HOLISTIC **I**NNOVATIVE **I**NTERVENTIONAL **P**AIN **A**SSOCIATES
Dr. Sara Goel, DO
7700 Main Street, Suite 400
Houston, TX 77030
Phone: 346-230-4070
Fax: 281-605-6804

NEW PATIENT INTAKE FORM

DEMOGRAPHIC INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Phone Type: ☐ Home ☐ Cell ☐ Work

Email Address: _____ Preferred Language: _____

Marital Status: _____ Employment Status: _____

Occupation: _____ Employer: _____

Referred from: ☐ Physician: _____ ☐ Online ☐ Other: _____

INSURANCE INFORMATION

☐ **MEDICAL INSURANCE**

Primary Insurance: _____ Policy Holder: _____

Policy Number: _____ Group Number: _____

☐ **WORKER'S COMPENSATION** Carrier: _____ **OR** ☐ **DEPARTMENT OF LABOR**

Case Number: _____ Date of Injury: _____

☐ **LEGAL/LETTER OF PROTECTION**

Attorney's Name: _____ Attorney's Phone Number: _____

☐ **SELFPAY**

PHARMACY INFORMATION

Pharmacy Name: _____ Pharmacy Phone Number: _____

Pharmacy Address: _____

MEDICAL HISTORY

☐ High Blood Pressure ☐ High Cholesterol ☐ Heart Disease (heart attack, etc.)

☐ Blood clots/Embolism ☐ Diabetes ☐ Ulcers/Gastritis

☐ Lung Disease ☐ Liver Disease ☐ Kidney Disease

☐ Cancer ☐ Hepatitis A/B/C ☐ HIV/AIDS

☐ Arthritis ☐ Pregnancy

☐ Other: _____

Allergies: _____

Are you allergic to Latex or Iodine/Contrast? ☐ Yes ☐ No

Current Medications: _____

_____

_____

REVIEW OF SYSTEMS

☐ Difficulty Walking ☐ Fever/Chills ☐ Chest Pain

☐ Shortness of Breath ☐ Bowel/Bladder disturbance ☐ Seizures

☐ Diarrhea ☐ Nausea ☐ Vomiting

☐ Other: _____

SOCIAL HISTORY

☐ Smoke/Chew Tobacco ☐ Alcohol Use ☐ Illicit Drug Use

☐ None ☐ Other: _____

SURGICAL HISTORY

Have you ever had surgery? ☐ Yes ☐ No Have you ever had back/neck surgery? ☐ Yes ☐ No

Please list all surgeries and the date performed:

FAMILY HISTORY

☐ Chronic Pain ☐ Diabetes ☐ Heart Disease (heart attack, etc.)

