TEXAS INSTITUTE OF
Pain & Spine
1920 Country Place Parkway, Suite 160
Pearland, TX 77584
P: 832-736-2677 F: 832-730-4574

NEW PATIENT INFORMATION FORM

Last Name: _____ First Name: _____ MI: _____

Address: _____ City/State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

SSN: _____ Date of Birth: _____ Male ___ Female _____

Employer: _____ Occupation: _____

Emergency Contact: Relationship: _____ Phone: _____

Referring Physician: _____ **Primary Care Physician:** _____

Marital Status: Married Divorced Widowed Single ___ Separated ___

Spouse's Name: _____ Date of Birth: _____

Spouse Employer: _____ Employer Phone: _____

_____ _____
Primary Insurance Carrier Subscriber Name / DOB / SSN

_____
Insurance ID # Insurance Group #

_____ _____
Secondary Insurance Carrier Subscriber Name / DOB / SSN

_____
Insurance ID # Insurance Group #

Note: We will bill your secondary insurance as a courtesy. If claims are not paid within 60 days the balance will be transferred to the patient responsibility.

Is your condition the result of a work related injury? _____ Date of Injury: _____
Is your condition the result of a MVA or any other accident? _____ Date of Injury: _____

My signature below indicates that I have been given the chance to read and review the following and understand and agree to their terms:

*Financial Policy, Consent for Treatment, and Release of Medical Information Form (see page 3)
*Notice of Privacy Practices at my discretion (located at front desk).

I agree that the above information is true and I authorize this information to be used to obtain financial reimbursement. Additionally, I authorize my attending physician to administer treatment and perform procedures as may be deemed necessary or advisable in my diagnosis. I further authorize the release of any medical information necessary to process my insurance claim and request payment of medical services to be assigned directly to my attending physician. In the event my insurance does not cover services rendered, I agree to be personally and fully responsible for payment. This authorization is to remain in full force unless I revoke the same in writing.

Patient's Signature: _____ Date: _____

Reviewed by: _____ Date: _____

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Financial Policy, Consent for Treatment, Release of Medical Information

Thank you for trusting us with your healthcare.

PLEASE READ CAREFULLY
You and your insurance carrier are responsible for your bill.
Knowing your insurance benefits plan is your responsibility.

If you have medical insurance, we are grateful to assist you in receiving your maximum allowable benefits. In order to achieve these goals, we need your support and understanding of our financial policy.

- Insurance information must be presented and updated at the time of making your appointment, not at the time of service. Most insurance companies have requirements for authorization of services and/or referrals from the Primary Care Physician prior to the services. If you present for your appointment and you have not provided your correct insurance to ensure verification, authorization of services, and all required referrals, you will not be seen and your appointment will be rescheduled.

- _____(Initial) **Payment in Full for non insurance services is expected at the time of service. Co-payments for services are required at the time of registration. Please be advised that we are contractually obligated by your insurance carrier to collect your co-payment at the time of service. If you arrive without the ability to pay for your services or your co-pay you will not be seen and your visit will be rescheduled.**

- If you have insurance, as a courtesy to you, we will file your primary and secondary insurance claim for services at no cost to you. However, we will not wait more than 45 days for the insurance to pay. After 45 days it is your responsibility to contact your insurance company and follow up on why your claim has not been paid. You must take the necessary action required to get your claim paid and communicate your actions to our office. Failure to assist our office in timely payment of your insurance claim will result in the total charges being transferred to patient liability. Any patient liability assigned to you by your insurance carrier will be billed to you. Once insurance has paid, payment in full of the patient assigned liability will be expected with the receipt of your statement. You will receive two billing statements regarding your balance. If we do not hear from you after these two statements, your account will be subject to our collection process unless prior arrangements are made with our financial office.

- _____(Initial) We are committed to providing the highest quality care for our patients and we charge what is usual and customary for our area. You are ultimately responsible for all clinic and surgery fees relating to your care. **You are responsible for payment regardless of your insurance company's arbitrary determination of usual and customary rates.** Your insurance policy is a contract between you and your insurance company. Any disagreement you have concerning the amount your insurance pays should be directed to your insurance company.

- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover or which they may consider medically unnecessary, and, in some instances, you will be responsible for these amounts. Your policy may also contain plan specific limitations that apply to referrals, referral dates and number of visits. We will make every effort to ascertain your coverage for our services before treatment and will make you aware of our findings.

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However, this does not guarantee payment from your insurance carrier. The contract of coverage is between you and your insurance carrier and it is your responsibility to understand your coverage, coverage requirements and limitations due to the variations between policies. You will be expected to pay for the patient liability assigned to you by your insurance carrier.

- _____(Initial) For services that are not covered by insurance, the practice requires payment of 100% of the total **estimated charges** unless prior payment arrangements have been set up with our office.

