



Date \_\_\_\_\_

Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail Address \_\_\_\_\_ Fax # \_\_\_\_\_ Cell \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Marital Status : M S W D

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_ Office Phone \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

Purpose of this appointment \_\_\_\_\_

Date symptoms appeared or accident happened? \_\_\_\_\_

Days lost from work \_\_\_\_\_

What medications or drugs are you taking? \_\_\_\_\_

Please check any and all insurance coverage that may be applicable in this case.

Major Medical    Worker's Compensation    Medicaid    Auto Accident    Other

Name of Primary Insurance Company \_\_\_\_\_

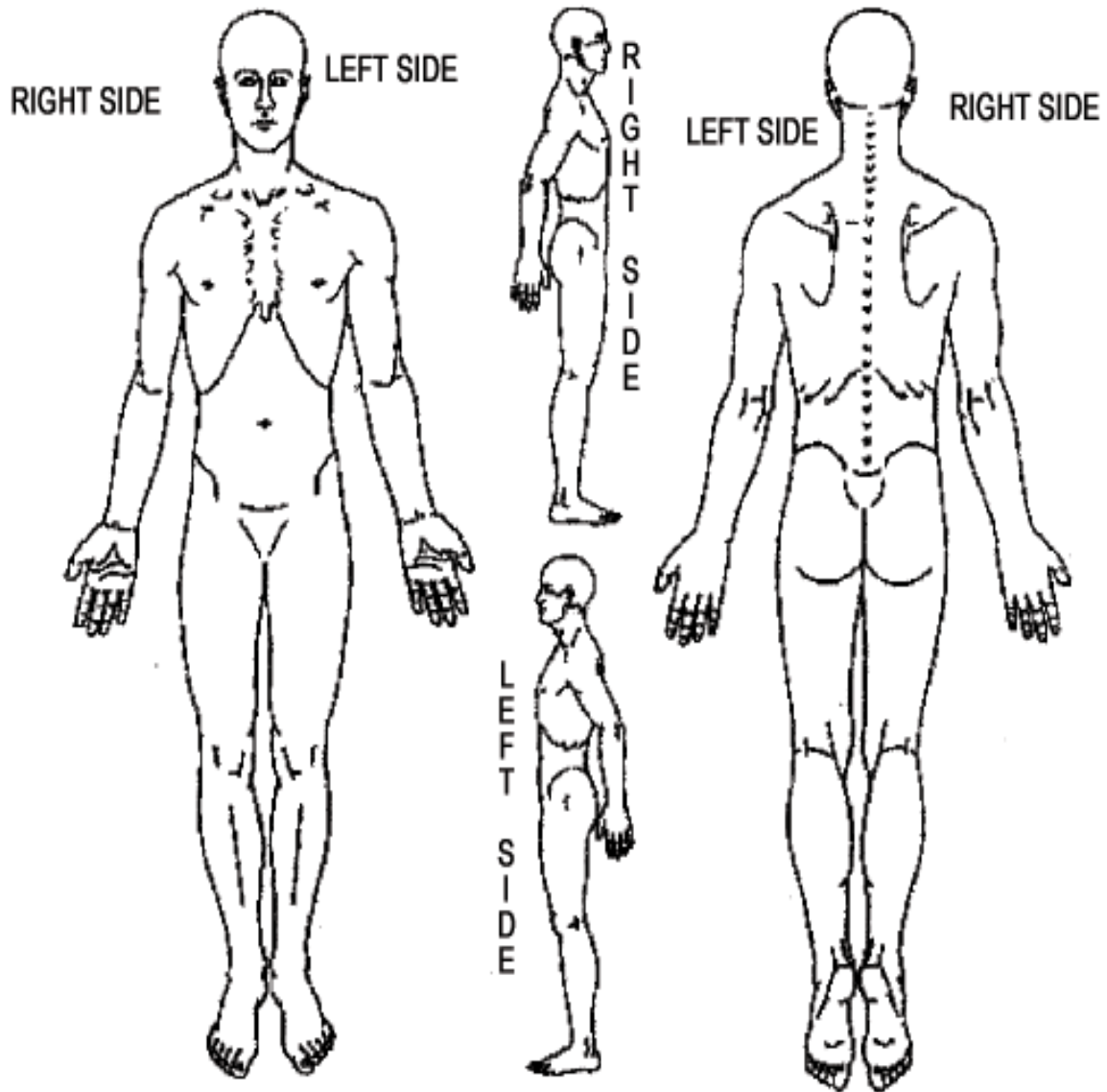
Name of Secondary Insurance Company (if any) \_\_\_\_\_

