COMPREHENSIVE PAIN AND SPORT REHABILITATION

2808 Columbia Street
Torrance, CA 90503

(P) 310.618.9922

(F) 888.618.2660

We hope that the following information will be helpful to you. We respect your time and would like to help make your visit as efficient as possible.

LOCATION: We are located off Columbia Street. We are the close to the Torrance courthouse. The closest main streets are Del Amo Blvd and Maple Ave. We recommend that you park in the parking lot directly in front and beside our building.

MEDICAL INFORMATION: YOU MUST BRING ALL YOUR IMAGING STUDIES/FILMS FOR BACK OR NECK PATIENTS PLEASE BE SURE THAT YOUR IMAGES ARE ON DISC. FAILURE TO BRING YOUR STUDIES WILL REQUIRE US TO SCHEDULE AN ADDITIONAL APPOINTMENT.

FORMS TO BE COMPLETED: Enclosed you will find various forms which must be reviewed, completed and signed. Please complete the registration forms, patient questionnaire and signatures on forms where indicated and bring them with you to your appointment.

FINANCIAL POLICY: We collect co-pays at the time you check in at our office, before seeing the Doctor.

PLEASE BRING ALL INSURANCE CARDS at the time of your visit. If you will be filing a workman's compensation, motor vehicle accident or personal injury claim, please bring all billing information including address and claim number. We do require a copy of your primary insurance card for these claims, as well.

MEDICAL INSURANCE: Before your appointment, please verify that your health insurance allows treatment by our office. Your plan may require that your primary care physician write a referral/authorization. **PLEASE BRING THE REFERRAL AT THE TIME OF YOUR APPOINTMENT. FAILURE TO BRING YOUR REFERRAL MAY NECESSITATE YOUR APPOINTMENT BEING CANCELLED UNTIL YOU HAVE OBTAINED THE PROPER REFERRAL.** Please be aware that your insurance reimbursement may not cover the full cost of your visit. Regardless of insurance, payment remains your personal responsibility.

JOSEPH C PECK, M.D. **COMPREHENSIVE PAIN AND SPORT REHABILITATION PATIENT QUESTIONNAIRE**

Referred by:_____

*Is your complaint today work related? Y/N
*Are you currently under the care of a skilled nursing facility (SNF)? Y/N

Today's Date: _____
Last Name:_____ First Name:_____ M:____

Address:_____
City:_____State:_____Zip:_____
Home Telephone: (____)_____
Work Telephone: (____)_____
Cell Phone: (____)_____
E-Mail Address: _____
Emergency Contact:_____
Tel: (____)_____ Relationship: _____

Social Security #:_____Gender: M/F
Date of Birth:____/____/____Age:_____
Marital Status: Single/ Married/ Divorced/ Widowed
Employer's Name: _____
Address:_____
City:_____State:_____Zip:_____

Work Status: regular duties / light duties / off work

First date missed:_____to _____

INSURANCE INFORMATION

Is your insurance plan an HMO / PPO / EPO / Medicare / Worker's Compensation / Other:

Primary Insurance	Secondary Insurance
insurance Company Name:_____	Insurance Company Name:_____
Insured's Name:_____	Insured's Name:_____
Insured's SS#:_____-_____-_____	Insured's SS#:_____
Insured's D.O.B.:____/____/____	Insured's D.O.B.:____/____/____
Insured's Employer Name:_____	Insured's Employer Name:_____
Group and ID#:_____	Group and ID#:_____
Relationship to patient: Self / Spouse / Dependent	Relationship to patient: Self / Spouse / Dependent

**********CONSENT FO MEDICAL TREATMENT & ASSIGNMENT OF BENEFITS**********

PATIENT's or INSURED's SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signature of patient (parent if minor): X_____Date:____/____/____

**********PREFERRED PHARMACY**********

Pharmacy Name and Address: _____ Phone number: _____

**********PRESENT COMPLAINT**********

*Part of Body:*_____Left/ Right/ Both *Specific Areas:* _____

Onset:____/____/_____ gradual/sudden Duration:_____days/weeks/months/years Pain Scale (1-10):_____
Status: Improving/ Worse/ Stable/ Resolved/ Fluctuating Frequency: Intermittent/ Constant/ Occasional/ Rare

Context: no injury/ injury/ sports injury/ motor vehicle accident/ Other: _____
"Describe:_____

Trauma: Type: fall/running/direct blow/twisting/lifting/crush History of injury to area? Y? N Year:_____
Where:_____Date: _____or around: _____

Aggravated by: Nothing / Bending / Lifting / Movement / Walking / Sitting / Standing / Pushing / Pulling / Stairs
Other:_____

Relieved by: Nothing / Splint / Ice / Heat / Massage / Therapy / Elevation / Exercise / Stretching / OTC Meds:_____
Associated Symptoms: Nothing/Bruising/Instability/Weakness/Numbness/Tingling/Swelling/Limping/Locking/Decreased Mobility

MEDICAL HISTORY FORM

NAME:_____ DATE:_____

YOUR DOCTORS: Please list your current doctors and their specialties:

DOCTOR	SPECIALTY	DOCTOR	SPECIALTY
1.		4.	
2.		5.	
3.		6.	