- **Insured individuals electing to be self-pay**. The patient has the right to elect not to file their health insurance and elect to be a self-pay patient for services provided. The patient will be financially responsible for charges incurred and payment will be due at the time of service. After services have been rendered, the patient will not be able to file their health insurance for the services due to insurance claim submission requirements. We will not file insurance for any services where the patient elected to be self-pay. The patient's election to not file the services to their insurance company does not affect or reduce any out of pocket financial responsibility for future services as determined by their insurance plan.

- _____(Initial) **If you do not have insurance coverage for the service, are self-pay, or have insurance that we do not participate in or accept,** payment is expected at the time of service. We have established a discounted self-pay rate for our services. Prior financial arrangements must be made and approved before your visit if you cannot pay 100% at the time of service.

  No discount of assigned insurance patient liability (co-pay, deductibles, co-insurance) will be made to comply with federal insurance regulations and law.

  If financial arrangements have not been made and you arrive without the ability to pay for the services you will not be seen and your visit will be rescheduled.

- _____(Initial) Out of Network Insurance – Some insurance plans require you to pay different out-of-pocket amounts based on the provider and/or location where the service is performed. Deductibles, co-insurance and co- payments may also apply according to your insurance plan. By law, you are responsible for these amounts, as well as any non-covered services outlined in your health plan. It is your responsibility to inquire about any plan specific coverage limitations with your insurance company. You can choose to have the services performed as "Out of Network" or as self pay. You may also apply for financial hardship review if the "Out of Network" patient liability exceeds your ability to pay.

- Insurance information provided after the services have been provided will be billed or not billed at our discretion. Due to the Insurance contractual requirements for referrals, authorization of services and timely filing limitations insurance must be presented prior to services being provided. If we agree to bil your insurance you will be held liable for the charges if the insurance denies your claim as untimely because of late presentation of coverage or for lack of timely authorizations or referrals.

- Patients who request payment arrangements and/or financial hardship adjustments are required to supply financial documentation to support their request. Financial documentation will include income and expenses as outlined on our financial assistance application. Failure to supply the required documentation will result in normal collection activity being adhered to.

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- In the event your account/s must be turned over for outside collections, you will be billed and are responsible for all fees involved in the collection process. Returned checks are subject to a handling fee of $30.00.

  In the event you have an account with a credit balance, we reserve the right to transfer credits to any other outstanding account balances prior to issuing a refund.

- Patients with a history of presenting for their appointment without the ability to pay their co-pay, short notice (less than 24 hours) cancelling of appointment or not showing up for their appointments will be subject to be reviewed for dismissal from our practice.

- There is a charge of $25.00 per page to complete FMLA paperwork, forms for disability claims, accident or injury claims, attorney verification of medical condition or any other non-medical services reimbursement paperwork. Payment must be made at the time the forms are complete. Some third party forms requests must be paid for prior to the forms being completed.

We realize that temporary financial problems do occur. If such problems do arise, we encourage you to contact us promptly for assistance. If you have any questions about the above information, or any uncertainty regarding your insurance coverage, PLEASE do not hesitate to ask us.

Authorization: I hereby authorize my attending physician to administer treatment, diagnostic testing and perform procedures as may be deemed necessary or advisable in my diagnosis. I further authorize the release of any medical information necessary to process my insurance claim and request payment of medical services to be assigned directly to my attending physician In the event my insurance makes payment directly to me for services I will immediately endorse and assign the payment to my attending physician If my insurance does not cover services rendered, I agree to be personally and fully responsible for payment. I give my attending physician permission to appeal any denials by my insurance for services rendered on my behalf. I will assist my attending physician with follow up of timely payment, requests for information and appeals to my insurance as necessary to ensure full and timely payment for services received.

I have read the Financial Policy, Consent for Treatment, Release of Medical Information, policy and understand and agree to its terms. This authorization is to remain in full force unless I revoke the same in writing.

_____ _____

(Patient/Responsible Party) Signature (Patient/Responsible Party) Printed Name

_____ _____

(Date) (Date)

Texas Institute of Pain and Spine

INFORMED CONSENT AND PAIN MEDICINE AGREEMENT

AS REQUIRED BY THE TEXAS MEDICAL BOARD

REFERENCE: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9, CHAPTER 170

5th Edition: Developed by the Texas Pain Society, January 2021 (www.texaspain.org)

NAME OF PATIENT: _____ DATE: _____

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 (medication) therapy to be used, so that you may mak an informed decision whether or not to take the drug(s) knowing the risks and hazards involved. This disclosu is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give withhold your consent/permission to use the drug(s) recommended to you by me, as your physician. It is essential for the trust and confidence required for a proper patient-physician relationship and is intended to inform you of your physician's expectations that are necessary for patient compliance. For the purpose of th agreement the use of the word "physician" is defined to include not only your physician but also your physician's authorized associates, physician assistants, nurse practitioners, technical assistants, nurses, staff, a other health care providers as might be necessary or advisable to treat your condition.

