Consent for Treatment | Assignment of Benefits

Patient Name: **Provider Name: Michael E Tschickardt, MD**
Date of Birth: **Date of Service:**

The undersigned, being the patient and/or guaranteeing party to the above named account, hereby acknowledges and agrees to the following:

I. CONSENT FOR TREATMENT: I hereby consent to the evaluation and management services provided by Dr. Tschickardt of Coastal Bend Pain Management and within this facility. Services may include diagnostic radiology and possibly surgical procedures. I understand that my consent may be revoked, in writing, at any time. However, such revocation does not release any financial obligation for services already rendered.

Signature: _____ **Date:** _____

II. AUTHORIZATION TO RELEASE/OBTAIN INFORMATION: The undersigned hereby authorizes Dr. Tschickardt of Coastal Bend Pain Management to release to any insurance carrier represented as contractually responsible for payment in whole or in part of the patient's health care bill, such information as is deemed minimally necessary for the proper and accurate processing of such healthcare claims. Further, the undersigned releases Dr. Tschickardt of Coastal Bend Pain Management to provide to outside healthcare providers/services such information as is necessary to facilitate proper healthcare, limited only to that which is deemed minimally necessary to execute referrals, etc. on behalf of the patient. In addition, by copy of this document the patient consents to the release of prior medical records from referring physicians, hospitals, nurses or other entities, which have records necessary for proper evaluation and treatment of the patient.

III. STATEMENT OF FINANCIAL RESPONSIBILITY: In consideration of medical treatment and service provided to the above-named patient, the patient or the undersigned guarantor unconditionally guarantees payment in full to Dr. Tschickardt of Coastal Bend Pain Management. Coastal Bend Pain Management agrees to abide by the terms and conditions set forth in individual managed care contracts with which the patient and physician both participate. Patients covered by insurance that do not have a managed care contract with Dr. Tschickardt of Coastal Bend Pain Management understand that Coastal Bend Pain Management will submit claims for processing. However, the patient/guarantor is ultimately responsible for payment of the entire account balance regardless of insurance coverage on insurance benefit determination. Should an insurance carrier not pay on a claim within the mandatory 45-day state limit, the balance due will be the responsibility of the patient/guarantor. All co-pays are due at the time of service. The patient/guarantor understands he/she is responsible for providing accurate and complete billing information.

IV. ASSIGNMENT OF INSURANCE BENEFITS: The undersigned hereby authorizes any insurance carrier represented as contractually responsible for payment in whole or in part of the patient's healthcare bill, including Personal injury Protection or Medical Payment coverage, to pay directly to Dr. Tschickardt of Coastal Bend Pain Management proceeds and benefits payable to me. Additionally, I agree that any payments shall be applied toward any settlement or judgment I receive under any auto liability or uninsured/underinsured motorists coverage provided by Medical Payments coverage. I acknowledge and accept the terms and conditions set forth in Sections III and IV of this policy statement:

Signature: _____ **Date:** _____

Relationship to Patient if other than self: ☐**Spouse** ☐**Parent** ☐**Guardian**

HIPAA | Notice of Privacy Practices Acknowledgement

Patient Name: **Provider Name: Michael E Tschickardt, MD**
Date of Birth: **Date of Service:**

I acknowledge that Coastal Bend Pain Management provided me with a written copy of his/her Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, pharmacy benefits and health care operations.

Signature: _____ **Date:** _____

If this consent is signed on behalf of the patient, by a personal representative, please complete the following:

_____	_____	_____
Legally Authorized Representative Signature	*Relationship to Patient*	*Date*

Consent | Patient Portal

Why call when you can click? Use our new online…

Patient Name: **Provider Name: Michael E Tschickardt, MD**
Date of Birth: **Date of Service:**

The Patient Portal is a web-based system that is your secure communication link with our office. When you log in to the Patient Portal with your private user name and password, you can:

- Request a medication refill
- View and Request appointments
- Use the messaging feature to contact us
- View your ledger and statement
- Update your contact information
- View your medical record, and print or save an electronic copy of your Clinical Summary

Patient Portal Consent Form

The patient portal is a secure way to access your medical records including medications, lab results, and medical history through the internet. You can also communicate with our office via secure messaging to ask questions, provide information, request appointments, and request medication refills.

