & PAIN ASSOCIATES

GETTING PEOPLE ACTIVE AGAIN

Christine Vidouria, D.O.

Board Certified Pain Management/Board Certified Rehabilitation Medicine/Fellowship Trained Interventional Pain Management

REQUEST FOR RELEASE OF MEDICAL RECORDS

Date of Request:_____

I hereby authorize:_____

Phone #_____Fax # _____

To release all medical information in your possessions including: office records, consultations, progress notes, hospitalizations records, history & physical examinations, laboratory test, all imaging study reports, and pathology & operative reports from _____ to _____ regarding

Patient:_____ DOB:_____

The above information is to be release to Christine Vidouria, D.O. at the address listed below or faxed. Your prompt attention to this request will be appreciated, as it will allow the medical care of this patient to proceed without delay.

Patient's (Guardian's) Signature: _____

Street Address:_____

City, State, & Zip Code: _____

Witness Signature:_____ Date:_____

9502 Huebner Ste. 101 San Antonio, Tx 78240 P 210-767-2258 F 210-767-2259/210-267-8032 www.pmpatx.com

MEDICATION LIST

NAME:_____ DOB____/_____/_____

ALLERGIES:_____

MEDICATION	*WHAT IS THE DOSAGE?*	*HOW OFTEN DO I TAKE IT?*	*WHAT DO I USE IT FOR?*

PHARMACY NAME: _____ *ZIP CODE:* _____

*PHONE NUMBER:*_____

PMPA

PHYSICAL MEDICINE & PAIN ASSOCIATES

GETTING PEOPLE ACTIVE AGAIN

Christine Vidouria, D.O.

Board Certified Pain Management/Board Certified Rehabilitation Medicine/Fellowship Trained Interventional Pain Management

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, & HEALTH CARE OPERATION

I consent to the use or disclosure of my protected health information by Dr. Christine Vidouria for the purpose of analyzing, diagnosing, or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the office. I understand that analysis, diagnosis or treatment of me by the doctor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Dr. Christine Vidouria is not required to agree to the restrictions that I may request. However, if the office agrees to a restriction that I request, the restriction is binding I have the right to revoke this consent, in writing, at any time, except to the extent that the practice has taken action in reliance on the Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Dr. Christine Vidouria and understand that I have a right that Notice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the practice. The Notice of Privacy Practices also describes my rights and duties of the physician with respect to my protected health information.

Dr. Christine Vidouria reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Printed Name

_____ _____

Date Description of Personal Representative's Authority

NOTICE OF PRIVACY PRACTICES

Effective Date: _____

THIS NOTICE DESCRIBES HOW PERSONAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

We respect patient confidentiality and only release personal health information about you in accordance with the State and Federal Law. This notice describes out policies related to the use of the records of your care generated by Christine Vidouria, DO.

Privacy Contact. If you have any questions about this policy or your rights contact Christine Vidouria. DO

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In order to effectively provide you care, there are times when we will need to share your personal health information with others beyond Christine Vidouria, DO.

Treatment. With your permission we may use or disclose personal health information about you to provide, coordinate, or manage your care or any related services, including sharing information with others outside the Practice that we are consulting with or referring you to.

Payment. Information will be used to obtain payment for the treatment and services provided. This will include contacting your insurance company for prior approval of planned treatment or for billing purposes.

Healthcare Operations. We may use information about you to coordinate our business activities. This may include setting up your appointments, reviewing your care, training staff.

Information Disclosed Without Your Consent. Under State and federal law, information about you may be disclosed without your consent in the following circumstances:

Emergencies: Sufficient information may be shared to address the immediate emergency you are facing.

Follow Up Appointments/Care. We will be contacting you to remind you of future appointments or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

As Required by Law. This would include situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases or suspected abuse and neglect such as child abuse, elder abuse, or institutional abuse.

Coroners, Funeral Directors. We may disclose personal health information to a coroner or personal health examiner and funeral directors for the purposes

Governmental Requirements. We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations inspections and licensure. There also might be a need to share information with the Food and Drug Administration related to adverse events or product defects. We are also required to share information, if requested with the Department of Health and Human Services to determine our compliance with federal laws related to health care.

Criminal Activity or Danger to Others. If a crime is committed on our premises or against our personnel we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement and to warn any potential victims when we believe an immediate danger may exist to someone, or if we believe you present a danger to yourself.

Fundraising. As a not for profit provider of health care services we need assistance in raising money to carry out our mission. We may contact you to seek a donation.

