



Consent & Acknowledgments

PLEASE READ AND SIGN

PATIENT DOB MRN DATE

Consent for Treatment

I authorize Abilene Pain and its physicians, advanced practice providers, and staff to evaluate and treat my condition. I understand that no guarantee has been made about the result of any treatment, and I agree to take an active part in my care. I certify that the information I have given on these forms is accurate and complete, and I understand it becomes part of my medical record.

Medication History

I consent to Abilene Pain retrieving and reviewing my prescription medication history from pharmacies, pharmacy benefit networks, and the Texas Prescription Monitoring Program as part of my care.

Notice of Privacy Practices

I acknowledge that I have been offered a copy of Abilene Pain's Notice of Privacy Practices, which is also posted at the office and on our website. The Notice describes how my health information may be used and disclosed and how I may obtain access to my records.

Release of Information for Treatment and Payment

I authorize Abilene Pain to release my health information to my referring provider, my primary care provider, and any provider I am referred to, and to my insurance carriers and other payers as needed to obtain authorization and process claims. Abilene Pain will not release my information to any other person, including family members, except as I designate below or on a separate written authorization.

People You May Speak With About My Care

Abilene Pain may discuss my care with the people listed here. I may change this list at any time in writing.

NAME	RELATIONSHIP	MAY DISCUSS
		☐ Appointments & scheduling only ☐ All aspects of my care
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How We May Contact You

☐ Leave detailed voicemail ☐ Text message ☐ Email

Phone on file: Email on file:

By providing a telephone number or email address, I agree that Abilene Pain and those acting on its behalf may contact me at that number or address about my appointments, care, and account, including by automated or pre-recorded calls and text messages. Message and data rates may apply. I may withdraw this consent at any time by notifying the office.

Your Signature

I have read this page. I consent to treatment, acknowledge the Notice of Privacy Practices, and agree to the releases and contact permissions above.

PATIENT SIGNATURE

DATE

If signed by a representative — printed name

Relationship / authority

Representative signature

Nicolas Pugh, MD | Adrienne Anders, NP | Ted Chaka, PA

Abilene Pain Locations

Main: 1925 Hospital Place, Abilene, TX 79606

Additional: 6819 Memorial Dr, Ste B, Abilene, TX 79606

Contact Numbers

Main: 325-326-3433

Memorial: 325-468-8096

Online

Email: info@abilenepain.com

Web: www.abilenepain.com