Please read the following policy carefully:

- We are offering the patient portal as a convenience to you at no cost. We will not sell or give away any private information, including email addresses.
- The portal is for **non-emergency** uses only. We will reply to your request/inquiry within two (2) business days. Please note: the portal is not checked or updated on weekends.
- We are not allowed to refill narcotics or other controlled medications through the internet portal.
- If you do not receive a timely email reply from us, please check your Junk or Spam email folder as messages are sometimes redirected into those folders.

By using this online patient portal, you agree to protect your password from any unauthorized individuals. It is your responsibility to notify us should your password be stolen. You agree to not hold Coastal Bend Pain Management responsible for any network infractions beyond our control.

Patient Portal Information:

Email Address:	
User Name:	
Temporary Password:	

After we create your account, visit www.coastalbendpain.com and click on "Patient Portal" to log in.

Signature: _____ **Date:** _____

If this consent is signed on behalf of the patient, by a personal representative, please complete the following:

_____ _____ _____

Legally Authorized Representative Signature *Relationship to Patient* *Date*

Consent | Release of Information to Family Members

Patient Name: **Provider Name: Michael E Tschickardt, MD**
Date of Birth: **Date of Service:**

Many patients allow family member(s) such as their spouse, parents, and caretakers, etc. to call on patient's behalf and request medical or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without a patient's written consent. If you wish to have your medical or billing information released to family members, you must sign this form. Information will only be discussed and or released to family members or individuals indicated below.

I authorize Coastal Bend Pain Management medical providers and personnel to disclose protected health information to the following:

1. _____ Relation to Patient: _____ Phone: _____
2. _____ Relation to Patient: _____ Phone: _____

I understand that certain information cannot be released without specific authorization as required by state or federal law. By initialing the lines below, I authorize the release of the following protected or sensitive information

____ **All health & billing information**
____ Physicians Orders
____ Billing and Insurance Information
____ Past/Present Medications
____Diagnostic Test Reports
____Radiology Reports & Images
____Lab Results
____**Other:** _____

Effective Period: This authorization shall be in force and in effect from **_____ until _____** at which time this authorization to use or disclose this protected health information expires. Unless specified above, this authorization will expire **365** days from the date of signing.

Right to Revoke: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named listed above. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

Signature Authorization: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Patient Name:	**Patient Signature:**	**Date:**
Legally Authorized Representative Name	*Legally Authorized Representative Signature*	*Date*

Demographics | Patient Information | Initial

Patient Name: **Provider Name: Michael E Tschickardt, MD**
Date of Birth: **Date of Service:**

SSN: _____-_____-_____ Gender: ☐M ☐ F Dominant Hand: ☐Right ☐Left
Race: _____ Ethnicity: _____ Language Spoken: _____
Address: _____
Cell Phone: _____ Home Phone: _____ Work Phone: _____
Email Address: _____
What is your preferred method of contact? ☐Cell Phone ☐ Home Phone ☐ Work Phone ☐ Email
Is it okay to leave a detailed message? ☐Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Disabled ☐ Home-maker/other
Place of Employment: _____ Employer Address: _____
Job Position: _____
Student: ☐ Full-Time ☐ Part-Time School Attending: _____

Pharmacy: _____ Address & Phone: _____
Primary Care Physician: _____ Other Treating Physician: _____
Who can we thank you referring you? _____

Spouse Name: _____ Phone Number: _____
Emergency Contact: _____ Phone: _____ Relationship: _____
Please advise if OK to release or discuss medical issues with your emergency contact: ☐ Yes ☐ No

***Please indicate if you have ever had a Spinal Cord Stimulator or Pain Pump implanted:** _____
Have you had any Imaging done in the Past or Recently? (MRI, X-Ray, CT) If so, where? _____

Is this a Work Related Injury? ☐ Yes ☐ No If yes, please provide DOI and adjuster contact: _____
Is this a Motor Vehicle accident injury? ☐ Yes ☐ No If yes, please provide date of accident: _____

Insurance Coverage Information

If you are NOT the insured, please fill out the requested information below.