PATIENT RIGHTS

You have the following rights under State and Federal Law

Copy of Record. You are entitled to inspect the personal health record Christine Vidouria, DO has generated about you. We may charge you a reasonable fee for copying and mailing your record.

Release of Records. You may ask us not to use or disclose part of the personal health information. This request must be in writing. Christine Vidouria, DO is not required to agree to your request if we believe it is in your best interest to permit use and disclosure of the information. The request should be given to the Program Director who will consult with the staff involved in your care to determine if the request can be granted.

Contacting You. You may request that we send information to another address or by alternative means. We will honor such request as long as it is reasonable and we are assured it is correct. We have a right to verify that the payment information you are providing is correct. Due to agency policy, we are not able to provide information by email.

Amending Record. If you believe that something in your record is incorrect or incomplete, you may request we amend it. To do this contact the Program Director and ask for the *Request to Amend Health Information* form. In certain cases, we may deny your request. If we deny your request for and amendment you have a right to file a statement you disagree with us. We will then file our response and your statement and our response will be added to your record.

Accounting for Disclousres. You may request a listing of any disclosures we have made related to your personal health information, except for information we used for treatment, payment, or health care operations purposes or that we shared with you your family, or information that you have us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years and after May 1, 2008, please submit your request in writing to our Privacy Officer. We will notify you of the cost involved in preparing this list.

Questions and Complaints. If you have an questions, or wish a copy of the Policy or have any complaints you may contact our Privacy Officer in writing at our office further information. You also may complain to the Secretary of Health and Human Services if you believe Christine Vidouria, DO has violated your privacy rights. We will not retaliate against you for filing a complaint.

Changes in Policy. Chrisitine Vidouria, DO reserves the right to change its Privacy Policy based on the needs of Christine Vidouria, DO and changes in state and federal law.

MEDICAL HISTORY/ REVIEW OF SYSTEMS

Name: _____ Date of Birth: ____/____/_____

Information on this page will help your doctor understand your medical problems. Please check the symptoms that you are experiencing:

☐ Weight Gain	☐ Trouble Reading	☐ Bloating	☐ Falls
☐ Weight loss	☐ Trouble Hearing	☐ Frequent urination	☐ Twitching
☐ Fatigue	☐ Ringing in ears	☐ Impotence	☐ Back Pain
☐ Trouble Sleeping	☐ Vertigo	☐ Loss of stool	☐ Leg Pain
☐ Sleepiness	☐ Dry Mouth	☐ Headache	☐ Arm Pain
☐ Fever	☐ Trouble Swallowing	☐ Passing Out	☐ Neck Pain
☐ Forgetfulness	☐ Trouble Chewing	☐ Weakness	☐ Stiffness
☐ Confusion	☐ Nausea	☐ Numbness	☐ Sad
☐ Dizziness	☐ Vomiting	☐ Tingling	☐ Anxious
☐ Double vision	☐ Diarrhea	☐ Shaking	☐ Nervous
☐ Blurry Vision	☐ Constipation	☐ Poor Balance	☐ Other: _____

Please indicate whether you have any of the conditions noted below:

Wearing glasses	☐ Yes ☐ No	Stomach ulcers	☐ Yes ☐ No
Ear/nose problems	☐ Yes ☐ No	Liver problems	☐ Yes ☐ No
Thyroid disease	☐ Yes ☐ No	Kidney problems	☐ Yes ☐ No
Diabetes	☐ N/A ☐ Type 1 ☐ Type 2	Arthritis	☐ Yes ☐ No
Heart valve problems	☐ Yes ☐ No	Back trouble	☐ Yes ☐ No
Heart rhythm problems	☐ Yes ☐ No	Rash	☐ Yes ☐ No
Heart attack/chest pain	☐ Yes ☐ No	Breathing problems	☐ Yes ☐ No
Poor circulation	☐ Yes ☐ No	Mental disease	☐ Yes ☐ No
Drug/alcohol abuse	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	If yes, what type: _____	

Allergies:

_____

_____

List any other medical illnesses not mentioned in the previous page:

_____

_____

List any surgeries you have had:

_____

_____

Do you smoke: ☐ No ☐ Yes: How many packs per day: _____ How many years: _____

Do you drink alcohol ☐ No ☐ Yes What kind: _____ How much a week: _____

Did you used to drink more heavily in the past: ☐ No ☐ Yes

Do you use drugs: ☐ No ☐ Yes

Assistive Devices: ☐ Wheelchair ☐ Walker ☐ Cane ☐ AFO ☐ Prosthetic ☐ Other

Family History:	Age(s) at death	Cause(s) of Death	Medical Problems
Mother	_____	_____	_____
Father	_____	_____	_____
Sister(s)/Brother(s)	_____	_____	_____

The above medical history/review of systems has be reviewed with the patient and/or family.