**AUTHORIZATION AND RELEASE:** I authorize payment of insurance benefits directly to Dr. Bond or the doctor's office. I authorize the doctor to release all information necessary to communicate with personal physicians and other health care providers and payers and to secure the payment benefits. I understand that I am responsible for all cost regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand that interest is charged on overdue accounts at the annual rate of 16 percent.

The patient understands and agrees to allow the Doctor's office to use their Patient Health Information for the purpose of treatment payment, healthcare operations and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Invasive Pain Management/Anesthesia



Draw the area of your pain.

1. How and when did your pain start?

2. Where is your pain?

3. Circle the words that describe your pain.

Indisposition	throbbing	sharp	stinging
acute	sore	burning	exhaustive
penetrating	constant	drowsy	fatigue
Miserable	unbearable	impaired	

Circle one:

Casual continual

At what time of the day is your pain worst?

Morning

Mid day

Afternoon

Night

4. Circle the number that better describes your worst pain in the past month:

No pain 0 1 2 3 4 5 6 7 8 9 10 worst imaginable pain

5. Circle the number that better describes your minor pain in the past month:

No pain 0 1 2 3 4 5 6 7 8 9 10 worst imaginable pain

6. Circle the number that better describes your most common pain in the past month:

No pain 0 1 2 3 4 5 6 7 8 9 10 worst imaginable pain

7. Circle the number that better describes your pain at this moment:

No pain 0 1 2 3 4 5 6 7 8 9 10 worst imaginable pain

8. What helps your pain get better?

9. What makes it worst?

10. What type of treatments or medications are you currently using?

Physical therapy          chiropractic          medication          epidural injections

Circle the number that provides the kind of relief you get from your treatment or medication

a) No relief 0 1 2 3 4 5 6 7 8 9 10 total relief

Treatment or medication (doses included) \_\_\_\_\_

b) No relief 0 1 2 3 4 5 6 7 8 9 10 total relief

Treatment or medication (doses included) \_\_\_\_\_

c) No relief 0 1 2 3 4 5 6 7 8 9 10 total relief  
Treatment or medication (doses included) \_\_\_\_\_

d) No relief 0 1 2 3 4 5 6 7 8 9 10 total relief  
Treatment or medication (doses included) \_\_\_\_\_

11. What type of secondary effects or symptoms are you experiencing? Circle the one that best describes your experience for the past week.

nausea	vomit	constipation	lost of appetite	fatigue
itch	nightmares	sweat	concentration	insomnia

12. Circle the number that describes how the pain interfered with you on the past week.

a. General activity  
Non 0 1 2 3 4 5 6 7 8 9 10 Completely

b. Mood  
None 0 1 2 3 4 5 6 7 8 9 10 Completely

c. Normal work  
None 0 1 2 3 4 5 6 7 8 9 10 Completely

d. Sleep  
None 0 1 2 3 4 5 6 7 8 9 10 Completely

e. Enjoying life  
None 0 1 2 3 4 5 6 7 8 9 10 Completely

f. Ability to focus  
Non 0 1 2 3 4 5 6 7 8 9 10 Completely

g. Relationships  
Non 0 1 2 3 4 5 6 7 8 9 10 Completely



Nelson Bond MD  
Interventional Pain Management/Anesthesia  
1302 Waugh Drive #533  
Houston, TX 77019  
Phone 281-461-4300  
Fax 888-266-0355

**Authorization of Release of Medical Information**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

I authorize the release of medical records requested by BACAS, please send to either address or fax given below as requested.