Primary Insurance:
Insurance Co Name: _____ Phone: _____
Member ID: _____ Group ID: _____
Name of Insured: _____ Relation to Patient: _____
Insured's SSN: _____ Insured's DOB: _____

Secondary Insurance:
Insurance Co Name: _____ Phone: _____
Member ID: _____ Group ID: _____
Name of Insured: _____ Relation to Patient: _____
Insured's SSN: _____ Insured's DOB: _____

Patient Signature: _____ Date: _____

(Patient/Guardian if patient is a minor): _____

Patient Name:
Date of Birth:

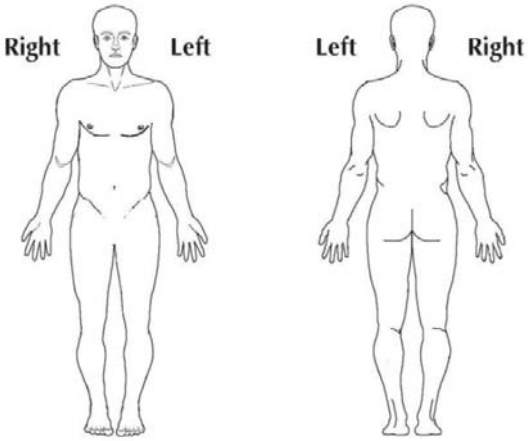
Provider Name: Michael E Tschickardt, MD
Date of Service:

CLINICAL: BRIEF PAIN INVENTORY

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other that these everyday kinds of pain today?

☐ Yes ☐ No

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3) Please rate your pain by circling the one number that best describes your pain at its WORST in the last 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its LEAST in the last 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

7) What treatments or medications are you receiving for your pain?

_____

_____

8) In the last 24 hours, how much relief have pain treatments or medication provided? Please circle the one percentage that shows how much RELIEF you have received.

0%	10	20	30	40	50	60	70	80	90	100%
No relief										Complete relief

9) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General Activity

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

B. Mood

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

C. Walking ability

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

D. Normal work (includes both work outside the home and housework)

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

E. Relations with other people

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

F. Sleep

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

G. Enjoyment of life

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

Brief Pain Inventory (Short Form). Source: Pain Research Group, Department of Neuro-Oncology, The University of Texas MD Anderson Cancer Center.
Used with Permission. Adapted to single page format.

Patient Name:
Date of Birth:

Provider Name: Michael E Tschickardt, MD
Date of Service:

In addition to completing the Brief Pain Inventory, to help your doctor better manage your pain, please tell us:

What does the pain feel like? Circle those words that describe your pain.

aching	throbbing	shooting
stabbing	gnawing	pricking
sharp	tender	burning
exhausting	tiring	penetrating
nagging	numb	miserable
unbearable	dull	radiating
squeezing	cramping	deep

How long have you had this pain? (Circle one)

less than a week	1 to 2 weeks
2 to 4 weeks	more than a month

What kinds of things make your pain feel better (for example, heat, medicine, rest)?

_____

_____

What does the pain feel like? Circle those words that describe your pain.

_____

_____

What does the pain feel like? Circle those words that describe your pain.

nausea	vomiting
constipation	diarrhea
lack of appetite	indigestion
difficulty sleeping	feeling drowsy
nightmares	dizziness
tiredness	itching
urinary problems	sweating
weakness	headaches

Talking About Your Pain

It's important to remember that each person's pain is different. The pain that you experience can't be compared to another person's pain. ONLY YOU know how and when you hurt, and how the pain affects your life.

It is important to describe what you are feeling to those who are trained to help you. Don't be embarrassed to talk to your doctor, nurse, or pharmacist. They need to know as much as possible about your pain in order to develop the best plan to control it. The questions on this form can help you describe your pain.

Why Is Pain Relief So Important?

Proper treatment for pain is not only a matter of comfort. Unrelieved pain can lead to nausea, loss of sleep, depression, loss of appetite, weakness, and other problems. Pain can also affect your life at home and at work. Relieving your pain means that you can continue to do the day-to-day things that are important to you.

Most Pain Can Be Controlled

It is important to know that most pain CAN be relieved. Your doctor will work with you to find the treatment that may be best for your pain.

The key to effective pain control is to take the RIGHT AMOUNT, of the RIGHT MEDICINE, at the RIGHT TIME. You should take your pain medicine on a regular schedule, as your doctor, nurse, or pharmacist tells you. Don't wait until the pain becomes severe. Pain is easier to control when it is mild when it is mild than when it has reached full force.

If your pain medicine wears off too soon, is not relieving the pain, or causes problems with side effects, you should call you doctor because you may need to have your treatment plan changed.

Comments: Write down any questions or information you need to share with your doctor, nurse, or pharmacist about your pain.

_____

_____

_____

_____

_____