MEDICAL CONDITIONS: Please list *your* medical conditions:

1.	4.	7.
2.	5.	8.
3.	6.	9.

SURGERIES: Please list *any* surgeries you've had, including the left or right side and year:

SURGERY	YEAR	SURGERY	YEAR

FAMILY MEDICAL HISTORY: Please list the *status* of your family members with medical conditions

RELATIVE	STATUS	AGE	MEDICAL CONDITIONS
Father	Alive____ Deceased ____		
Mother	Alive____ Deceased ____		
Sibling #1 Bro/Sis	Alive____ Deceased ____		
Sibling #2 Bro/Sis	Alive____ Deceased ____		
Child #1 M/F	Alive____ Deceased ____		
Child #2 M/F	Alive____ Deceased ____		

SOCIAL HISTORY: Occupation:_____Hand dominance: R____L_____Ambidextrous_____
Tobacco use: No___Yes___ Former:___Quit Date:_____ Type: Cigarettes/ Chew/ Pipe/ Cigar
Amount/ packers per day _____ # of years_____
Alcohol consumption: No___ Yes ___ Type: Beer/ Wine/ Hard Liquor: _____ # per day/ week/ month_____
History of alcohol abuse: No___ Yes___ Recreational drug use: No___ Yes___ Type:_____Needle use? When:____

ALLERGIES: Please list any medication allergies or reactions to medications/ other agents

Allergy:	Reaction:

CURRENT MEDICATIONS: Please list prescription and non prescription meds including herbal supplements
PHARMACY: CVS/ Walgreens/ Rite-aid/ Costco/ Pavilions/ Sav-on Other:_____
Address:_____Ph: (_____)_____

MEDICATION	STRENGTH	DIRECTIONS	MEDICATION	STRENGTH	DIRECTIONS

SYSTEM REVIEW: Please check all that apply:

Constitutional: __ Fever __Weight Loss __ Night Sweats
HEENT: __ Headaches __ Vision __ Hearing Loss
Respiratory: __ Cough __ Difficulty Breathing
Skin: __ Swollen Glands __ Lumps __ Rashes
Cardiovascular: __Chest Pain __Leg Swelling __Irregular heartbeat
Gastrointestinal: __ Abdominal Pain __Black tarry/bloody stools __Diarrhea __Nausea/Vomiting
Neurological: __Memory Loss __Numbness __Seizures __ Tremors
Psychiatric: __Anxiety __Depression __Insomnia
Hematologic: __Bleeding __Clotting __Bruising
Urologic: __ Pain with Urination __ Increased frequency of urination

JOSEPH C PECK, M.D. **COMPREHENSIVE PAIN AND SPORT REHABILITATION PATIENT QUESTIONNAIRE**

PATIENT PAIN QUESTIONNAIRE

PATIENT NAME: _____ BIRTH DATE:_____AGE:_____

Referred to this office by: _____

Are you: ____right or ___left hand dominant?

HISTORY OF PRESENT ILLNESS

When did your pain originally begin? _____

_____

If you have arm or leg pain, when did it begin? _____

_____

When did your current episode begin? _____

Did your pain begin _gradually _suddenly injury/date _____

If with "Injury", did the injury occur at work auto accident other

If "other", please explain _____

Describe injury: _____

Have you had back surgery? _Yes _no If yes, date:_____

Have you had neck surgery? _yes _no If yes, date:_____

If you have had:	Was it helpful? Yes	No	Last Date
Physical Therapy	☐	☐	_____
Chiropractic	☐	☐	_____
Acupuncture	☐	☐	_____
Injections	☐	☐	_____

IF YES, what type and how many _____

TENS Unit? _____

Medication? _____

Do you have any:

Numbness Weakness or tingling in the right or left arm?
right or left leg?
right or left arm?
right or left leg?