CONSENT TO TREATMENT AND/OR DRUG THERAPY: I voluntarily request my physician (name at bottom of agreement) to treat my condition of chronic pain, which is a state of pain that persists beyond the usual course of an acute disease or healing of an injury. 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 a part of the treatment of my chronic pain.

It has been explained to me that these medication(s) include opioid/narcotic drug(s). I have discussed with m Pain Medicine Physician the risks and benefits of the use of controlled substances for the treatment of chroni pain, including an explanation of the following: (a) diagnosis; (b) treatment plan; (c) anticipated therapeutic results, including realistic expectations for sustained pain relief, improved functioning and possibilities for la of pain relief; (d) therapies in addition to or instead of drug therapy, including physical therapy or psycholog techniques; (e) potential side effects and how to manage them; (f) adverse effects, including the potential for dependence, addiction, tolerance, and withdrawal; and (g) potential complications and impairment of judgm and motor skills. 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 th it only describes the most common side effects or reactions, and that accidental overdose, injury and death a also possibilities as a result of taking these medication(s).

I understand that concurrently consuming sedating substances like alcohol, or taking additional types of sedating controlled medications, such as benzodiazepines, along with opioids increases my chance for accidental overdose, injury, and death. If in the unusual situation it is medically indicated for me to receive multiple types of controlled substances, I understand that I will require close supervision of medical speciali to maximize my safety. I agree to follow their direction on the proper use of these medications. Deviation f using medications as directed is grounds for discontinuation of pain therapy.

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 A EXAMINATIONS BEFORE AND DURING MY TREATMENT. Those tests include random unannoun checks for drugs (urine, blood, saliva or any other testing indicated and deemed necessary by my physician a any time) 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 substance or absence of authorized substances may result in my being discharged from my Pain Medicine Physician's care.

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 tc urinate), orthostatic hypotension(low blood pressure), arrhythmias(irregular heartbeat), insomnia, depression impairment of reasoning and judgment, respiratory depression (slow or no breathing), impotence, tolerance t medication(s), physical and emotional dependence or even addiction, and death. I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction times might still be slowed. Such activities include bu are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself.

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 ar functional life. I realize that I may have a chronic illness and there is a limited chance for complete cure, but goal of taking medication(s) on a regular basis is to reduce (but probably not eliminate) my pain so that I car enjoy an improved quality of life. I realize that the treatment may 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 fro this treatment plan and discontinue the use of the medication(s) at any time and that I will notify my physici 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 any condition. The long-term use of medications to treat chronic pain is controversial because of the uncerta regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask quest about my condition and treatment, risks of non-treatment and the drug therapy, medical treatment or diagno 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.

For female patients only:

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

_____If I am not pregnant, I will take appropriate precautions to avoid pregnancy 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.**

I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) 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, or baby.

PAIN MEDICINE AGREEMENT:

I UNDERSTAND AND AGREE TO THE FOLLOWING:

That this pain medicine agreement relates to my use of any and all medication(s) called dangerous drugs and controlled substances (i.e., opioids, also called narcotics or painkillers, and other prescription medications) fo chronic pain prescribed by my physician. I understand that there are many strict federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). **Therefore, medication will only be provided so long as I follow the rules specified in this Agreement.**

The term "Pain Medicine Physician" below means your primary Pain Medicine Physician or your physician who is managing your pain, or that physician's Physician Assistant or Nurse Practitioner, or another physician covering for your primary Pain Medicine Physician.

My Pain Medicine Physician may at any time choose to discontinue medication(s). Failure to comply w any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or m discharge from care and treatment. Discharge may be immediate for any criminal behavior.

(***Patient Shall Acknowledge All Provisions by Initialing***)

_____ I am aware that all controlled substance prescriptions are now being monitored by the Texas State Board of Pharmacy and that information must be accessed by my Pain Medicine Physician every time a prescription is written, and by my pharmacist every time before my prescription is dispensed.

_____ I will not consume alcohol or use any illegal substances (such as marijuana, heroin, cocaine, methamphetamines, etc.) while being prescribed dangerous and controlled substances for the treatmer chronic pain.

_____I agree to submit to laboratory tests for drug levels upon request, including urine and/or blood screens, to detect the use of non-prescribed and prescribed medication(s) at any time and without prio warning. If I test positive for alcohol or illegal substance(s), 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.

_____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 schedule

refill, even if my prescription(s) run out. My Pain Medicine Physician may limit the number and frequency of prescription refills.

_____ 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 nc be replaced. But if my medications were stolen and I provide my Pain Medicine Physician with a copy of the police report, my Pain Medicine Physician after carefully reviewing my situation, ma issue an early refill.

