The Woodlands Pain Institute

Dr. E. Mikhail Bishai, M.D.
1006 Windsor Lakes Blvd, Ste 150
Conroe, TX 77384

Phone: 281-292-7246
Fax: 281-292-3996

Date: ________________

Name: ____ Date of Birth: ________________________

Address: __________________________________ City: ______________ State: _____ Zip: _______

Home Phone: _________________ Cell Phone: ___________________ Work Phone: _____________

Social Security: ____________________ **Email Address:** ____________________________________

Spouse: _______________________ Date of Birth: _____________ Phone Number: _____________

Friend or Relative to be called in case of emergency (other than spouse)

1st Contact: __________________________ Phone: _________________ Relationship: ____________

2nd Contact: __________________________ Phone: _________________ Relationship: ____________

Insurance Information

Primary Insurance: ______________________________ Member ID: __________________________

Group ID: ___________________________________ Phone Number: _________________________

Address: _________________________ City: ________________ State: ______ Zip: ____________

Secondary Insurance: __________________________ Member ID: ____________________________

Group ID: ___________________________________ Phone Number: _________________________

Address: _________________________City: ________________ State: ______ Zip: ____________

Pharmacy Information

Name: _____________________________ Address: ____

City: _________________ State: ______ Zip: ___________ Phone: ____________________________

Referring Physician: _________________________________ Phone: ___________________________

Primary Care Physician: ______________________________ Phone: ___________________________

Payment is expected at time of service:
We accept – Cash, Check, Visa, MasterCard, and Discover

I certify that the information given in the New Patient Paperwork Packet is correct to the best of my knowledge. I will not hold my doctor or any member of his staff responsible for any errors or omissions that I may have made in the completion of the packet.

Signature: ____ Date: _________________________

The Woodlands Pain Institute

Name: ______________________________________ D.O.B.: ___________________________

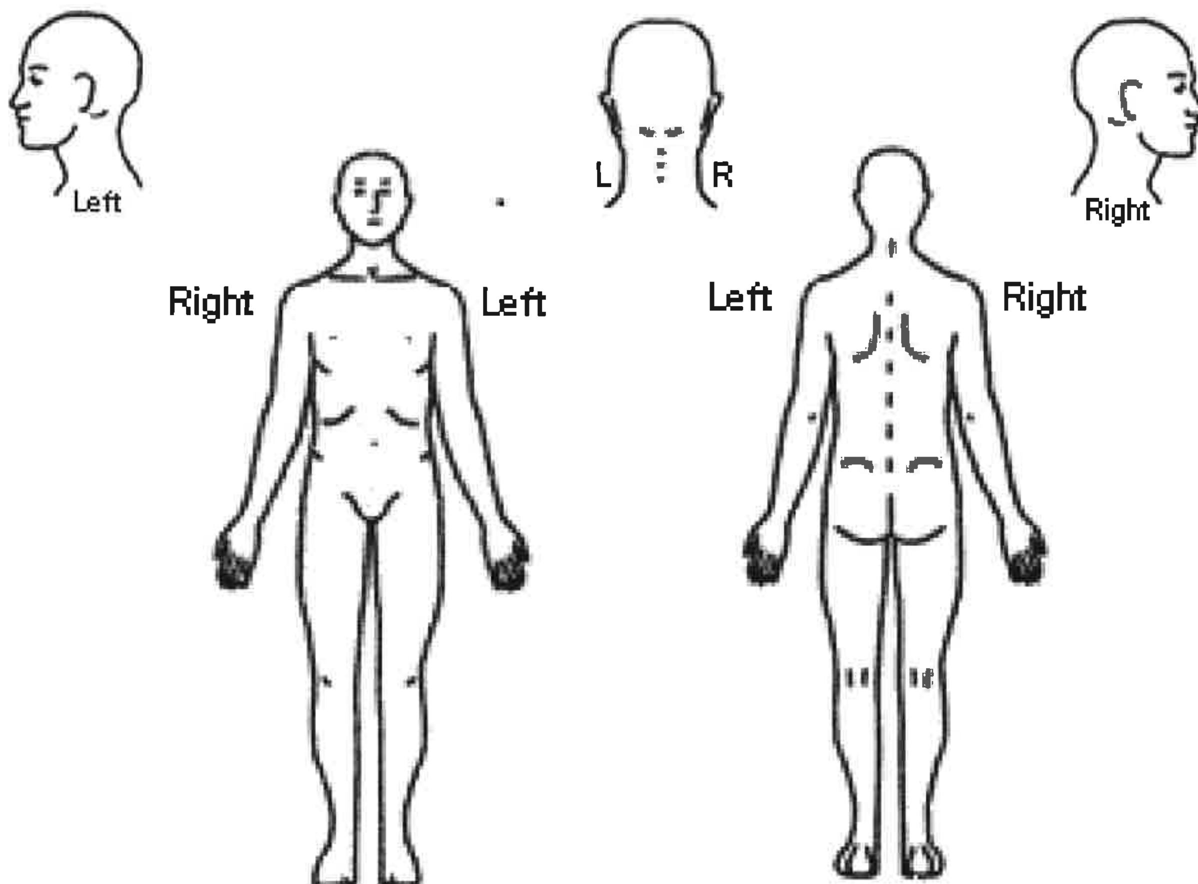
Briefly describe your main pain complaint:

