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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.

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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_____

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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:*_____

Fall Prevention Balance and Dizziness Survey

Patient Name: _____ **Age:** _____ **Date:** _____

To help determine if you may be headed for a fall or have a balance disorder, take the Balance Self Test belo If you answer yes to one or more of the questions, you could be at risk. The best way to determine if you hav problem is to share with the doctor any fears or concerns you have regarding falling, dizziness or vertigo, so that he or she may help determine the cause of your symptoms.

Please read each question and check the box that most describes your answer.	Yes or Often	Some-times	No Nev
1. Do you ever lose your balance or feel dizzy or unsteady?			
2. Have you continued to experience dizziness after an injury or accident?			
3. Do you feel unsteady when you are walking or climbing stairs?			
4. Do you feel dizzy while sitting down or rising from a seated or lying position?			
5. Does walking down the isle of a supermarket or stopping next to moving traffic make you dizzy?			
6. Does moving your head quickly make you dizzy or cause you to feel nauseous?			
7. Are you dizzy or unsteady when you first get up in the morning?			
8. Do you ever fall or feel like you are about to fall for no apparent reason?			
9. Do you use a walker, cane, or any other form of assistance for your mobility?			
10. Have you had a recent loss of, or decrease in, your vision or hearing?			
11. Do you fear falling?			
12. Have you experienced dizziness, vertigo, or serious imbalance in the past six months?			
13. Has your balance problem caused problems in your social life?			
14. Have you fallen more than once in the past year without an obvious cause?			
15. Does dizziness or imbalance interfere with your job or your household responsibilities?			

Please fill out the top with your name and date, sign the survey at the bottom and provide this to your physician during your visit.

_____ Patient Signature

_____ Phone

Patient Survey

Name:_____ Age: _____

Phone:_____ Cell:_____ _____ Email:_____

Insurance Type (Circle One): Medicare; Medicaid; Worker's Compensation; Cash; Commercial.

If "Commercial", please specify the name of your insurance Carrier: _____

Check and/or Circle any of the following conditions you are currently experiencing:

☐ Scarification / Wound Care
☐ Low Back Pain
☐ Neck Pain
☐ Headaches
☐ Joint Pain _____

Which Joint?_____

☐ Tendonitis
☐ Epicondylitis
☐ Fibromyalgia
☐ Post-Herpetic Neuralgia
☐ Plantar Fasciitis
☐ Post Laminectomy Pain

☐ Post-Operative Wound (problem with scarring)
☐ Numbness / Tingling in Arm or Hand
☐ Numbness / Tingling in Legs or Feet (Right or Left)
☐ Pain in the Arm / Hand / Leg / Feet (Right or Left)
☐ Tense Muscles _____

Which Muscles?_____

☐ Bursitis
☐ Osteoarthritis
☐ Diabetic Neuropathy
☐ General Neuropathy
☐ Myofascial Pain / RSD / CRPS
☐ Chemo-Induced Neuropathy

Please answer the following about the above conditions:

Which of the above conditions is the worst? _____

On a scale of 1 to 10, how would you rate the pain? _____

[1 = minimal pain and 10 = severe pain]

How long have you been suffering with this condition? _____

How is this condition affecting your ability to perform daily tasks? _____

_____

Would you like to get rid of or reduce this problem? ☐ Yes ☐ No

Have you tried medications that have not helped? ☐ Yes ☐ No

If yes, what have you tried? ☐ Oral ☐ Injectable ☐ Over-the-Counter ☐ Prescription

I authorize the release of this Patient Survey for use in research and understand that I can revoke this granted permission at any time.

☐ If it were available, I would be interested in receiving a new and alternative non-addictive medication protocol.

_____
Patient Signature

For Physician Office Use Only: (Patients Please Do Not Enter Any Information Below)

Today's Date: ____/____/____ Circle One: Male Female DOB: ____/____/____

ICD-10 Classification:_____ Patient Email: _____

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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.

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MEDICATION MAINTENANCE FOR CHRONIC PAIN

CONTRACT & RULES

The following agreement concerns my use of opioids and other medications for chronic pain prescribed by a physician from Physical Medicine & Pain Associates. I agree to follow the rules listed below:

1. I will only take pain medications as prescribed by my physician at Physical Medicine & Pain Associates. I will not take more than the amount directed on the bottle without contacting the office and getting approval for the change in dose.
2. I agree to receive pain medications **only** from a Physical Medicine & Pain Associates physician. If I receive these medications from any other physician without express consent from a physician with Physical Medicine & Pain associates, my pain treatment will be stopped and the medications discontinued. If this occurs, I will agree to release Physical Medicine & Pain Associates as my pain management physicians and I will find another doctor to care for me. I also agree to supply this group with the names of other doctors who are treating me.
3. Refills will be made at the time of a scheduled appointment or by calling for a refill no later than 3 days before running out of the medication. Refills will not be made after 4:00 p.m. Monday through Thursday, on Fridays, on weekends, or when the office is closed.
4. Physical Medicine & Pain Associates will not replace lost, stolen, damages, defective or missing prescriptions.
5. I will select one pharmacy to fill my medications and U will inform Physical Medicine & Pain Associates of any change. The pharmacist letter (copy attached) will be explained and compliance is mandatory.
6. I understand that combining other medications with those prescribed may cause drowsiness, intoxication, or death. Some of the medications that can cause problems are tranquilizers (downers), stimulants (uppers), diet pills, sleeping pills, alcohol, and street drugs.
7. I understand that if I use more medications than prescribed, sell or let other people use them, collect them or obtain/use other medication not authorized by Physical Medicine & Pain Associates that this is reason for dismissal from the care of Physical Medicine & Pain Associates, and that a referral to an addiction treatment center could be recommended.

8. I understand that I must be seen by a Physical Medicine & Pain Associates physician at regular intervals of every three months or less. Refills will not be made if I do not keep scheduled appointments. My response to medication therapy will be evaluated at that time.
9. I understand that psychological consultation or evaluation may be recommended during my treatment. This would be to help solve the difficult psychological problems associated with chronic pain.
10. I understand that I may require laboratory studies including liver functions and/or drug blood levels and/or urine drug screen that could be needed and ordered during my treatment.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

_____ _____

Physician Signature Date

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Phone 210-767-2258

9502 Huebner Ste. 101

San Antonio, Tx 78240

Fax 210-767-2259

210-267-8032

Patient Name: _____ Date:_____

Please initial each section after reading

PRESCRIPTIONS:

- Prescription hours are Monday through Thursday, 9 a.m. to 4 p.m.
- Please note that you MUST give 72-hour notice for any prescription refills
- No medications will be filled Fridays.
- For all other prescriptions, please have your pharmacy fax a prescription refill request to our office or receive your prescription refill at the time of your office visit.

Initials: _____

REQUESTS FOR FORM/LETTERS:

- For any letters of medical necessity, please allow 7 to 10 days.
- For any forms needing to be completed, please allow 7 to 10 days.

Initials: _____

OFFICE CO-PAYS:

- Please remember that you will not be seen without your required co-pay, which must be paid at the time you check in. We accept checks, cash, and credit cards.

Initials: _____

QUESTIONS OR CONCERNS:

- Please be patient with us during clinic hours. One of the medical assistants will return your call as soon as possible. Please direct any questions when calling.

Initials: _____

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