_____ My Pain Medicine Physician will manage all of my chronic pain symptoms. Only my Pain Medicine Physician may prescribe Dangerous Drugs and Controlled Substances for the treatme of chronic pain. I will receive controlled substance medication(s) only from ONE Pain Medicine Physician, unless it is for an emergency or the medication(s) that is being prescribed by another physician is approved by my Pain Medicine Physician. Information that I have been receiving medication(s) prescribed by other physicians that has not been approved by my Pain Medicine Physici may lead to a discontinuation of medication(s) and treatment. All other health related issues must be managed by my primary care physician and my other specialists.

_____I agree that I will inform any physician who may treat me for any other medical problem(s) tha am enrolled in a pain medicine program and have signed this Pain Medicine Agreement.

_____I hereby give my Pain Medicine Physician permission to discuss all diagnostic and treatment details with my other physician(s) and my pharmacist(s) regarding my use of medications prescribed b my other physician(s). I give my Pain Medicine Physician permission to obtain any and all medical records necessary to diagnose and treat my painful conditions.

_____ I will use the medication(s) exactly as directed by my Pain Medicine Physician. Any unauthorized increase in the dose of medication(s) may cause the discontinuation of my pain treatment(s).

_____ If anyone other than my Pain Medicine Physician prescribes me medication(s) to treat acute, p surgical or chronic pain, then I will disclose this information to my Pain Medicine Physician at or bef my next date of service, which must include, at a minimum, the name and contact information for the person who issued the prescription, the date of the prescription, the name and quantity of the drug prescribed, and the pharmacy that dispensed the medication.

____I will alert my physician if I receive a prescription for Naloxone or any opioid antagonist which designed to reverse the effects of an accidental or intentional overdose of pain medication.

_____ All medication(s) must be obtained at one pharmacy designated by me, with exception for th circumstances for which I have no control or responsibility, that prevent me from obtaining prescribe medications at my designated pharmacy. Should the need arise to change pharmacies, my Pain Medi Physician must be informed at or before my next date of service regarding the circumstances and the identity of the pharmacy. I will use only one pharmacy and I will provide my pharmacist a copy of th

agreement. I authorize my Pain Medicine Physician to release my medical records to my pharmacist as needed.

_____ My progress will be periodically reviewed and, if the medication(s) are not improving my functi and quality of life, the medication(s) may be discontinued.

_____ I must keep all follow-up appointments as recommended by my Pain Medicine Physician or m treatment may be discontinued.

_____ I agree not to share, sell or otherwise permit others, including my family and friends, to have access to my medications.

_____ I will not use any cannabidiol (CBD) products unless one of my physicians has prescribed Epidiolex, and I will immediately provide you with that physician's name and lab work so that I can make sure it is not causing problems with my current medications. I understand that the us of over-the-counter CBD products increases my risk of failing a urine drug test because of the presence of illegal substances present in many over-the-counter CBD products.

_____ I agree to be seen in in-person office visits because in Texas it is illegal to use Telehealth for th treatment of chronic pain with controlled substances.

_____ If it appears to my Pain Medicine Physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then my Pain Medicine Physician may try alternative medication(s) or may taper me off all medication(s). I will not hold my Pain Medicine Physician liable for problems caused by the discontinuance of medication(s).

_____ I recognize that my chronic pain represents a complex problem which may benefit from physic therapy, psychotherapy, alternative medical care, interventional pain medicine (e.g. steroid injections, nerve ablations, implants to relieve pain, etc.) etc. I also recognize that my active participation in th management of my pain is extremely important. I agree to actively participate in all aspects of the p medicine program recommended by my Pain Medicine Physician to achieve increased function and improved quality of life.

_____ I understand many prescription medications for chronic pain produce serious side effects inclu drowsiness, dizziness, and confusion. Alcohol will enhance all of these side effects and I will disconti it before starting these medications.

I certify and agree to the following (*Patient Shall Acknowledge All Provisions by Initialing*):

_____ 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 agreeme 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** to me 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) 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.**

_____ 5) If I become a patient in this clinic and receive controlled substances to control my pain, this Pain Medicine Agreement supersedes any other pain management agreement that I may have signed in the past.

_____

Name and contact information for pharmacy

_____

Patient Printed Name

Physician Printed Name *(or Appropriately Authorized Assistan*

_____

Patient Signature

Physician Signature *(or Appropriately Authorized Assistant)*

A. Notifier:
B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D._____below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws. Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE (_____) _____ ALT. PHONE (_____) _____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____) _____ Fax (_____) _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name Texas Institute of Pain and Spine
Address 1920 Country Place Parkway Suite 160
City Pearland State TX Zip Code 77584
Phone (832) 736-2677 Fax (832) 730-4574

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ All health information
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other _____

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes)
_____ Drug, Alcohol, or Substance Abuse Records
_____ Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

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 under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." 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.

