Noor Gajraj, M.D., F.R.C.A., D.A.B.P.M.
Office 972 612 3800 Fax 972 612 3811

Patient Information

Patient Name_____ SSN_____-_____-_____ DOB_____

Address_____ City_____ St._____ Zip_____

Home #_____ Cell #_____ Pharmacy #_____

Email_____ Married? Yes ( ) No ( )

Patient Employment

Employer_____ Occupation_____ Phone #_____

Address_____ City_____ St._____ Zip_____

Emergency Contacts

Name_____ Relationship_____ Contact #_____

►Referring Physician_____ Office #_____

►Primary Care Physician_____ Office #_____

Insurance Information

►Primary Insurance_____ PPO HMO EPO Other: _____

Policy #_____ Group#_____ Guarantor_____

Guarantor's Date of Birth:_____

►Secondary Insurance_____ PPO HMO EPO Other: _____

Policy #_____ Group#_____ Guarantor_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize all insurances, healthcare & other benefits, proceeds, and other monies payable to the Patient of for the Patient's benefit for services and/or supplies provided, including but not limited to liability settlements, group medical, indemnity, self-insured, ERISA, COBRA, personal injury protection, uninsured motorist, underinsured motorist, liability, automobile, and/or homeowner insurance benefits and coverage and I direct all such entities to make checks jointly payable to the beneficiary or covered person and to mail payment to the covered person in care of Noor Gajraj, M.D. and I authorize Noor Gajraj, M.D. to open such correspondence. I agree, as part of this consent for payment operations, that the provider, its group, and their billing personnel, billing agents, or management company can disclose billing information to any person that calls the provider with billing questions after the provider inquires as to the identity of the calling person and the calling person provides my correct social security number or health plan number

I understand that I am fully financially responsible for any and all charges incurred for the above named Patient by Noor Gajraj, M.D. I understand that I am responsible for all charges whether or not paid by insurance. I further acknowledge that I am responsible for any financial charges even if there is no recovery from person(s) responsible for the condition. This assignment authorizes but does not obligate Noor Gajraj, M.D. to file or prosecute suits or insurance claims or appeals.

I have read the above and understand it. In exchange for and in consideration of treatment provided to the Patient, I agree to the above terms and conditions.

Patient or Responsible Party Signature_____ Date_____

Date:_____ Name:_____ Age: _____

1. What part of your body hurts? _____

2. For how long have you had pain?_____

3. Did the pain start with an injury? Yes ( ): No ( ) If yes, explain _____

4. Have you had any surgery for your pain condition? Yes ( ): No ( ) If yes, explain_____

_____

5. When is the pain the worst? Morning Afternoon Night

6. Is your pain constant ? Yes ( ) No ( )

7. Circle the best descriptions of your pain: Burning Aching Sharp Stabbing Shooting Throbbing

8. What activity makes the pain worse? Standing Sitting Walking Bending Lying down

9. What activity makes your pain better ? _____

10. Grade your pain from 0 to 10 *(zero= no pain / 10 = worst pain imaginable)*: _____

11. Have you had any of these treatments (circle): Physical therapy / Epidural steroid injections / Facet blocks / Trigger point injections, chiropractic treatments, other_____

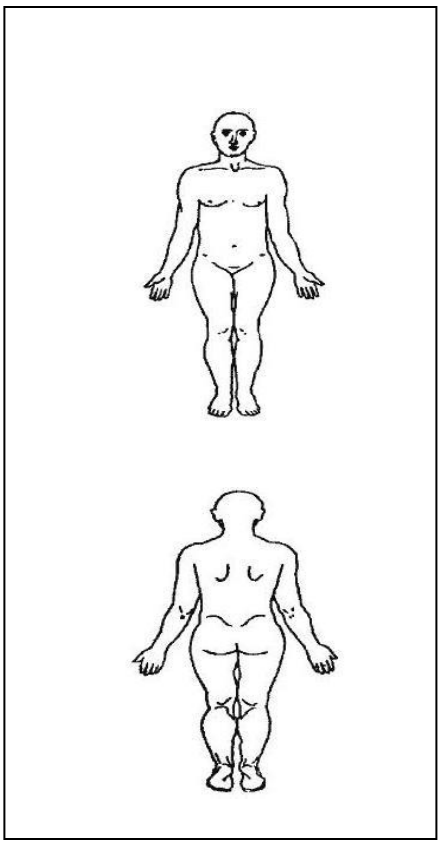
12. Are you involved in any lawsuits concerning your case? Y ( ) N ( )

13. Have you ever had psychological/psychiatric counseling? Y ( ) N ( )

14. Please list all other physicians who are involved in your care_____

_____

Mark the location of your pain on the diagrams to the right, ▶



Please list all your medical conditions:

_____

._____

._____

_____

_____

Do you have any allergies to any medications? Yes ( ) No ( )