☐ Arthritis ☐ Cancer ☐ Depression

☐ Substance/Drug/Alcohol Abuse ☐ Blood Clots/Bleeding Disorder

☐ Other: _____

PAIN DETAILS

Chief Complaint: _____

What caused your pain? ☐ Motor vehicle accident ☐ Job related injury ☐ Slip/Fall

☐ Other: _____

Please give details: _____

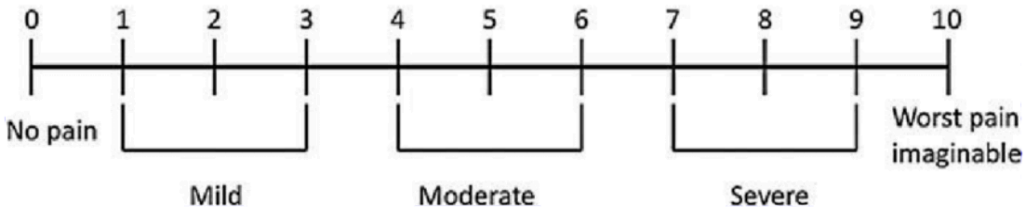
_____

_____

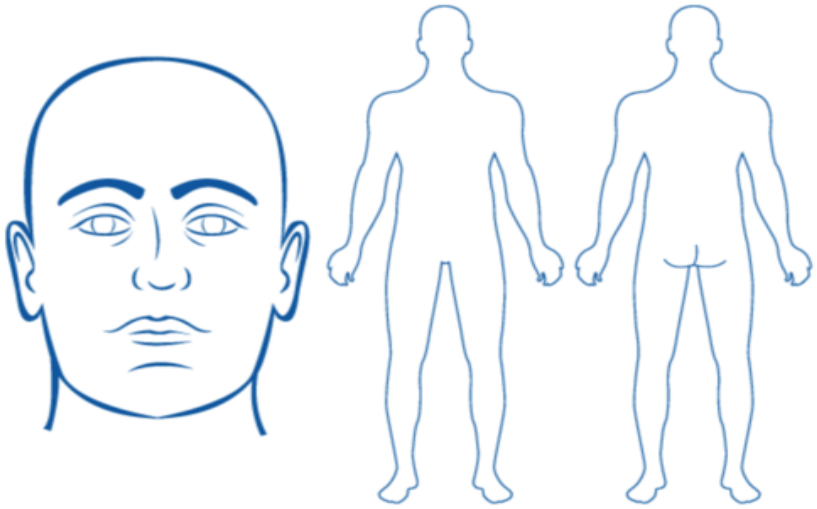
_____

_____

On a scale from 1-10, what is your current pain level? (please circle)



Where is your pain?



☐ **NECK PAIN**

Frequency of pain: ☐ Constant ☐ Intermittent
Pain rating (1-10): _____
The pain feels: ☐ Dull ☐ Achy ☐ Sharp ☐ Burning ☐ Stabbing
Associated with: ☐ Weakness ☐ Numbness ☐ Stiffness ☐ Burning ☐ Tingling ☐ Tightness ☐ Soreness ☐ Swelling
Pain is aggravated by: ☐ Prolonged Standing ☐ Prolonged Walking ☐ Prolonged Sitting ☐ Leaning Backward ☐ Bending Forward ☐ Physical Activity ☐ Sudden Movement
Pain is relieved by: ☐ Lying Down ☐ Therapy ☐ Massage ☐ Medications ☐ Heat ☐ Ice ☐ Injections ☐ Nothing
Does the pain radiate? ☐ Yes ☐ No
If yes, where? ☐ Shoulder: Left / Right / Both ☐ Arm: Left / Right / Both

☐ **THORACIC PAIN**

Frequency of pain: ☐ Constant ☐ Intermittent
Pain rating (1-10): _____
The pain feels: ☐ Dull ☐ Achy ☐ Sharp ☐ Burning ☐ Stabbing
Associated with: ☐ Weakness ☐ Numbness ☐ Stiffness ☐ Burning ☐ Tingling ☐ Tightness ☐ Soreness ☐ Swelling
Pain is aggravated by: ☐ Prolonged Standing ☐ Prolonged Walking ☐ Prolonged Sitting ☐ Leaning Backward ☐ Bending Forward ☐ Physical Activity ☐ Sudden Movement
Pain is relieved by: ☐ Lying Down ☐ Therapy ☐ Massage ☐ Medications ☐ Heat ☐ Ice ☐ Injections ☐ Nothing
Does the pain radiate? ☐ Yes ☐ No
If yes, where? ☐ Chest Cavity: Left / Right / Both

☐ **LOWER BACK PAIN**

Frequency of pain: ☐ Constant ☐ Intermittent
Pain rating (1-10): _____
The pain feels: ☐ Dull ☐ Achy ☐ Sharp ☐ Burning ☐ Stabbing
Associated with: ☐ Weakness ☐ Numbness ☐ Stiffness ☐ Burning ☐ Tingling ☐ Tightness ☐ Soreness ☐ Swelling
Pain is aggravated by: ☐ Prolonged Standing ☐ Prolonged Walking ☐ Prolonged Sitting ☐ Leaning Backward ☐ Bending Forward ☐ Physical Activity ☐ Sudden Movement
Pain is relieved by: ☐ Lying Down ☐ Therapy ☐ Massage ☐ Medications ☐ Heat ☐ Ice ☐ Injections ☐ Nothing
Does the pain radiate? ☐ Yes ☐ No
If yes, where? ☐ Hip: Left / Right / Both ☐ Leg: Left / Right / Both