SIGNATURE X _____ _____
Signature of Individual or Individual's Legally Authorized Representative — DATE

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X _____ _____
Signature of Minor Individual — DATE

TEXAS INSTITUTE OF
Pain & Spine

1920 Country Place Parkway, Suite 160
Pearland, TX 77584
P: 832-736-2677 F: 832-730-4574

AUTHORIZATION TO DISCUSS OR DISCLOSE HEALTH INFORMATION

I authorize Dr. Lance LaFleur to discuss and/or disclose my health information with the following person/persons below:

1. _____
2. _____
3. _____
4. _____
5. _____

I understand that this information may include any and all treatment plans, medication issues, history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service / psychiatric care and evaluations; treatment for alcohol and/or drug abuse; or similar conditions.

The following information should not be released: _____

Patient's Name: _____

SSN# _____ DOB: _____

Patient's Signature: _____ Date: _____

Witness: _____ Date: _____

This form is valid for one year from the patient signature date.

TEXAS INSTITUTE OF
Pain & Spine

J. Lance LaFleur, MD
1920 Country Place Parkway, Suite 160
Pearland, TX 77584
P: 832-736-2677 F: 832-730-4574

NO SHOW/ APPOINTMENT POLICY

The following outlines the policy of cancelling and/or not showing up for appointments without a 24 hour notice.

- There will be a fee accessed to your account should you not show up and/or cancel your new patient and/or follow up appointments of $30.00 per occurrence. After 3 violations you could be subject to termination from the practice.

- There will be a fee accessed to your account should you not show up and/or cancel your procedure appointment of $60.00 per occurrence. After 3 violations you could be subject to termination from the practice.

- If you are more than 15 minutes late to your appointment you will be rescheduled, and this is considered not showing up for your appointment. After 3 violations you could be subject to termination from the practice.

- All patients that are undergoing or expect to be under sedation for a procedure MUST have their driver stay in the clinic or front lobby. Patient will not be allowed to proceed with the procedure if driver is not present at all times.

These fees will be due immediately and are not eligible for payment arrangements. If you cannot pay the no show fee, then your appointment with be **CANCELLED** until payment of fee is made. By signing this acknowledgement, you hereby agree that you have read the policy in full and agree to adhere to the policy.

_____
Patient Name

_____
Patient Signature

_____
Date

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Pearland, TX 77584

Physician Ownership Disclosure Form

To: Patients at the time of referral

On the date of your first contact with Lance LaFleur, M.D. (The "Physician") or when your records were updated, you were informed that the Physicians may refer you to a facility, laboratory, or other entity, including, but not limited to, Altus Houston Hospital, Ascendant of Houston, Alliance MRI, Complete Surgery, Healthcare Solutions Holdings, Premier Performance Physical Therapy, Townsen Memorial Surgery Center, and River Basin Medical Center (the "Entities").

The Physicians may recommend that you be referred to one or more of the Entities. In connection with such referral to the Entities, you are hereby advised again that the Physicians may have an investment interest in one or more of the Entities and, therefore, may receive, directly or indirectly, remuneration as a result of such referral.

This disclosure is being provided to you at the time of your referral by one of the Physicians to help you make an informed decision about your health care. You have the right to choose your health care Physician. You have the option of obtaining health care ordered by your Physician at a different facility other than the Entities. You will not be treated differently by your Physician, the Physician's staff, or the Entities if you choose to use a different facility.

Should you prefer to be referred to a facility other than one of the Entities, you will be provided with a list of alternative health care Physicians or facilities and you have the right to choose one of these alternative referral Physicians or facilities.

_____
Patient name (please print)

_____
Patient signature

_____
Date

Texas Institute of Pain and Spine
1920 Country Place Parkway, Suite 160
Pearland, TX 77584

Patient Name: _____ Date: _____

Modified Oswestry Low Back Pain Questionnaire

This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by marking in each section **one circle** that most applies to you. We realize that you may feel that more than one statement may relate to you, but please **just mark the circle that most closely describes your problem.**

Section 1 – Pain Intensity

- o The pain comes and goes and is very mild.
- o The pain is mild and does not vary much.
- o The pain comes and goes and is moderate.
- o The pain is moderate and does not vary much.
- o The pain comes and goes and is severe.
- o The pain is severe and does not vary much.

Section 2 – Personal Care

- o I do not have to change my way of washing or dressing to avoid pain.
- o I do not normally change my way of washing or dressing even though it causes me pain.
- o Washing and dressing increase the pain, but I manage not to change my way of doing it.
- o Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- o Because of the pain I am unable to do some washing and dressing without help.
- o Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting (skip if you have not attempted lifting since the onset of your low back pain)

- o I can lift heavy weights without extra low back pain.
- o I can lift heavy weights but it causes extra pain.
- o Pain prevents me lifting heavy weights off the floor.
- o Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- o Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- o I can only lift light weights at the most.

Section 4 - Walking

- o I have no pain walking.
- o I have some pain on walking, but I can still walk my required to normal distances.
- o Pain prevents me from walking long distances.
- o Pain prevents me from walking even short distances.
- o Pain prevents me from walking at all.