____

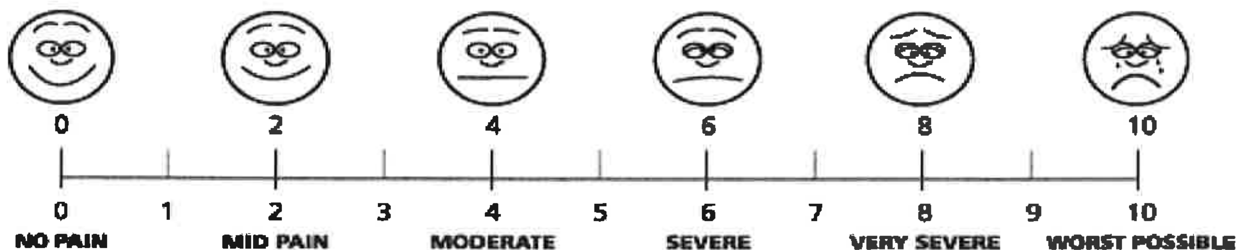
How did your originally begin? (check one)
□ Accident at Work □ Following Surgery □ Auto Accident □ Following Illness □ Pain Just Began

When did your pain begin? (check one)
□ ______ days □ ______ weeks □______ months □ ______ years

Below, please shade in the area where you have pain. Put an "X" over the area that hurts the most.



Rate your pain below by circling on the line to describe you average pain in the past month



The Woodlands Pain Institute

Name: ______________________________ D.O.B: ______________________________

Check the box(s) that BEST describes your current pain:

□ Sharp □ Shooting □ Throbbing □ Cramping □ Aching □ Hot □ Stabbing

□ Cold □ Numb □ Burning □ Tingling □ Dull □ Other ____________________

Check the box(s) of the following treatments that you have tried to treat your pain:

□ None □ Traction □ TENS □ Physical Therapy □ Injection Treatment

□ Biofeedback □ Acupuncture □Chiropractor □ Other ________________________

How often do you have your pain?

□ Constant □ Most of the time □ Occasionally □ Rarely

In general, when is your pain worse?

□ No specific time □ Morning □ Afternoon □ Evening □ Bedtime

Which of the following makes your pain worse? (check all that apply)

□ Sitting □ Standing □ Walking □ Bending □ Twisting □ Lifting □ Lying

□ Heat □ Cold □ Stress □ Weather Changes □ Other ____________________

Which of the following makes your pain better? (check all that apply)

□ Exercise □ Activity □ Relaxation □ Cold □ Heat □ Prayer □ Inactivity

□ Other ____________________

Are there any other symptoms associated with your pain?

□ Numbness □ Weakness □ Vomiting □ Redness □ Swelling □ Bowel Incontinence

□ Anger □ Fatigue □ Sexual Dysfunction □ Nausea □ Other ________________

Has the pain affected your mood? □ Yes □ No
Has the pain affected your sleep? □ Yes □ No

Choose how your pain has interfered with your life

Normal Daily Activity: □ Does not interfere □ Completely Interferes □ Somewhat Interferes
Normal Work or Day: □ Does not interfere □ Completely Interferes □ Somewhat Interferes

The Woodlands Pain Institute

Name: ______________________________ D.O.B.: ______________________

Medical History

Please list all ALLERGIES:

Name	Reaction

Do you have any of the following? (please check all that apply)

☐ High Blood Pressure ☐ Heart Disease ☐ Seizure ☐ Stroke ☐ Kidney Disease ☐ Diabetes

☐ Thyroid Disease ☐ Depression ☐Asthma ☐ HIV ☐ Fibromyalgia ☐ Hepatitis

☐ Peripheral Neuropathy ☐ On a blood thinner ☐ Cancer ☐ Migraines ☐GERD

☐ Other ______________________________

Please List all SURGERIES

Date	Reason

Please list all your current medications (if there is no more room, please attach)