☐ **JOINT PAIN**

☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand ☐ Hip ☐ Knee ☐ Ankle ☐ Foot
Where? ☐ Left ☐ Right ☐ Both
Frequency of pain: ☐ Constant ☐ Intermittent
Pain rating (1-10): _____
The pain feels: ☐ Dull ☐ Achy ☐ Sharp ☐ Burning ☐ Stabbing
Associated with: ☐ Weakness ☐ Numbness ☐ Stiffness ☐ Burning ☐ Tingling ☐ Tightness ☐ Soreness ☐ Swelling
Pain is aggravated by: ☐ Prolonged Standing ☐ Prolonged Walking ☐ Prolonged Sitting ☐ Leaning Backward ☐ Bending Forward ☐ Physical Activity ☐ Sudden Movement
Pain is relieved by: ☐ Lying Down ☐ Therapy ☐ Massage ☐ Medications ☐ Heat ☐ Ice ☐ Injections ☐ Nothing

TREATMENTS TRIALED

Have you tried medication? ☐ Yes ☐ No

If yes, please indicate which of the following types of medications you have tried. If you remember, please write the name and doses of the medication.

☐ NSAIDs _____

☐ Neuropathic medications _____

☐ Muscle relaxers _____

☐ Pain medications _____

☐ Other _____

Have you tried therapy? ☐ Yes ☐ No

If yes, please indicate which of the following types of therapy you have tried. Please indicate how often you attended, how many sessions you completed and if you are currently attending.

☐ Physical Therapy _____

☐ Occupational Therapy _____

☐ Speech Therapy _____

☐ Chiropractor _____

☐ Psychology Sessions _____

☐ Other _____

Have you ever had injections or other interventions? ☐ Yes ☐ No

If yes, please describe what type of injection/intervention you had and when you had it done.

_____

_____

_____

_____

_____

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FINANCIAL POLICY

General Information:
For your convenience, we accept cash and debit/credit cards. We will assist you with insurance questions. However, **knowing your insurance benefits – including eligibility, covered benefits, and medically necessary procedures – is your responsibility.** Please contact the customer service department at your insurance company for any questions regarding your coverage. Any outstanding balances are required to be paid before additional treatment can be rendered.

Managed Care Patients:
Our office contracts with a number of insurance companies, and for patients who are participating in these plans, we will submit a claim to your insurance carrier for services rendered. All necessary insurance information and appropriately completed forms must be presented to and verified by our staff prior to your appointment.

Current insurance information (copy of your card) and valid identification (driver's license) may be requested and obtained at each visit. To properly bill your insurance company, we require that you disclose all insurance information, including primary and secondary insurance, as well as any changes to your coverage or personal information. **Failure to provide complete and accurate insurance information may result in the entire bill being categorized as your financial responsibility.**

Payments for copays, deductible, and/or coinsurances as specified by your insurance carrier will be collected at the time of service. Copays will be collected upon arrival. For deductible and coinsurance amounts, we will make a good-faith estimate of your portion due, based on our contract with your plan. You may receive a statement for any remaining balance after your insurance company processes the claim. **Payment is expected at the time of service for procedures as well as office visits.** You may refuse to have a procedure performed for financial reasons; however, refusal may affect our ability to provide you the level of care expected of a board-certified specialist.

You are financially responsible for any charges not covered by your insurance plan, including charges denied for lack of medical necessity or non-covered benefits. We do not alter documentation or diagnoses to influence insurance coverage determinations.

If your insurance plan requires a referral from your primary care physician or prior authorization from your insurance company, **it is your responsibility to ensure it is obtained** before your appointment. If authorization is not received by the time of your appointment, the visit may be rescheduled. Failure to obtain authorization or referral may result in a denial of coverage, in which case you are responsible for payment in full.

Personal Injury Claims:
Validated personal injury claims may be billed to your attorney or auto insurance carrier. Should the carrier deny a previously validated claim, you are financially responsible for all charges.

I hereby authorize and direct my attorney, as well as any subsequent attorney I may obtain, to pay directly to Holistic Innovative Interventional Pain Associates all amounts due for services rendered, including those unrelated to the accident.

Workers' Compensation:
Validated workers' compensation services will be billed either to the employer or the employer's insurance carrier. If your employer does not confirm the injury as work-related, you will be responsible for payment. In the event that a previously validated claim is later denied, the patient will be responsible for all services rendered.