Section 5 - Sitting

- o Sitting does not cause me any pain.
- o I can sit as long as I need provided I have my choice of sitting surfaces.
- o Pain prevents me from sitting more than 1 hour.
- o Pain prevents me from sitting more than ½ hour.

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- Pain prevents me from sitting more than 10 minutes.
- Pain prevents me from sitting at all.

Section 6 - Standing

- I can stand as long as I want without pain.
- I have some pain while standing, but it does not increase with time.
- I cannot stand for longer than 1 hour without increasing pain.
- I cannot stand for longer than ½ hour without increasing pain.
- I cannot stand for longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain immediately.

Section 7 - Sleeping

- I have no pain while in bed.
- I have pain in bed, but it does not prevent me from sleeping well.
- Because of pain I sleep only ¾ of normal time.
- Because of pain I sleep only ½ of normal time.
- Because of pain I sleep only ¼ of normal time.
- Pain prevents me from sleeping at all.

Section 8 – Social Life

- My social life is normal and gives me no pain.
- My social life is normal, but increases the degree of pain.
- Pain prevents me from participating in more energetic activities e.g. sports, dancing.
- Pain prevents me from going out very often.
- Pain has restricted my social life to my home.
- I hardly have any social life because of pain.

Section 9 - Traveling

- I get no pain while traveling
- I get some pain while traveling, but none of my usual forms of travel make it any worse.
- I get some pain while traveling, but it does not compel me to seek alternative forms of travel.
- I get extra pain while traveling that requires me to seek alternative forms of travel.
- Pain restricts all forms of travel.
- Pain prevents all forms of travel except that done lying down.

Section 10 – Employment / Homemaking

- My normal job/homemaking duties do not cause pain.
- My normal job/homemaking duties cause me extra pain, but I can still perform all that is required of me.
- I can perform most of my job/homemaking duties, but pain prevents me from performing more physically stressful activities e.g. lifting, vacuuming, etc.
- Pain prevents me from doing anything but light duties.
- Pain prevents me from doing even light duties.
- Pain prevents me from performing any job or homemaking chores.

SCORE _____

Patient Name:_____ Date:_____

DOB:_____

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

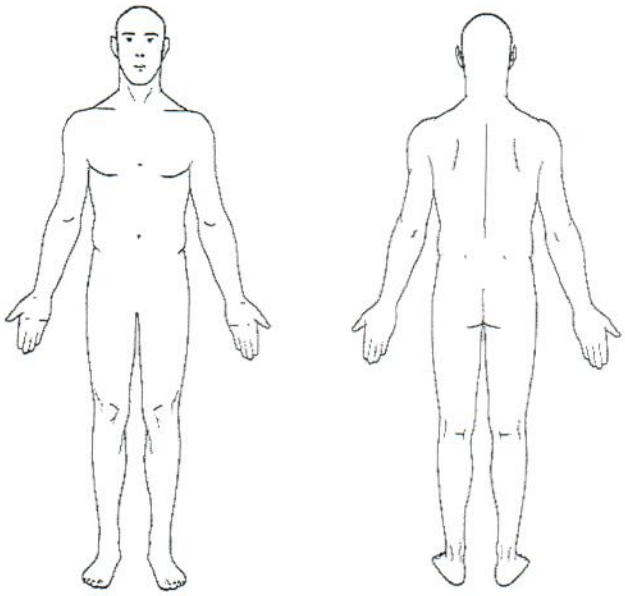
Texas Institute of Pain and Spine– NEW PATIENT INTAKE FORM

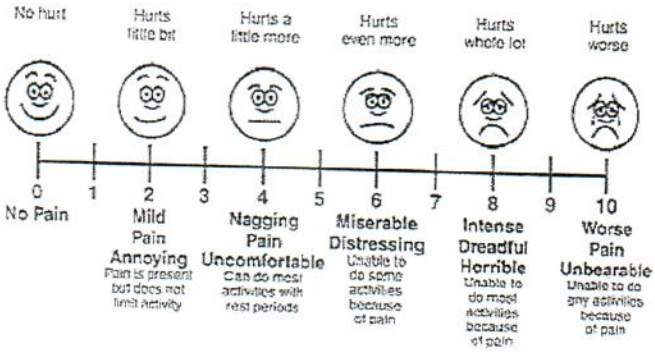
Patient's Name: _____ Date: _____

PCP: _____ Were you referred by another physician? _____

If not, how did you hear about us? _____

Please use the diagram above to specify your areas of pain





What number on the scale (0-10)…

…best describes your pain **right now**? _____

…best describes your **worst pain**? _____

…best describes your **least pain**? _____

…best describes your **average pain over the last month**? _____

Mark on the diagram above where your pain is located.