_____ _____

Physician Signature Date

PMPA
PHYSICAL MEDICINE & PAIN ASSOCIATES
GETTING PEOPLE ACTIVE AGAIN

Christine Vidouria, D.O.

Board Certified Pain Management/Board Certified Rehabilitation Medicine/Fellowship Trained Interventional Pain Management

Pain Diagram And Pain Rating Form

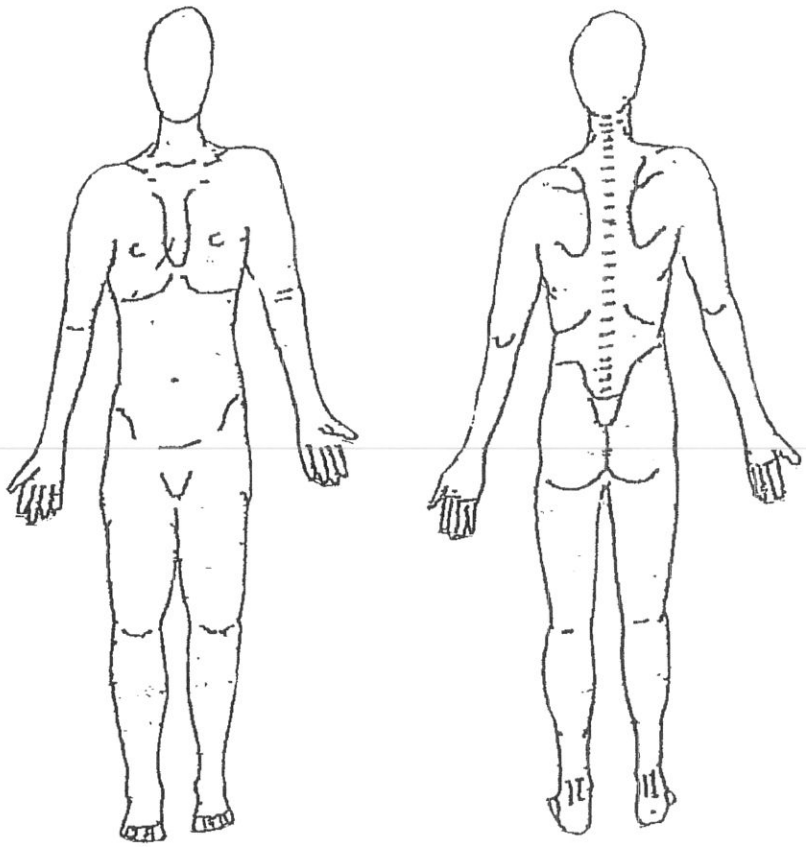
Name:_____ Today's Date:_____

ROOM # [ ]
(for office staff use only)

Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours. Use the key to indicate the type of symptoms.

KEY: OOOOO = Numbing and or tingling • /////// = Stabbing • XXXXX = Burning • ZZZZZ = Deep Ache

Blood Pressure: _____
Pulse: _____
Temp: _____
Pulse Ox: _____
Height: _____
Weight: _____
Beck Score: _____



Please rate your current level of pain on a scale of 0 to 10. *Please circle your answer.*
The number 0 being no pain and the number 10 being the worst imaginable pain.

1. Please rate your CURRENT level of pain
   0 1 2 3 4 5 6 7 8 9 10
2. Please rate your worst level of pain in the last 24 hours
   0 1 2 3 4 5 6 7 8 9 10
3. Please rate your best level of pain in the last 24 hours
   0 1 2 3 4 5 6 7 8 9 10

7950 Floyd Curl • Suite 801 • Tower 1 • San Antonio, TX 78229 • (O) 210-767-2258/210-615-9000 • (F) 210-767-2259 • WWW.PMPATX.COM

PMPA
PHYSICAL MEDICINE & PAIN ASSOCIATES
GETTING PEOPLE ACTIVE AGAIN
Christine Vidouria, D.O.
Board Certified Pain Management/Board Certified Rehabilitation Medicine/Fellowship Trained Interventional Pain Management

Pain Diagram And Pain Rating Form (continued)