If yes, what are your allergies?_____

Please list all Major surgeries: **Date:**

1._____ _____

2._____ _____

3._____ _____

4._____ _____

5._____ _____

CURRENT Medications and their Doses: **Frequency:**

1._____ _____

2._____ _____

3._____ _____

4._____ _____

5._____ _____

6._____ _____

7._____ _____

8._____ _____

9._____ _____

10_____ _____

Previous Medications used: (Please circle)

Oxycontin, Morphine, Methadone, Fentanyl patch (Duragesic), Opana, Nucynta, Exalgo
Dilaudid , Percocet, Percodan, Hydrocodone, Tylenol # 3, Ultram, Ultracet, Lortab, Lorcet , Vicodin
Norco Oxycodone, Suboxone, Butrans patch

Have you had any problems with over use or abuse with any of the prescription drugs as listed above? Y ( ) No ( )

Social History:

Married ( ) Single ( ) Divorced ( ) Separated ( ) Widowed ( )
Number of children_____
Are you currently employed? Yes ( ) No ( ) Occupation_____
Do you collect social security disability or work related disability? Yes ( ) No ( )_____
Do you Smoke? Yes ( ) N ( ) If yes, how much do you smoke?_____
Do you drink alcohol? Yes ( ) N ( ) If yes how many drinks per _____day _____week or _____month
Have you been through drug or alcohol rehab? Yes ( ) No ( )
Have you experienced any childhood abuse Yes ( ) No ( )
Have you ever overused pain medications? Yes ( ) No ( )
Do you have ever taken any of the following? Yes ( ) No ( ) If yes then circle: Marijuana, Cocaine Heroin, Methamphetamine, Amphetamines, PCP, Ectascy Crack

Family History:

Mother's medical history:
Living or Deceased
Age_____ If deceased, cause of death_____
List mother's medical problems:_____

Father's medical history:
Living or Deceased
Age_____ If deceased, cause of death,
List father's medical problems:_____

Are there any family members with a history of acoholism? Y/ N If yes, who_____
Are there any family members with a history of drug abuse? Y/ N If yes, who_____

Do you currently suffer from any of these problems? (Please circle)

1. **General:** Weight loss Fever Chills Weakness Fatigue
2. **Eyes, Ears and throat:** Double vision Blurred vision Hearing loss
   Sneezing Runny nose Sore throat.
3. **Skin:** Rash Itching
4. **Psychiatric:** Anxiety Depression Thoughts of suicide
5. **Neurologic:** Headache Dizziness Tremors Vertigo Numbness
   Change in bowel or bladder control
6. **Cardiovascular:** Chest pain Chest pressure Palpitations Swelling of legs
7. **Respiratory :** Cough Shortness of breath Wheeze
8. **Gastrointestinal:** Abdominal pain Constipation Diarrhea Nausea Vomiting
9. **Genitourinary:** Burning on urination
10. **Musculoskeletal:** Muscle pain Joint pain
11. **Hematological:** Anemia Bleeding Bruising
12. **Lymphatics:** Enlarged glands or nodes Spleen removed
13. **Endocrine:** Sweating Feeling too hot Feeling too cold Excessive urination
    Excessive thirst
14. **Allergies:** Allergies Asthma Hives Eczema

Height: _____Current Weight: _____

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT

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 therapy to be used, so that you may make the informed decision whether or not to take the drug after 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. For the purpose of this agreement the use of the word "physician" is defined to include not only my physician but also my physician's authorized associates, technical assistants, nurses, staff, and other health care providers as might be necessary or advisable to treat my condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician (name at bottom of agreement) to treat my condition which has been explained to me as chronic pain. 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 an element in the treatment of my chronic pain.

It has been explained to me that these medication(s) include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. 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 death is also a possibility as a result from taking these medication(s).

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 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 may result in my being discharged from your care.

For female patients only:

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

If I am not pregnant, I will use appropriate contraception/birth control 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.

All of the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e.

opioids/narcotics 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 / baby.

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 understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.

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 active 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 for some will 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. 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.

FINANCIAL DISCLOSURE:

I have been informed that Dr, Gajraj has a financial interest in the facilities listed below.

Baylor Surgicare at Plano	**Lotus Labs**
1701 Ohio Dr.	1735 Keller Springs Suite 210
Plano, Texas 75093	Carrollton TX, 75006

The facilities and physicians are committed to providing clinical excellence. This involvement helps to ensure the highest quality of care for you. You have the option to use a health care facility other than a facility to which you are referred. Should you have any concern regarding this, please ask Dr. Gajraj or a member of the staff.