Have you had any changes in? bowel or bladder function: __yes __no

If Yes, please describe _____

What time of day is your pain worse? __morning__afternoon __night __during sleep
__upon awakening __ all day

JOSEPH C PECK, M.D. **COMPREHENSIVE PAIN AND SPORT REHABILITATION PATIENT QUESTIONNAIRE**

Does your pain occur: ☐ continuously frequently occasionally rarely

Which of the following are you currently able to perform?

__bathe and dress independently __light housework
__light shopping __your usual work

Describe your usual recreational activities: _____

_____

What activities are you unable to do because of your pain? _____

_____

How do the following affect your pain?	Better	Worse	No Different
Sitting	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐
Lifting	☐	☐	☐
Bending Forward	☐	☐	☐
Lying Flat on Stomach	☐	☐	☐
Lying on Side with Knees Bent	☐	☐	☐
Reach Overhead	☐	☐	☐
Awake in AM	☐	☐	☐
Sleep	☐	☐	☐
Stairs	☐	☐	☐
Squat	☐	☐	☐
Kneel	☐	☐	☐
Heat	☐	☐	☐
Ice	☐	☐	☐
Cold Weather	☐	☐	☐

Other: _____

How long can you sit at one time? _____
How long can you stand at one time? _____
How long can you walk? _____ How Far? _____
How much can you comfortably lift? _____ Lbs

Have You Had:	Yes	No	Approximate Date
X-rays?	☐	☐	_____
CAT Scan?	☐	☐	_____
MRI?	☐	☐	_____
EMG?	☐	☐	_____

JOSEPH C PECK, M.D. **COMPREHENSIVE PAIN AND SPORT REHABILITATION PATIENT QUESTIONNAIRE**

PERSONAL HISTORY

Are you: __married __single
__separated __divorced __ Widowed

Are you currently working: __yes __no
If Yes, are you working? _full duty __light duty

What (is/was) you (current/previous) job? _____
(Circle One) *(Circle One)*

If you are NOT working, when did you last work? _____

Is your quality of sleep: _good _fair _poor

Do you feel depressed: __no __mildly __severely
__moderately

Do you smoke: _yes _FAO If Yes, how much? _____

Do you drink alcoholic beverages: __yes _no
If Yes, do you drink? _daily _rarely _occasionally

What is your height? _____
What is your weight? _____

Has there been a change in your weight in the last 3-6 months?
___Yes _____No How much? ____
If Yes, was this a: ___gain ___loss

Do you have any additional information which would be helpful to understand your problem?

_____

_____

Do you have an attorney helping you in this matter?
__Yes ___No

Are you on Disability compensation? __ Yes ___No

List any medications you have taken in the past for your pain:

_____ _____

_____ _____

_____ _____

Non-Contracted Insurance Waiver

Joseph Peck, MD/Comprehensive Pain & Sport Rehabilitation are contracted with most major insurance plans PPO products. We accept Medicare assignment and treat Workers Compensation injuries. We are only contracted with THIPA HMO in this office. We are providing you with this list of our current contracted third party plans. If you don't see your plan listed, please ask us about it.

Affiliated Health Funds
Anthem Blue Cross
Blue Shield of California
Cigna
Corvel PPO
Beach Street
Bellflower USD
First Health
Great West
Medicare
Orange County Foundation EPO/PPO
Multiplan
NPPN
PHCS
Pinnacle Claims
PPO Next
Provider Select PPO
Tri-west/Tri-care
United Health Care

We do not take Medical.

If you seek services of a non-contracted / out of network provider, your insurance plan may require a higher out-of-pocket amount from the patient /subscriber and in some cases, there is no coverage for non-contracted/out of network providers. Please see our financial policy regarding usual and customary charges. Out of network plans include Aetna and Blue Shield Covered California.

I have read and understand that my insurance coverage may be a non-contracted carrier for my services and therefore I may be financially responsible for all or part of my services in the form of a higher deductible or co-insurance amount.