Name	Dose	Frequency

Family Medical History

Please check if you immediate family has a history of:

☐ Back Disorder ☐ Diabetes ☐ Cancer ☐ Stroke ☐Thyroid Disease ☐ Migraines

☐ Pain Problem ☐ High Blood Pressure ☐ Other ______________________________

PAIN MANAGEMENT CONTRACT

I understand and agree to the following:

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 substances(s). Therefore, medication(s) will only be provided as 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** medications that I take at any time, prescribed by any physician.
- I will use the medications exactly as directed by my physician.
- 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 medications 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 any medications will be refilled on a regular basis. I understand that my prescriptions and medications are like money. **IF EITHER ARE LOST OR STOLEN, THEY MAY NOT BE REPLACED.**
- **REFILLS WILL NOT BE ORDERED BEFORE THE SCHEDULED REFILL DATE.** I will not expect to receive additional medications prior to the time of my next scheduled refill, even if my prescriptions run out. If I overuse my medication and run out, I will go through withdrawal (a severe "flu-like" illness caused by sudden cessation of opioids).
- Refills will be made only during regular office hours—Monday through Friday, 8:30AM-4:00 PM. No refills on nights, holidays, or weekends. I must call at least three (3) working days ahead (M-F) to ask for a refill of my medicine. **NO EXCEPTIONS WILL BE MADE.**
- **There is a fee of $25 for all medication refills that are issued without a regular scheduled appointment.**
- I will receive medications **only from one physician** unless it is for and emergency or the medication that is prescribed by another physician is approved by my physician. Information that I have been receiving medications prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medications and treatment.

- If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medications, then my physician may try alternative medications or may taper me off all medications. I will not hold my physician liable for problems caused by the discontinuation of medications.

PAIN MANAGEMENT CONTRACT CONT.

- I agree to submit a urine/blood screen to detect the use of non-prescribed and prescribed medications at any time without prior warning. If I test positive for illegal substances, 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 medical problem that I am enrolled in a pain management program.
- I must take the medications as instructed by my physician. Any unauthorized increase in the dose of medication 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 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 pain killers) or illegal substances (marijuana, cocaine, heroin, etc.)
3. No guarantee or assurance has been made as to the result 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 is provides me an opportunity to lead a more productive and active life.

ALL PATIENTS PRESCRIBED NARCOTICS MAY BE REQUIRED TO HAVE MONTHLY VISITS

Patient Name ______________________________

Signature __________________________________ Date ___________________________

The Woodlands Pain Institute

PATIENT AUTHORIZATIONS AND AGREEMENTS

Patient's Name ______________________________

Your clear understanding of our Financial Policy is important to us:

- Co-pay, co-insurance and deductible payments are due at the time of service. We accept cash, checks, Visa/MasterCard, Am Exp, and Discover.
- Parents/Guardians accompanying minor patients are responsible for full payment at the time of service.

TREATMENT AUTHORIZATION

__I authorize The Woodlands Pain Institute to examine, diagnose and treat ____________________ (Name of Patient), giving reasonable and proper medical care by today's standards which may include: various procedures and therapeutic services. I authorize and give The Woodlands Pain Institute consent to submit specimens (blood, urine, tissue, etc.) to the laboratory(ies) of choice for analyses and study to include diagnosis for submission for payment to the insurance carrier for the named patient.

______________________________ (Signature of Patient/Parent or Guardian) Date____________

AUTHORIZATION FOR RELEASE OF INFORMATION

__I hereby authorize The Woodlands Pain Institute to release any information necessary to my insurance company(ies), including governmental health care insurer (such as Medicare and Medicaid) or other health care practitioners involved in the care of the named patient. I understand that the progress of my treatment may be discussed with my referring physician. I understand that I am giving this authorization only in the case of a subpoena or for the release of information necessary for the provision of continuity of care, to determine insurance benefits and the payment of any claims, and/or for all health plan procedures related to the evaluation of the quality and cost-efficiency of care.