BACAS  
1302 Waugh Drive #533  
Houston, TX 77019  
Phone: 281-461-4300  
Fax: 888-266-0355

Information being requested:

- Entire record file
- All Clinic notes
- Clinic notes from \_\_\_\_\_ to \_\_\_\_\_
- Radiology studies
- Operative Notes
  
- Please fax to 888-266-0355.
- Please mail to the above facility

\_\_\_\_\_  
Signature of Patient /Patient Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date



***Prescription Refills***  
***Document Fees and Cancellations***

Beginning on January 1, 2008 we will be adopting a new policy regarding medication refills. We thank you in advance for your cooperation in following our instructions. You are always welcome to call us if you feel that it is necessary. However, it is important that when you need a refill you call the pharmacy, not our office with your request. We will work directly with the pharmacist to insure prompt attention to your needs.

Please be aware of the fact that when an appointment cancellation becomes necessary, you must call our office no later than 24 hours before the appointment in order to avoid paying a fee for late cancellation. The reason for this request is that we can reschedule the appointment and allow another patient to take advantage of that time. A fee of \$20.00 will be charged for any appointment that is not cancelled within the specified time; for procedure appointments the fee will be \$50.00.

When disability forms are required, our office should be informed with five to seven days of anticipation in order to complete them. Please understand that our treatment plan does not include this service, a fee of \$25.00 per page will apply.

Medical records can be provided after five to seven days from the time they are requested. The fee for medical records is \$25.00 for the first 20 pages and \$5.00 for each additional page.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Patient Contract  
for  
Using Opioid Pain Medication in Chronic Pain**

This is an agreement between \_\_\_\_\_ (the patient) and Dr. \_\_\_\_\_ (the doctor) concerning the use of opioid analgesics (narcotic pain-killers) for the treatment of a chronic pain problem. The medication will probably not completely eliminate my pain, but is expected to reduce it enough that I may become more functional and improve my quality of life.

1. I understand that opioid analgesics are strong medications for pain relief and have been informed of the risks and side effects involved with taking them.
2. In particular, I understand that opioid analgesics could cause physical dependence. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (flu-like syndrome such as nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24-48 hours of the last dose. I understand that opioid withdrawal is quite uncomfortable, but not a life-threatening condition.  
  
I understand that if I am pregnant or become pregnant while taking these opioid medications, my child would be physically dependent on the opioids and withdrawal can be life-threatening for a baby.
3. Overdose on this medication may cause death by stopping my breathing; this can be reversed by emergency medical personnel if they know I have taken narcotic pain-killers. It is suggested that I wear a medical alert bracelet or necklace that contains this information.
4. If the medication causes drowsiness, sedation, or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy.
5. I understand it is my responsibility to inform the doctor of any and all side effects I have from this medication.
6. I agree to take this medication as prescribed and not to change the amount or frequency of the medication without discussing it with the prescribing doctor. Running out early, needing early refills, escalating doses without permission and losing prescriptions may be signs of misuse of the medication and may be reasons for the doctor to discontinue prescribing to me.
7. I agree that the opioids will be prescribed by only one doctor and I agree to fill my prescriptions at only one pharmacy. I agree not to take any pain medication or mind-altering medication prescribed by any other physician without first discussing it with the above-named doctor. I give permission for the doctor to verify that I am not seeing other doctors for opioid medication or going to other pharmacies.
8. I agree to keep my medication in a safe and secure place. Lost, stolen, or damaged medication will not be replaced.
9. I agree not to sell, lend, or in any way give my medication to any other person.
10. I agree not to drink alcohol or take other mood-altering drugs while I am taking opioid analgesic medication. I agree to submit a urine specimen at any time that my doctor requests and give my permission for it to be tested for alcohol and drugs.

**Agreement - page 2**

- 11. I agree that I will attend all required follow-up visits with the doctor to monitor this medication and I understand that failure to do so will result in discontinuation of this treatment. I also agree to participate in other chronic pain treatment modalities recommended by my doctor.
- 12. I understand that there is a small risk that opioid addiction could occur. This means that I might become psychologically dependent on the medication, using it to change my mood or get high, or be unable to control my use of it. People with past history of alcohol or drug abuse problems are more susceptible to addiction. If this occurs, the medication will be discontinued and I will be referred to a drug treatment program for help with this problem.

I have read the above, asked questions, and understand the agreement. If I violate the agreement, I know that the doctor may discontinue this form of treatment.

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Patient signature

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Doctor signature

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Date

Addendum:

I understand that the medication is prescribed as follows:

Type of medication \_\_\_\_\_

Number of pills and frequency \_\_\_\_\_

Total number of pills \_\_\_\_\_

Next refill due \_\_\_\_\_

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Patient signature

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Doctor signature



Nelson Bond MD  
Invasive Pain Management/Anesthesia  
1302 Waugh Drive, PMB #533  
Houston, TX 77019

## **Prednisone Side Effects**

Prednisone is also known as a corticosteroid; it has anti-inflammatory effects and is known to have a rapid onset of action. The side effects of prednisone, are related to the dose and the length of time the patient takes it. It is important to mention that not all patients experience all side-effects listed below:

- **Hirsutism**

Among the possible side effects of prednisone and other forms of corticosteroids is the excessive growth of body hair, known as hirsutism.

- **Weight Gain**

Patients who take prednisone may suffer some degree of weight gain. The amount of weight gain varies from patient to patient and is dependent upon the amount and duration that the drug is taken. The distribution of body fat goes particularly to the face, back of the neck (known as buffalo hump) and abdomen.

- **Glucose Intolerance**

Also known as steroid-induced diabetes. This simply resolves with the decreased use of the medication or when they are discontinued.

- **Hypertension**

Also known as High blood pressure. Usually improves as the dose is reduced.

- **Increased Susceptibility to Infections**

Minor fungal infections in the mouth to life-threatening infections such as pneumonia become an increased risk for patients taking corticosteroids. Based on the duration of the treatment and the amounts taken, the risk of infections can become greater. This risk can be greatly reduced with the use of antibiotics.

- **Bone Thinning (Osteoporosis)**

Even people who are not at risk for osteoporosis may suffer thinning of the bones with the use of Prednisone. There are treatments and preventive measures available for this and all patients on prednisone for prolonged periods of time are candidates for these medicines.

- **Easy Bruising**

Also known as “thin skin” can be suffered by patients taking prednisone. Moderate to high doses can cause for the patient to bruise easily even as a result of slight trauma.

- **Mood Swings/Insomnia**

While taking high doses of steroids, many patients have difficulty sleeping. They also become more irritable than usual and in extreme cases it can cause depression. When the drug is discontinued or reduced the symptoms improve.

- **Avascular Necrosis of Bone**

Patients taking doses of 20 milligrams a day or higher for long periods are predisposed to joint damage, most often this occurs in the hips. The reason for this is unknown but may be due to avascular necrosis and could ultimately lead to joint replacement.

- **Abdominal Striae (stripes)**

Occurs more frequently in patients who take high doses of steroids for long periods of time.

- **Cataracts**

The eye can develop cataracts due to the long-term use of steroids. Cataracts frequently require surgical removal.

- **Acne**

Some patients become predisposed to facial acne, due to high dose use of prednisone. It can also develop on the chest, back and upper extremities. This usually resolves following cessation of the drug and requires no treatment.

When prednisone is taken for extended periods of time, it can suppress the ability of the body to produce natural cortisone causing the adrenal glands to shrink. Slow tapering of the drug minimizes this risk. Steroid withdrawal symptoms such as muscle or joint aching can occur when prednisone is tapered too rapidly or discontinued.

I certify that I have received this document and have read and understood its content. I further consent to the use of and give Dr. \_\_\_\_\_ permission to utilize these medications in the treatment of my condition.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Staff