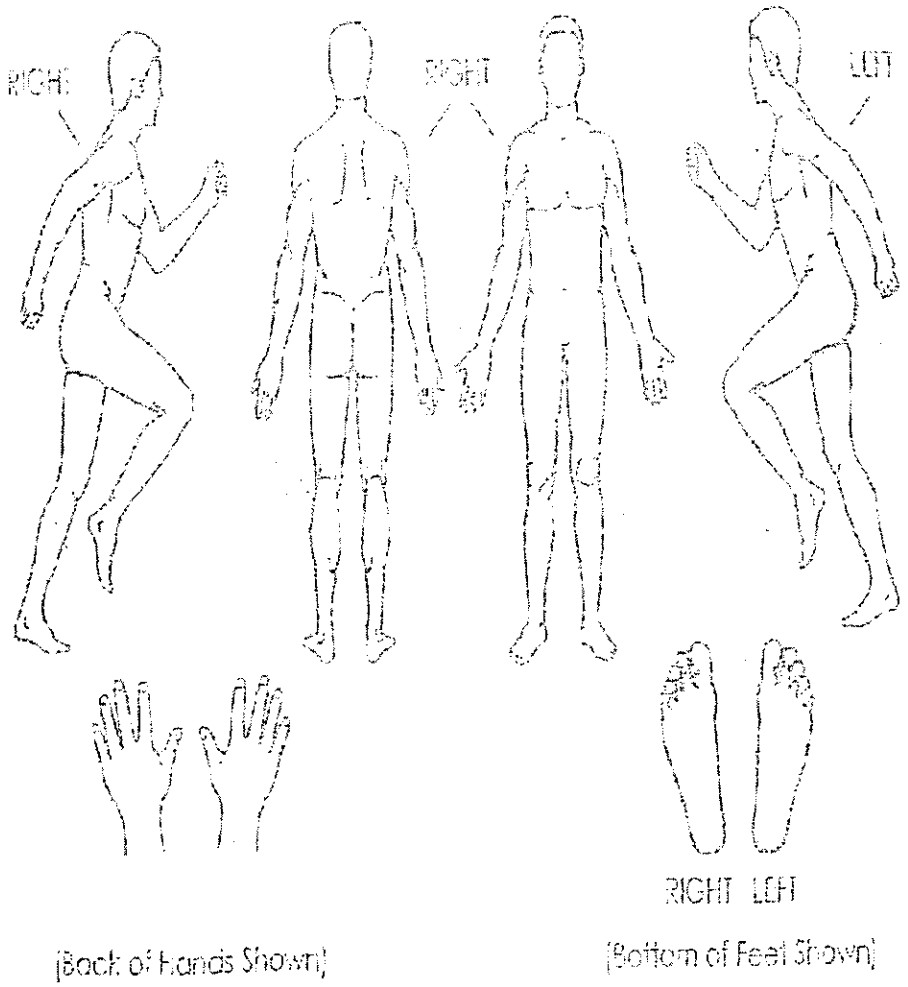
_____ _____ _____

Print Patient Name Signature Patient/Parent/Guardian Date

JOSEPH C PECK, M.D. **COMPREHENSIVE PAIN AND SPORT REHABILITATION PATIENT QUESTIONNAIRE**

PLEASE SHADE IN THE AREAS WHERE YOU FEEL PAIN AND/OR NUMBNESS

Ache	Burning	Numbness	Pins & Needles	Stabbing	Other
A	B	N	P	S	O (troublesome, shooting, Stubborn,gnawing, sharp)



(Back of Hands Shown) (Bottom of Feet Shown)

Please rate your pain: 0=No Pain 10+ the worst pain you can imagine

1. RightNow	0	1	2	3	4	5	6	7	8	9	10
2. AtItsWorst	0	1	2	3	4	5	6	7	8	9	10
3. AtItsBest	0	1	2	3	4	5	6	7	8	9	10
4. OnAverage	0	1	2	3	4	5	6	7	8	9	10

JOSEPH C PECK, M.D. COMPREHENSIVE PAIN AND SPORT REHABILITATION PATIENT QUESTIONNAIRE

Joseph Peck, MD

Financial Policy

We would like to thank you for choosing us to provide your care. We are committed to providing you with excellent and affordable healthcare. Because you may have questions regarding personal and insurance responsibility for services rendered, we have developed this payment and financial policy. Please read it and ask for clarification if needed, and sign in the space provided. A copy of this policy will be given to you. All patients must complete the Patient Information and Insurance Form before seeing the doctor.
WE ACCEPT CASH, CHECKS, VISA, & MASTERCARD

Regarding Insurance Billing
You must provide proof of insurance. If you are not able to provide proof of insurance coverage, you will be considered uninsured and you will be responsible for full payment at the time of the service. We will bill your insurance company as a courtesy. Your insurance policy is a contract between you and your insurance company. It is your responsibility to know your benefits and how they will apply to your treatment by the doctor. We are not a party to that contract. If your insurance company has not paid your account in full within 60 days, the balance will be transferred to you and/or the guarantor listed on the Patient Information form.