______________________________ (Signature of Patient/Parent or Guardian) Date____________

RESPONSIBLE PARTY AGREEMENT/ASSIGNMENT OF BENEFITS

__I do hereby acknowledge that I am the guarantor of this account and agree to pay for services rendered, including any supplies or pharmaceuticals that are provided to me in my treatment. I authorize payment of medical benefits to The Woodlands Pain Institute for professional services rendered. If any charges are submitted to my insurance carrier by either The Woodlands Pain Institute or by a provider of healthcare services/products/ equipment which are ordered by my physician for the care of the named patient and these services are not covered medical services or are services where benefits are limited and charges above and beyond these limits are incurred, I agree to pay for any balance deemed applicable according to my health insurance rules and regulations. I understand that TWPI will only accept payment from identified payers per insurance card & insurance verification process. I hereby agree that I am responsible for the payment of any co-payment, deductible and co-insurance and that I agree to make payment for these amounts at the time of service. If I am not covered by any insurance carrier, I agree to pay for services rendered at the time of service unless other payment arrangements have been made. COLLECTIONS: When your account goes to collections, there is a 45% collection administration fee applied to the balance of the account.

______________________________ (Signature of Patient/Parent or Guardian) Date____________

REFERRALS

_A referral from a primary care physician is required for Gatekeeper Plans, ie HMO's. A referral must be on file before a patient can schedule an appointment. IT IS THE RESPONSIBILITY OF PATIENT TO MAKE SURE ALL APPOINTMENTS ARE AUTHORIZED. The patient must know how many dates of service and when their current referral expires. IT IS THE RESPONSIBILITY OF THE PATIENT TO GET FUTURE REFERRALS, PRIOR TO THE EXPIRATION DATE ON FILE.

______________________________ (Signature of Patient/Parent or Guardian) Date____________

MEDICARE AUTHORIZATION

_ I request that payment of authorized Medicare benefits be made on my behalf to The Woodlands Pain Institute for any services furnished by my physician to the named patient. I understand my signature requests that payment be made directly to the provider of care and that the provider agrees to accept the charge determination of the Medicare carrier as the full charge, and that the insured patient is responsible only for the deductible, co-insurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier. I attest that I am eligible for Medicare coverage.

______________________________ (Signature of Patient/Parent or Guardian) Date______________

CANCELLED APPOINTMENT/"NO SHOW" POLICY

_If it is necessary for you to cancel any appointment, please advise us at least **24 HOURS in advance for office appointments and 48 hours in advance of a scheduled procedure. If you fail to cancel your scheduled office visit within 24 hours, a NO SHOW fee of $50 is charged. If you fail to cancel your scheduled procedure within 24 hours, a NO SHOW fee of $150.00 is charged. TWPI reserves the right to terminate you for multiple NO SHOW's due to noncompliance issues.**

______________________________ (Signature of Patient/Parent or Guardian) Date______________

NSF/CLOSED ACCOUNTS FEE

_A fee will be charged for checks returned to the practice. The fee is $45 in addition to the amount of the check. All NSF/CLOSED ACCOUNT Fees must be paid in cash or with a credit card or money order. You will no longer be able to write checks to the practice. No action taken will result in the account being turned over to the County for NSF activity.

______________________________ (Signature of Patient/Parent or Guardian) Date______________

NURSE PRACTITIONER CONSENT

_Our facility has Nurse Practitioners on staff to assist in the delivery of pain management care. A nurse practitioner is not a doctor. A Nurse Practitioner is a Registered Nurse who has received advanced education in the provision of health care. A Nurse Practitioner can diagnose, treat, and monitor acute and chronic diseases as well as provide health maintenance care. I have read the above and hereby consent to the services of a Nurse Practitioner for my health care needs and understand that I may refuse to see a Nurse Practitioner and request to see a physician.

______________________________ (Signature of Patient/Parent or Guardian) Date______________

OWNERSHIP DISCLOSURE from Emad M. Bishai M.D.

__To further my commitment to quality of surgical care for my patients, I, Emad M. Bishai, MD, have chosen to be an owner in Executive Surgery Center, Lone Star Toxicology, and Alliance and Priceline Pharmacy. My ownership enhances my ability to direct the manner in which your care is delivered at the facility. If this is of concern to you, I will be happy to answer questions. I am on the medical staff at other healthcare facilities and will be happy to discuss your option of choosing an alternative location.

______________________________ (Signature of Patient/Parent or Guardian) Date______________

The Woodlands Pain Institute

1006 Windsor Lakes Blvd, Suite 150
Conroe, TX 77384
281-292-7246 fax 281-292-3996

HIPAA Notice of Privacy Practices

I am aware of the HIPAA Notice of Privacy Practices and know the copies of the notice are available for me to take upon request.

Authorization to release Protected Health Information (PHI) to designated persons:
I give my authorization to release medical/surgical information to the following designated representatives:

Please Initial: _______

____
Name Relationship Phone No

____
Name(s) Relationship Phone No

____
Name(s) Relationship Phone No

Please Initial: _______ Information may not be given to anyone other than myself.