Out-of-State Workers' Compensation or Unverified Occupational Injuries:
Payment in full is required at the time of the visit. A receipt will be provided for you to submit to your carrier. You or your legal representative remain responsible for all charges if the claim is denied or unpaid.

Assignment of Insurance Benefits and Release of Information:
I hereby authorize and request that payment of authorized Medicare or other insurance benefits be made on my behalf, directly to **Holistic Innovative Interventional Pain Associates**, for any medical or surgical services rendered by its affiliated medical groups.

I authorize any holder of medical or other information about me to release to the **Social Security Administration, Centers for Medicare & Medicaid Services (CMS), its agents or carriers, and my insurance company** any information necessary to determine benefits payable for related services.

I understand that I must notify the healthcare provider of any other party who may be responsible for payment for my treatment.

Acknowledgment of Financial Responsibility and Agreement

By signing below, I acknowledge that I have read, understand, and agree to the terms outlined in this Financial Policy. I accept full financial responsibility for all charges not covered by my insurance.

Patient Name: _____ **DOB:** _____

Patient Signature: _____ **Date:** _____

***OR* Authorized Representative Signature:** _____ **Date:** _____

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CONSENT FOR PAIN MANAGEMENT

Please **initial** each line and **sign** the second page.

_____ I understand that Dr. Sara Goel ("my physician") may be recommending opioid medicine to treat my pain.

_____ I understand that many medications can interact with opioids, either increasing or decreasing their effect. Therefore, I have disclosed all medications, supplements, and treatments I am currently receiving, including over-the-counter items, and I agree to notify my physician of any new medications or treatments immediately.

_____ I have informed my physician of my complete personal substance use history and any relevant family history.

_____ I understand that initiating opioid medication is considered a **therapeutic trial**, and continued prescribing depends on functional improvement, tolerability of side effects, and adherence to the treatment plan.

_____ I understand that if I do not experience meaningful improvement in function or quality of life, or if side effects outweigh benefits, my physician may reduce the dose, change medications, or discontinue treatment.

_____ I understand that taking opioid medication has certain risks associated with it. These include, but are not limited to, the following:

- Allergic reactions
- Overdose (which may lead to hospitalization or death)
- Slowing of breathing rate
- Slowing of reflexes or reaction time
- Sleepiness, drowsiness, dizziness, and/or confusion
- Impaired judgment and inability to operate machines or drive motor vehicles
- Gastrointestinal issues (e.g., constipation, nausea, vomiting)
- Hormonal changes (e.g., reduced libido, menstrual irregularities)
- Risk of falls, particularly in elderly or medically fragile patients
- Hyperalgesia (increased sensitivity to pain)
- Itching
- Physical dependence or tolerance to the pain relieving properties of the medication (This means that if my medication is stopped, reduced in dose, or rendered less effective by other medications I may be taking, I may experience runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body, and a flu-like feeling. These can be very painful but are generally not lifethreatening.)
- Addiction
- Failure to relieve pain

_____ If I become pregnant or plan to, I will notify my physician and my OB-GYN immediately, as opioid medications may cause harm to a fetus, including withdrawal symptoms in newborns (neonatal abstinence syndrome).

_____ I will take my medications **only as prescribed**. I will not change the dosage or frequency without explicit approval from my physician.

_____ I understand that unauthorized changes may result in running out of medication early. **Early refills are not permitted under any circumstances.**

_____ I understand that improper use of opioids or abrupt cessation may result in withdrawal symptoms, including anxiety, sweating, nausea, vomiting, abdominal cramping, and general discomfort.

_____ I will obtain all opioid prescriptions **exclusively** from Dr. Goel and her affiliated clinic.

_____ I will not request opioid prescriptions after hours, on weekends, or from other providers without prior authorization.

_____ I will not use alcohol while taking opioid medications.

_____ I understand that even if I hold a state-issued medical marijuana card, **opioid prescriptions will not be provided if I am using marijuana in any form**, including inhaled, edible, topical, or tincture.

_____ I agree to comply with random **pill counts, urine drug screens (UDS), blood drug screens, or other monitoring** as required by my physician and clinic policy to confirm adherence and screen for illicit or unauthorized drug use.

_____ I understand that **any evidence of non-prescribed substances, illicit drugs, or absence of prescribed medication in my system may result in the immediate discontinuation of opioid therapy**, and referral to a substance use treatment program may be initiated.