PAIN DESCRIPTION

Where is your WORST area of pain located? _____

Does your pain radiate? **YES / NO**: If so, where to? _____

Do you have any additional areas of pain? **YES / NO:** If so, where? _____

How long have these symptoms occurred? _____ **(DAYS / WEEKS/ MONTHS/ YEARS)**

Is this from a prior injury? **(YES/NO)** What is the date of injury ___/___/_____

How did the injury/symptoms occur? Motor vehicle accident / work related / sports / slip or fall

If other, please explain: _____

How did it begin: **GRADUALLY / SUDDENLY**

Since your pain began, has it **(DECREASED / INCREASED / REMAINED THE SAME)**?

What word best describes your frequency of pain? **(CONSTANT / INTERMITTENT)**

When is your pain at its worse? **(MORNING / DAY / EVENINGS / MIDDLE OF NIGHT)**

SYMPTOMS

Circle all that apply:

Aching Cramping Hot/Burning Tiring/Exhausting Dull Shock-like Shooting Spasms Squeezing

Throbbing Numbness Stabbing/Sharp Tingling/Pins & Needles Clicking Locking Popping

Swelling Pain at Night Pain at rest Pain with Activities Soreness OTHER: _____

Circle all of the following activities that are adversely/negatively affected by pain:

Enjoyment of Life Ability to work Normally Worsened sleep General Activity Sleep Mood

Recreational Activities Relationships with People Ability to walk normally Worsened mood Walking

In the past three months have you developed any new? Circle all that apply:

Balance Problems Bladder Incontinence Vomiting Nausea Numbness/Tingling Where? _____

Difficulty Walking Bowel Incontinence Chills Fever Weakness Where? _____

Symptoms worsen when… *Circle all that apply:*

Weight bearing Standing Driving Squatting Kneeling Sitting Bending Climbing Twisting

Lying Supine Moving Walking Engaging in activities Lifting OTHER: _____

PREVIOUS STUDIES

Circle all that apply:

X-RAYS CT SCAN MRI EMG/NCV BONE SCAN MYELOGRAM
DISCOGRAM DEXA SCAN ULTRASOUND *OTHER:* _____

*Circle all previous treatments tried and * the items that have worked:*

Acupuncture Biofeedback Chiropractic Massage Physical Therapy Psychological Therapy TENS Unit
Joint Injections Epidural Steroid Injections Podiatrist Treatment
Ice Heat Rest Elevation Muscle Relaxants Assistive Device Immobilization NSAIDS Steroid Injections
Home Exercises Hypnosis Trigger Point Injections Medial Branch Blocks Nerve Blocks Radiofrequency Ablation
Spinal Cord Stimulator Spine Surgery Vertebroplasty/Kyphoplasty *OTHER:* _____

Have you seen anyone else for your condition? Circle all that apply.

Primary Care Physician Orthopedic Surgeon Spine Surgeon Pain Management Physician Chiropractic
Rheumatologist Emergency room Physician Podiatrist Psychologist Neurologist
Physical Therapist

ANESTHESIA HISTORY

Have you ever had anesthesia (sedation for a surgical procedure)? **YES / NO**
If so, have you ever had any adverse reaction to anesthesia? **YES / NO**

Which type of anesthesia did you react adversely to? Please circle all that apply.

LOCAL ANESTHESIA EPIDURAL GENERAL ANESTHESIA IV SEDATION

Do you have any family history of adverse reactions to anesthesia? If so, which of the following?

LOCAL ANESTHESIA EPIDURAL GENERAL ANESTHESIA IV SEDATION

PAST MEDICAL HISTORY

Please circle all that apply:

MUSCULOSKELETAL
Amputation Rheumatoid Arthritis Carpal Tunnel Syndrome Bursitis
Fibromyalgia Phantom Limb Pain Tennis Elbow Chronic Low Back Pain
Chronic Joint Pain Osteoporosis Chronic Neck Pain Osteoarthritis
Vertebral Compression Fracture Lupus

GENITOURINARY/NEPHROLOGY
Bladder Infection Urinary Incontinence
Kidney Infection Kidney Stone
Dialysis

LIVER
Hepatitis A
Hepatitis B
Hepatitis C

CARDIOVASCULAR/HEMATOLOGIC
Anemia High Cholesterol Stroke Bleeding Disorder Mitral Valve
Prolapse Coronary Artery Disease Murmur Heart Attack Phlebitis
High Blood Pressure Pacermaker/Defibrilator
Poor Circulation

HEAD/EYES/NOSE/THROAT
Headaches Head Injury
Thyroid Disease Migraines
Glaucoma

GENERAL
Cancer
Diabetes
HIV/AIDS

NEUROPSYCHOLOGICAL
Alcohol Abuse Alzheimer Disease Epilepsy Depression
Multiple Sclerosis Paralysis Prescription Drug Abuse
Peripheral Neuropathy Schizophrenia Seizures Bipolar

RESPIRATORY
Bronchitis Pneumonia
Exposure to Mold Asthma
Emphysema/COPD Tuberculosis

GASTROINTESTIONAL
Bowel Incontinence Acid reflux
Constipation Gastrointestinal Bleeding

PAST SURGICAL HISTORY

Please indicate any surgical procedures you have had done in the past, including the date, type, and any pertinent details.

Please circle all that apply.

Gallbladder Removal Appendectomy Caesarean Section Hysterectomy Laparoscopy Ovarian
Shoulder: Left/Right Hip: Left/Right Knee: Left/Right Valve Replacement Aneurysm Repair
Stent Placement Discectomy Laminectomy Spinal Fusion Hemorrhoid Surgery Tonsillectomy
Hernia Repair Vascular Surgery Thyroidectomy Other: _____
(Attach an additional sheet if necessary).

ALLERGIES

Do you have any known allergies? **YES / NO**

Are you allergic to shellfish or iodine? **YES / NO**

Are you allergic to Iodine / Tape / Latex? Circle all or any that apply.

If so, please list all medications and food you are allergic to:

_____

_____

_____

FAMILY HISTORY

Circle all appropriate diagnosis as they pertain to your biological mother & father ONLY

MOTHER	
Alcohol Problems	Headaches
Gambling Problems	Heart Disease
Diabetes	Liver Disease
Drug Problems	High Blood Pressure
Kidney Disease	Smoking
Rheumatoid Arthritis	Cancer
Stroke	

FATHER	
Alcohol Problems	Headaches
Gambling Problems	Heart Disease
Diabetes	Liver Disease
Drug Problems	High Blood Pressure
Kidney Disease	Smoking
Rheumatoid Arthritis	Cancer
Stroke	

☐ Please ***check*** if you have no significant family medical history.

Were you adopted? **YES/ NO**

SOCIAL HISTORY

Are you capable of becoming pregnant? **YES / NO**

If so, are you currently pregnant? **YES / NO**

What is your occupation? _____

Are you currently working? **YES / NO**

Circle all that apply below.

ALCOHOL USE
Current Alcoholism
History of Alcoholism
Social Alcohol Use
Never Drinks Alcohol
Daily limited Alcohol Use

TOBACCO USE
Current tobacco user
Former tobacco user
Never used tobacco

ILLICIT DRUG USE
Denies any illicit drug use
Currently using illicit drugs

Please list all illicit drugs: _____

Have you formerly used illicit drugs? **YES / NO** If so, please list which. _____

Have you ever abused narcotic or prescription medications? **YES / NO**

Are you recovering from drugs, alcohol, or any addiction? **YES / NO**

REVIEW OF SYSTEMS

Circle the following symptoms that you currently suffer from.
Note: Diagnosed conditions/diseases should be noted under past medical history section.

CONSTITUTIONAL

Weakness
Weight gain
Fatigue
Weight loss
Fever
Chills
Night Sweats

EYES

Recent vision changes
Eye glasses/contacts
Double Vision

EARS/NOSE/THROAT

Dental Problems
Ringing in ears
Earaches
Sinus Problems
Nosebleeds
Recurrent sore throat

CARDIOVASCULAR

Chest Pain
Irregular Heartbeat
Blood clots
Murmur
Rapid Heartbeat
Palpitations
Swollen Extremities
Fainting

RESPIRATORY

Cough
Wheezing
Shortness of breath on exertion/effort
Shortness of breath at rest

GASTROINTESTIONAL

Acid Reflux
Abdominal cramps
Constipation
Diarrhea
Vomiting
Coffee ground appearance in vomit
Dark & tarry stools

GENITOURINARY/NEPHROLOGY

Blood in urine
Low frequency/volume
Painful urination
Incontinence
Erectile dysfunction
Decreased urine
Flank pain

INTEGUMENTARY/SKIN

Change in skin color
Rashes
Puritis
Dry skin

MUSCULOSKELETAL

Joint swelling
Joint pain
Back pain
Muscle spasms
Neck pain
Pelvic pain
Joint Stiffness

PSYCHIATRIC

Depressed mood
Stress
Anxiety
Suicidal thoughts

ENDOCRINE

Heat intolerant
Cold intolerant
Hair changes
Excessive thirst

NEUROLOGICAL

Dizziness
Seizures
Headaches
Memory loss
Numbness/tingling
Difficulty with speech
Incoordination

HEMATOLOGIC/LYMPHATIC

Easy bruising
Easy bleeding
Slow healing wounds
Lymphadenopathy

ALLERGIC/IMMUNOLOGIC

Recurrent infections
Hives
Swelling
Itching eye/nose

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Patient Name: _____ Date: _____

MEDICATIONS:

Please indicate which (if any) of the following **BLOOD THINNERS** you are taking?

☐Aggrenox ☐Coumadin ☐Effient ☐Eliquis ☐Lovenox ☐Plavix ☐Pletal

☐Pradaxa ☐Ticlid ☐Xarelto ☐Warfarin

Other: _____

Please list ALL medications you are currently taking. Attach an additional sheet, if required.

Medication Name, Dose, Frequency

Pharmacy Name _____

Pharmacy Address _____

Pharmacy Phone Number _____