I hereby authorize medical information to be relayed to me via voicemail/answering machine

________ Home Phone # ________________________

________ Cell Phone # ________________________

________ Work Phone# ________________________

________ Patient Portal ________________________

Patient Signature ______________________________ Date ______________

Fall Risk Assessment

The Woodlands Pain Institute

My Falls-Free Plan **Name**________________________ **Date:** ______________

As we grow older, gradual health changes and some medications can increase your risk of falling, but many falls can be prevented. Use this tool to learn how to stay active and independent.

Check "Yes" If You Experience Any Of The Following:	Yes	No	Facts About Falls. What To Do If You Checked "Yes"
I have fallen in the last 6 months.			People who have fallen once are likely to fall again, so discuss your concerns about falling with your Doctor(s).
I am worried about falling.			People who are worried about falling are more likely to fall. Create a safe home environment by adding railings to all stairs and grab bars in your bathroom.
I take four or more prescription or over-the-counter medications daily?			Side effects from some medications can sometimes increase your risk of falling. Review your medications with your Doctor(s) or Pharmacists at each visit, and with each new prescription.
Sometimes I feel unsteady, dizzy, or weak while I am walking.			Unsteadiness or needing support while walking are signs of poor balance.
I use or have been advised to use a cane or walker to get around safely.			People who have been advised to use a cane or walker may already be more likely to fall so be sure to ask your Doctor for a physical therapy referral to learn what device is best for you and how to use it safely.
I steady myself by holding onto furniture when walking at home.			These can also be signs of poor balance. Tell your Doctor(s) if treatment by a Physical Therapist would improve your balance.
I need to push up with my hands to stand up from a chair.			Ask your Doctor for a physical therapy referral to learn exercises to straighten your arm and leg muscles.
I have had an eye exam in the last 2 years.			Schedule an eye exam every two years to protect your eyesight and your balance.
My hearing has declined as I get older or my family or friends tell me I have a hearing problem.			Schedule a hearing test every two years to help restore and protect your hearing, which helps improve balance.
I exercise for at least two days a week for 30 minutes at a time.			Find an exercise partner to exercise with at least two days a week for at least 30 minutes at a time.
I have more than three chronic health conditions such as heart or lung issues, diabetes, high blood pressure, arthritis, etc.			See your Doctor(s) as often as recommended to keep your health in good condition. Report any health changes to your Doctor(s) immediately.

Total_________

Add up the number of points for each "**yes**" answer. If you scored 4 points of more, you may be at risk for falling. Remember many falls can be prevented. Discuss your concerns about falling with your Doctor.

Reviewed by: ________________

The Woodlands Pain Institute

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: ______________________________ **Date:** ______________________________

Over the last 2 weeks how often have you been bothered by any of the following problems?
(Use **X** to indicate your answer)

	Not at all **0**	**Several days** **1**	**More than half the day** **2**	**Nearly everyday** **3**
1) Little interest or pleasure in doing things	☐	☐	☐	☐
2) Feeling down, depressed, or hopeless	☐	☐	☐	☐
3) Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4) Feeling tired of having little energy	☐	☐	☐	☐
5) Poor appetite or overeating	☐	☐	☐	☐
6) Feeling bad about yourself or that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
7) Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8) Moving or speaking so slowly that other people have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9) Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

INTERPRETATION

Total Score [ ]

- ☐ Minimal Depression
- ☐ Mild Depression
- ☐ Moderate Depression
- ☐ Moderately Severe Depression
- ☐ Severe Depression

Reviewed by: ________________

Patient Name ______________________________

Please choose ONLY for your gender

OPIOID RISK TOOL

Check Each Box That Applies

		Female	Male
1. **Family History of Substance Abuse**	Alcohol	[ ]	[ ]
	Illegal Drugs	[ ]	[ ]
	Prescription Drugs	[ ]	[ ]
2. **Personal History of Substance Abuse**	Alcohol	[ ]	[ ]
	Illegal Drugs	[ ]	[ ]
	Prescription Drugs	[ ]	[ ]
3. **Age** (Mark box if 16-45)		[ ]	[ ]
4. **History of Preadolescent Sexual Abuse**		[ ]	[ ]
5. **Psychological Disease**	Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, Schizophrenia	[ ]	[ ]
	Depression	[ ]	[ ]
	None Apply		[ ]

Patient Signature ______________________________ Date ______________

FOR CLINICAL USE ONLY

Score ________________

Reviewed by: ______________________________