_____ I will not share, sell, trade, or permit anyone else to access my medication. **I understand that doing so is illegal and may result in dismissal from care and notification to law enforcement.**

_____ I will keep my medication in a secure location. **Stolen medications will not be replaced without a police report and will be reviewed on a case-by-case basis.**

_____ I understand that this clinic follows all state and federal prescribing laws, including Prescription Drug Monitoring Program (PDMP) reporting, and I consent to having my prescribing and pharmacy history reviewed.

_____ I understand that this clinic has a **zero-tolerance policy** for abusive, threatening, or dishonest behavior regarding narcotic prescriptions. Violations may result in immediate discharge from the practice.

_____ I HAVE READ OR HAD THIS FORM READ TO ME.

_____ I UNDERSTAND ALL OF ITS CONTENTS.

_____ I HAVE HAD A CHANCE TO HAVE ALL OF MY QUESTIONS REGARDING THIS TREATMENT ANSWERED TO MY SATISFACTION.

_____ BY SIGNING BELOW, I GIVE VOLUNTARY INFORMED CONSENT FOR THE USE OF OPIOID MEDICATIONS IN THE TREATMENT OF MY PAIN.

_____ I UNDERSTAND THAT FAILURE TO ADHERE TO THIS AGREEMENT WILL BE CONSIDERED NON-COMPLIANCE AND MAY RESULT IN THE TERMINATION OF OPIOID PRESCRIBING AND POSSIBLE DISMISSAL FROM THE PRACTICE.

Patient Name: _____ **DOB:** _____

Patient Signature: _____ **Date:** _____

***OR* Authorized Representative Signature:** _____ **Date:** _____

Physician Signature: _____ **Date:** _____

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APPOINTMENT OFFICE POLICIES

We are committed to providing all patients with high-quality care in a timely and efficient manner. The following policies are in place to help ensure smooth scheduling, communication, and continuity of care.

All Patients

While we strive to remain on schedule, unforeseen delays may occur. Patients are advised to avoid scheduling other appointments or commitments within at least two hours of their scheduled visit. If this presents a conflict, please notify the receptionist so we can assist with rescheduling.

A valid phone number and email address must be provided to facilitate appointment reminders and communication. Our confirmation policy is strictly enforced.

Patients may be asked to provide a urine sample during their visit. To avoid delays, please arrive prepared to do so.

Our staff works to ensure your medical record includes up-to-date labs, MRIs, and other imaging before your visit. Please inform us when new studies are completed and where they were performed so we may obtain them. If you see another provider, kindly request that a copy of your visit be sent to our office.

Follow-Up Patients

Follow-up appointments require confirmation via text or email. A final confirmation message will be sent at least 48 hours before the scheduled time. Appointments not confirmed will be canceled.

Patients will be subject to a **$50 no-show fee** if they cancel or reschedule within **24 hours** of their appointment time. This policy is in place to help us offer timely care to other patients in need. Repeated short-notice cancellations or no-shows limit access to care and reduce appointment availability for others. Outstanding balances must be resolved before future appointments can be scheduled.

Thank you for your cooperation. We appreciate the opportunity to care for you and are dedicated to providing the highest quality service.

— Management

I have read and understand the above appointment office policies.

Patient Name: _____ **DOB:** _____

Patient Signature: _____ **Date:** _____

***OR* Authorized Representative Signature:** _____ **Date:** _____

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MEDICAL RECORDS RELEASE AUTHORIZATION

Person Allowed to Disclose Information: _____

Medical Information to be disclosed

- Medical Consultations
- Discharge Records
- History & Physical Exams
- Imaging Reports
- Laboratory & Pathology Reports
- Progress Notes
- Psychological Tests
- Other: _____

Other Information allowed to be disclosed

- I give consent to the release of my HIV/AIDS testing information if there is any.
- I give consent to the release of information pertaining to drugs and alcohol.
- I give consent to the release of my genetic information and family background information, I give consent to the release of information pertaining to mental health diagnosis or treatment.

Patient Name: _____ **DOB:** _____

Patient Signature: _____ **Date:** _____

***OR* Authorized Representative Signature:** _____ **Date:** _____