Patient Name:_____ Today's Date:_____

0	☐ I do NOT feel sad	0	☐ I don't feel I am worse than anybody else
1	☐ I feel sad	1	☐ I am critical of myself for my weakness or mistakes
2	☐ I am sad all the time and I can not snap out of it	2	☐ I blame myself all the time for my faults
3	☐ I am so sad or unhappy that I can not stand it	3	☐ I I blame myself for everything bad that happens
0	☐ I am not particularly discouraged about the future	0	☐ I do not have any thoughts of killing myself
1	☐ I feel discouraged about the future	1	☐ I have thoughts of killing myself, but would not carry them out
2	☐ I feel I have nothing to look forward to	2	☐ I would like to kill myself
3	☐ I feel that the future is hopeless and that things can not improve	3	☐ I would like to kill myself if I had the chance
0	☐ I do not feel like a failure	0	☐ I do not cry more than usual
1	☐ I feel I have failed more than the average person	1	☐ I cry more now than I used to
2	☐ as I look back on my life, all I can see is a lot of failure	2	☐ I cry all the time now
3	☐ I feel I am a complete failure as a person	3	☐ I used to be able to cry, but now I can't cry even though I want to
0	☐ I get as much satisfaction out of things as I used to	0	☐ I am no more irritated by things than I ever am
1	☐ I do not enjoy things the way I used to	1	☐ I am slightly more irritated now than usual
2	☐ I do not get any real satisfaction out of anything anymore	2	☐ I am quite annoyed or irritated a good deal of the time
3	☐ I am dissatisfied or bored with everything	3	☐ I feel irritated all the time now
0	☐ I do NOT feel particularly guilty	0	☐ I have not lost interest in other people
1	☐ I feel guilty a good part of the time	1	☐ I am less interested in other people than I used to be
2	☐ I feel guilty most of the time	2	☐ I have lost most of my interest in other people
3	☐ I feel guilty all of the time	3	☐ I have lost all my interest in other people
0	☐ I do not feel I am being punished	0	☐ I make decisions about as well as I ever could
1	☐ I feel I may be punished	1	☐ I I put off making decisions more than I used to
2	☐ I expect to be punished	2	☐ I have greater difficulty in making decisions than before
3	☐ I feel I am being punished	3	☐ I can not make decisions at all anymore
0	☐ I do not feel disappointed in myself	0	☐ I do not feel that I look any worse than I used to
1	☐ I am disappointed in myself	1	☐ I am worried that I am looking old or unattractive
2	☐ I am disgusted with myself	2	☐ I feel that there are permanent changes in my appearance that make me look unattractive
3	☐ I hate myself	3	☐ I believe that I look ugly

PMPA
PHYSICAL MEDICINE & PAIN ASSOCIATES
GETTING PEOPLE ACTIVE AGAIN

Christine Vidouria, D.O.

Board Certified Pain Management/Board Certified Rehabilitation Medicine/Fellowship Trained Interventional Pain Management

Pain Diagram And Pain Rating Form (continued)

Patient Name: _____ Today's Date: _____

0	☐ I can work about as well as before	0	☐ I have not lost much weight, if any, lately
1	☐ It takes an extra effort to get started at doing something	1	☐ I have lost more than five pounds
2	☐ I have to push myself very hard to do anything	2	☐ I have lost more than ten pounds
3	☐ I can not do any work at all	3	☐ I have lost more than fifteen pounds (score 0 if you have purposely are trying to loose weight
0	☐ I can sleep as well as usual	0	☐ I am no more worried about my health than usual
1	☐ I do not sleep as well as I used to	1	☐ I am worried about physical problems such as: aches pains, constipation, or upset stomach
2	☐ I wake up 1-2 hours earlier than usual and find it hard to get back to sleep	2	☐ I am very worried about physical problems, and it's hard to think of much else
3	☐ I wake up several hours earlier than I used to and can not get back to sleep	3	☐ I am so worried about my physical problems that I can not think about anything else
0	☐ I do not get more tired than usual	0	☐ I have not noticed any recent changes in my interest in sex
1	☐ I get tired more easily than I used to	1	☐ I am less interested in sex than I used to be
2	☐ I get tired from doing almost anything	2	☐ I am much less interested in sex now
3	☐ I am too tired to do anything	3	☐ I have I lost interest in sex completely
0	☐ My appetite is no worse than usual		
1	☐ My appetite is not as good as it used to be		
2	☐ My appetite is much worse now		
3	☐ I have no appetite at all anymore		

7950 Floyd Curl • Suite 801 • Tower 1 • San Antonio, TX 78220 • (O) 210-767-2259 / 210-615-9000 • (F) 210-767-2259 • WWW.PMPATX.COM