PAIN MANAGEMENT AGREEMENT:

I UNDERSTAND AND AGREE TO THE FOLLOWING:
That this pain management agreement relates to my use of any and all medication(s) (i.e., opioids, also called 'narcotics, painkillers', and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand that there are 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.**

My physician may at any time choose to discontinue the 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:

- My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the **medication(s) may be discontinued**.
- I will **disclose** to my physician **all medication(s)** that I take at any time, prescribed by any physician.
- I will use the medication(s) **exactly as directed by my physician**.
- I will keep my medications safe and secure, and out of the reach of children.
- I agree **not to** share, sell or otherwise permit others, including my family and friends, to have access to these medications.
- I will **not allow or assist in the misuse/diversion of my medication**; **nor will I give or sell them** to anyone else.
- All medication(s) must be obtained at **one pharmacy, where possible**. Should the need arise to change pharmacies, my physician must be informed. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my physician to release my medical records to my pharmacist as needed.
- 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.**
- 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.
- I will receive medication(s) **only from ONE physician** unless it is for an emergency **or** the medication(s) that is being prescribed by another physician is approved by my physician. Information that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.
- If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then **my physician may try alternative medication(s) or may taper me off all medication(s**). I will not hold my physician liable for problems caused by the discontinuance of medication(s).
- I **agree to submit to 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 illegal substance(s), such as marijuana, speed, cocaine, etc., 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.

- I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, 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 management program** recommended by my physician to achieve increased function and improved quality of life.
- I agree that I **shall inform any doctor** who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.
- I hereby give my physician **permission to** discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).
- I must take the medication(s) as instructed by my physician. **Any unauthorized increase** in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.
- I must **keep all follow-up appointments** as recommended by my physician or my treatment may be discontinued.
- I will dispose of medications as recommended. Drugs should be taken out of their containers, mixed with undesirable substances, (e.g., cat litter, used coffee grounds) and put into a disposable container with a lid or into a sealed bag before putting in the trash. Remove any personal information by covering the information with black marker, or duct tape, or by scratching it off.

I certify and agree to the following:

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** 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) IMPORTANT WARNING: **I understand that if I must get medical attention right away if I experience symptoms of an irregular heart beat such as palpitations, dizziness, lightheadedness, or fainting or if I experience symptoms suggestive of taking too much pain medication, such as slow or shallow breathing; extreme tiredness or sleepiness; blurred vision; inability to think, talk or walk normally; and feeling faint, dizzy or confused.**

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.**

_____

Patient Name (PRINTED) Signature

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Consent for the Use and Disclosures of Protected Health Information ("PHI")

I, the undersigned patient, give my consent to the provider Noor Gajraj, MD, and his agents to use or disclose my protected health information ("PHI") to carry out treatment, payment, or health care personnel including, but not limited to, physicians, certified registered nurses anesthetists, anesthesia assistants, nursing staff, nurse practitioners, physicians assistants, child life specialists, physical therapists, respiratory therapists, X-ray personnel, audiologists, students in each of the above disciplines, and other such entities or persons as deemed related to treatment, payment, and health care operations, as determined in sole discretion of the provider, his/her/practice group, and their respective agents.

Permission to Release Medical Records or Providers

If another provider who is involved with treatment, payment, or health care operations relating to me requests my medical records, I consent to the release of my entire medical records maintained by the provider to those other providers.

Permission to Call and Leave Voice Messages and Email Appointment Reminders

I agree that the provider, Noor Gajraj,MD or his agents or representatives may call and leave a voice mail message at my home or other numbers I provide them, regarding medical appointments, billing or payment issues, or other information related to treatment, payment, or health care operations. In addition, I agree to an email, appointment reminder being sent.

Permission to Discuss Protected Health Information with Third Persons

I agree that the provider, Noor Gajraj, MD may discuss my PHI with any person that accompanies me to a visit or is present with me when the provider is present. The provider may rightly assume that if another person is with me, I have no objection to disclosure of my PHI to that person. I also agree the provider may discuss my PHI with any persons that identifies him or herself as active in my mental, physical, emotional, spiritual care, including but not limited family, friends, clergy, and patient advocates. I also agree that the provider, his/her practice group, and their agents may disclose my PHI to employers who arrange and pay, directly or indirectly, for my medical treatment.

Permission to Discuss Protected Health Information Regarding Minors

I agree that the provider, Noor Gajraj, MD and his/her practice group, and their agents may discuss my child's PHI with the person accompanying the child. I agree that the provider may discuss PHI with both natural parents and step parents. I acknowledge that state may grant my child certain privacy rights regarding the child's PHI, and that I have no right to receive this information.

Person(s) or Organization(s) NOT authorized to receive this information:

_____

_____

Notice to the Patient

By signing this form, you grant us consent to use and disclose your protected healthcare information for the purpose of treatment, various activities associated with payment and healthcare operations. If there is not a copy of the Notice with this form, please ask for one. By signing this form, you understand that if the person or organization that receives the information is not a healthcare provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations. We reserve the right to change our privacy practices. Since revisions may apply to your healthcare information, you have a right to receive a copy and can do so by contacting our office. You have the right to revoke your consent by giving a written notice to our office. The revocation will not affect actions that were already taken in reliance upon this consent. You should also understand that if you revoke this consent we may decline to treat you. Upon request, you are entitled to a copy of this consent form after you have signed it

_____ _____

Patient's Signature: Date: