FOUNDATION PHYSICIANS GROUP

Patient Name_____ Arrival Time _____ am/pm

Sex_____Birthdate_____Age_____Weight_____

Social Security #_____

Patient Address_____

City_____State_____Zip_____ Home

Phone_____ Cell Phone _____Work Phone_____ Email

address _____ Referring

Physician_____ Follow up

appointment scheduled: Yes/No Date _____ Time _____ Health Insurance

Company _____ Person

Insured_____Relationship_____ Insured's

Birthdate_____ Insured Social Security #_____ Policy #

_____ Group #_____ Employer

_____ Employer Phone _____ Employer

Address _____ Victim of a

violent crime? _____ (ask front desk if you're eligible for compensation)

X_____ (please initial) I authorize this facility to release any information or films which were acquired in the course of my examination or treatment. Written reports generated from your visit will be provided to your referring physician. You may obtain a copy of the written report from your referring physician.

X_____ (please initial) I understand that this office bills insurance as a courtesy and that payment of these services are my responsibility. I permit the insurance company to make payment directly to Foundation Physicians Group for services rendered. Also to appeal any claims to my insurance on my behalf. This does not apply to TWCC guidelines.

Sign Here:_____Date_____

BENEFIT ASSIGNMENT RECORD RELEASE PAYMENT AGREEMENT

This agreement is entered into this date by and between _____ hereinafter called "Patient" and Prime Diagnostic Imaging, JTP diagnostics, Foundation Physicians Group, Silverstar, Cellular Medicince Solutions, Lakepointe Radiology and MT Med herereinafter "Provider". Whereas Patient desires to receive healthcare services from Provider and desires to assign certain rights and benefits to Provider as an inducement to cause Provider to wait for payment of such benefits, it is hereby agreed:

SECTION 1. Patient assigns to Provider any and all benefits payable by Patient's insurance or healthcare plan(s) as a result of charges incurred by Patient for services rendered by Provider. Patient also assigns to Provider any and all contractual rights Patient has against any insurance company, healthcare benefit plan or any other party contractually liable to Patient for payment of healthcare costs incurred by Patient as a result of services rendered by Provider. This assignment of benefits and contractual rights to those benefits shall not exceed the total amount of charges incurred by patient for services rendered by Provider. Patient agrees that payment for services rendered by Provider is due upon receipt of said services and Provider's acceptance of patient assignment of benefits is a convenience to Patient and that Provider may revoke this assignment at any time.

SECTION 2. Patient thereby directs all insurers and other persons responsible for Patient's healthcare costs to make all payment for the healthcare services rendered by Provider directly to Provider.

SECTION 3. Patient agrees to waive any applicable statute of limitations which may at any time interfere with Provider's right to collect for services rendered to Patient.

SECTION 4. Patient agrees that in the event Patient receives any check, draft or other payment subject to this Agreement, patient will act as a fiduciary agent for Provider and will immediately deliver said check, draft or payment to Provider. Provider agrees to apply the proceeds from the check, draft or payment to Patient's debt for services rendered.

SECTION 5. A copy of this document shall be as binding as the document bearing original signatures. At the time each claim is submitted, a copy of the claim will be stored for safekeeping in Patient's file and may be picked up by the Patient/insured at any time or will, upon request by the Patient/insured or be mailed to a designated address.

SECTION 6. Patient agrees to be responsible for any deductibles or co-payments required by the terms of any applicable insurance or healthcare plan. Patient further agrees to pay for any services not covered by Patient's insurance or healthcare plan. A refund, if any, will be calculated upon receipt of payment from your insurance company.

SECTION 7. In the event that any Section or provision of this Agreement is legally void, invalid or unenforceable, all other sections and provisions of this Agreement shall remain in full force and effect.

SECTION 8. Provider participates/contracts with many, but not all insurance companies. Provider can be determined dependent of the type of service provided. Contracts are not all the same and certain services may not be covered depending on your benefits. Whether provider participates with an insurance company or not, you must pay your copayment, coinsurance and/or remaining deductible at the time of service. Imaging services may be billed globally or split, technical and professional. You may receive one or two bills. Pain procedures may be billed by up to three providers, physician, facility and anesthesiology.

IN WITNESS THEREOF, this agreement has been explained to the (patient's) satisfaction and having due knowledge and understanding entered into the day and year set forth below.

_____ _____
Patient Date

_____ _____
Guardian (If patient is a minor) Date

_____ _____
Witness Date

Foundation Physicians Group
PO BOX 821537
Dallas, TX 75238
Phone: 214-442-8908 Fax: 214-341-1603

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient: _____

Social Security Number: _____ DOB: _____

Release to:

Name and address of recipient to whom information is to be released if other than PDI:

☐Any Requesting Physician ☐Insurance Co. ☐Attorney ☐Hospital ☐Other (Specify):

GENERAL AUTHORIZATION: I authorize the above named healthcare provider to release the information specified below to the organization or individual named on this request. I understand that my physician(s) may be notified about this request. I agree to pay the facility's reasonable charge for copying any documents, and I understand that the facility may require a reasonable time to make any copies.

INFORMATION REQUESTED:

☐Radiology Reports

☐Radiology Films

☐Clincal Reports

CONDITIONS AND DATES OF CARE COVERED:

☐All exams at this facility provided as of the date of my signature.

☐Limited to exam dates and/or conditions described below:

_____

PURPOSE(S) OR NEEDS FOR WHICH INFORMATION IS TO BE USED:

☐Continuing Medical Care ☐Insurance Request ☐Other (Specify): _____

EXPIRATION OR REVOCATION OF AUTHORIZATION: I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken to comply with it. I understand that this authorization will not apply to admission or care provided after the date of my signature. Even if I do not revoke this authorization in writing, this authorization will automatically expire (initial one):

_____ On the following date: _____

_____ 180 days from the date of signing

►Sign Here _____ _____

Signature of Patient or Designated Representative Date

Records to be: ☐ Picked up ☐Mailed

If picked up by other than patient: _____

Authorized Individual

Acknowledgement of Receipt of Notice of Privacy Practices

I have received the Notice of Privacy Practices of Foundation Physicians Group, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document for my records.

_____ _____

Patient Sign Here **Date**
(or Personal Representative)

_____

Printed Name of Above

_____

Relation to Patient if Signed by Representative

_____

Foundation Physicians Group Witness

Foundation Physicians Group
PO BOX 821537
Dallas, TX 75238
Phone: 214-442-8908 Fax: 214-341-1603

PLEASE READ AND SIGN NARCOTIC AGREEMENT IN THE EVENT YOU ARE PRESCRIBED NARCOTICS AT ANY POINT IN TREATMENT.

NARCOTIC ADMINISTRATION AGREEMENT

I have agreed to use opioids (narcotics) as part of my treatment for pain management. My Foundation Physicians Group physician has discussed with me the uses of these medications including the issues of appropriate, realistic goals for pain relief, proper methods of taking the medications, risks or side effects and specific issues of developing tolerance, dependence, habituation, addiction, and withdrawal problems due to these medications. I understand that these drugs are very useful but have a potential for misuse and are therefore closely controlled by the local, state, and federal government. Because my physician is prescribing such medications to help manage my pain, I agree to the following conditions outlined below. I am aware that failure to abide by any of these conditions will be considered a breach of this contract and at the sole discretion of my Foundation Physicians Group physician will result in the termination of our physician-patient relationship.

1. I am responsible for my pain medications. I agree to take the medication only as prescribed and to contact my Foundation Physicians Group physician before making any changes.

    a) I understand that increasing my dose without the close supervision of my Foundation Physicians Group physician could lead to drug overdose causing severe sedation, respiratory depression and death.

    b) I understand that decreasing or stopping my medication without the close supervision of my Foundation Physicians Group physician could lead to withdrawal reactions. Withdrawal symptoms may include yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot and cold flashes, "goose flesh", abdominal cramps and diarrhea. These symptoms can occur 24 to 48 hours after the last dose and can last up to three weeks.

2. I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from my physician at Foundation Physicians Group unless written permission is first obtained from the Foundation Physicians Group physician. I understand that if it is found that I received narcotic medications from a source other than a Foundation Physician Group physician I will be discharged.

3. I understand that there can be side effects that are related to opioid medication. Common side effects are nausea and vomiting (similar to motion sickness), drowsiness, and constipation. Less common side effects are mental slowing, flushing, sweating, itching, urinary difficulty, and twitching. These side effects would occur at the beginning of my treatment and often go away within a few days without treatment. It is my responsibility to notify my Foundation Physicians Group physician of any side effects that continue or are severe (such as sedation or confusion). I am also responsible for notifying my physician immediately if I need to visit another physician or emergency room due to pain or if I become pregnant.

4. **I also realize that opioids can cause impairment of motor skills including the ability to drive, operate heavy machinery, etc. Accordingly, I realize that it is my responsibility to monitor myself and avoid these activities if I am impaired in any way by my medications.**

Date signed:_____

Foundation Physicians Group
PO BOX 821537
Dallas, TX 75238
Phone: 214-442-8908 Fax: 214-341-1603

5. I understand that the opioid medication is strictly for my own use. The opioid should never be given to others. If children are in the house, a childproof top is necessary and must be kept out of reach of children at all times.

6. I understand that I must contact my Foundation Physicians Group physician before taking benzodiazepines (drugs like Valium, Xanax or Ativan), sedatives (drugs like Soma or Fiorinal) and antihistamines (drugs like Benadryl). I understand that the combination use of the above drugs and opioids, as well as alcohol and opioids may produce profound sedation, respiratory depression, blood pressure drop, and even death. I cannot use recreational drugs while on opioids; such use will result in termination from the program.

7. During the time that my dose is being adjusted, I will be expected to return to the clinic no less frequently than once a month. After I have been placed on a stable dose I will return to the clinic whenever instructed by my physician, generally on a monthly basis.

8. I am responsible for my opioid prescriptions. I understand that refill prescriptions:

    a) Can only be written for a one-month supply and will be filled at the same pharmacy, unless otherwise approved by the Foundation Physicians Group physician.

    b) Shall be made during regular office hours Monday through Thursday. Refills will not be made at night, on holidays, or on weekends. Triplicate prescriptions must be picked up only in person.

    c) Shall not be made if I "run out early" or lose a prescription" or spill or misplace my medication. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. If any medication is stolen, I will report this to my local police department and obtain a stolen item report. I realize that I will be covered with non-prescription analgesics and withdrawal type medications until my next prescription is due.

    d) Shall not be made as an "emergency" such as on Friday afternoon because I suddenly realize I will "run out tomorrow". I will call at least one week ahead to schedule pick-up for my prescriptions.

9. Addiction is a psychological and behavioral syndrome that is recognized when the patient abuses the drug to obtain mental numbness or euphoria. When the patient shows a drug craving behavior, tries obtaining narcotics from multiple doctors, when the drug is quickly escalated by the patient without correlation to pain relief, and/or when the patient shows a manipulative attitude toward the physician and staff in order to obtain the drug. If I exhibit these or any other unacceptable behaviors I realize that I will be discharged. Additionally, unacceptable behavior includes, but is not limited to the following:

    a) Frequent i.e. greater than 1-2 times a month calls to the staff regarding pain medications.
    b) Disruptive, abusive, disrespectful, threatening, or generally disagreeable behavior.

Date signed:_____

Foundation Physicians Group
PO BOX 821537
Dallas, TX 75238
Phone: 214-442-8908 Fax: 214-341-1603

10. I understand that if it is discovered that I am not taking my opioids, drug diversion will be assumed; I also understand that this diversion is a felony.

11. I understand that the goals of my Foundation Physicians Group physician's treatment plan may include time-contingent use of opioids. If it appears to the physician that there is no improvement in my daily function or quality of life from the controlled substance, my opioids may be discontinued. I will gradually taper my medication as prescribed by the Foundation Physicians Group physician.

12. I agree to submit to urine and blood screens at any time as determined by my physician to detect the use of both prescribed and non-prescribed medication. Specimen is to be collected at Prime Diagnostic Imaging Center.

13. I further understand that if I do not follow any of the above conditions or provisions I will, at my Foundation Physicians Group physician's discretion, be discharged and/or reported to the local/federal law enforcement authorities.

14. I agree to allow the Foundation Physicians Group physician to communicate with the referring physician and any specialists or pharmacies regarding the use of my narcotics.

I have read the above information (or it has been read to me) and have received a copy of the contract. All my questions regarding the treatment of pain with opioids have been answered to my satisfaction.

_____
Patient Sign Here

_____
Patient Printed Name

_____
Witness

_____
Date