- PPO Plans (with which we are contracted): We have agreed to take a discount from your insurance company. Your co-insurance and/or unmet deductible are your responsibility and are due at time of treatment. In the event your insurance coverage changes to a plan where we are not a participating provider, you will be responsible for any out of network deductible or coinsurance amount. All co-pays will be collected at the time of service. If your co-payment is not made at time of service, a $20.00 administrative fee will be added to your account due and payable by you, not your insurance company. If you are scheduled to have a procedure you may be required to pay a $100 deposit for outpatient procedure or $50 deposit for in-patient procedure. This is a deposit which will secure your time on the doctor's procedure schedule. It will be applied toward any out-of-pocket expenses deemed patient responsibility by your insurance company. You may forfeit all or part of this deposit if you do not cancel your surgery in a timely fashion. Please ask the doctor's secretary for further details regarding this deposit.
- Medicare: We accept assignment with Medicare. Medicare pays 80% of their allowed amount after satisfaction of the annual deductible. We will bill your secondary insurance for the remaining 20% of the Medicare allowed amount as a courtesy; however, you are responsible for the balance regardless of payment from a secondary insurance. We do not accept Medical.

Self-Pay Patient:
Please be prepared to pay for services as they are rendered. We require payment at the conclusion of your visit and will extend a cash discount in most cases. If surgery is needed, an estimate of your charges will be provided, and a 50% payment deposit is required prior to the procedure. The deposit is for our services only. We cannot estimate the charges you may incur from other providers involved with your treatment. *Any overpayments will be credited to the account and refunded to the payer after the full course of treatment has been completed.*
Usual and Customary Rates:
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment to us regardless of any insurance company's determination of usual and customary rates.
Forms fee- There is a fee of $20.00 per form for completing disability and/or insurance forms. Payment for these is due when the form is dropped off. Please allow 5 business days to complete the form(s).
No Show Appointments- There is a $25.00 fee for appointments not cancelled within 24 hours. There is a $50.00 fee for the cancellation of EMG & office procedures not cancelled within 24 hours. This is the patient's financial responsibility not payable by insurance and must be paid prior to your next appointment.
I have read the above Financial Policy. I understand and agree to Financial Policy.

_____ _____ _____

Print Patient Name Signature Patient/Parent/Guardian Date

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Patient Record of Disclosures

In general, the HIPPA privacy rules give individuals the right to request a restriction on uses and disclosures of *protected health information (PHI).* The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check/circle all that apply):

Voice Communication (Telephone).

Home #:_____ Work #:_____ Cell #:_____ Other: _____

- O OK to leave message with detailed information on: HOME / WORK / CELL / OTHER
- U Leave message with call back number only: HOME / WORK / CELL / OTHER
- O The following people are authorized to receive my medical information:

Name:	Phone:( )	Relationship:
Name:	Phone:( )	Relationship:
Name:	Phone:( )	Relationship:

Written Communication

- O OK to mail to home address
- O OK to mail to work/office address
- O OK to email to:_____
- O Home fax: ( )_____
- D Work fax: ( )_____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures.

I have received the *Notice of Privacy Policies* that provides a more complete description of information uses and disclosures. I understand it may become necessary to disclose my *protected health information* to another entity as part of my medical treatment, payment of my account or other healthcare operations as defined in the *Notice of Privacy Policies.* I consent to such disclosures for these permitted uses to include electronic interchange, telephone, fax mail and mail.

I understand that I may request restrictions regarding the use of my health information nor revoke this consent by following the procedures outlined in the *Notice of Privacy Policies.* However, the office is not required to agree with any restrictions I request and may refuse to treat me as permitted by *Section 164.506 of the Code of Fedal Regulations.*

Note Use and disclosure for treatment, payment, and operations (TPO) information may be permitted without prior consent in an emergency.

Signature of Patient/Parent/ Guardian:_____ Date: _____

Printed Name:_____ Name of Patient if Different: _____

Joseph Peck, MD
Board Certified in Physical Medicine & Rehabilitation
Board Certified in Pain Medicine

PAIN REHABILITATION INSTITUTE

www.painreductiondr.com

Appointment Cancellation and Fees

Without cancellation 24 hours prior to my appointment, I understand that I will be charged $25.00 for each late cancellation or failed appointment. If I fail to keep my appointment, another appointment will not be scheduled until I have paid any outstanding charges.

Print Name: _____

Signature:_____

Date: _____

Are you feeling worn out? A little fatigued?

Ask us about our B12 shots today!

- Vitamin B-12, or cobalamin, is a nutrient you need for good health. It's one of eight B vitamins that help the body convert the food you eat into glucose, which gives you energy.
- Nearly 40% of the population have B_{12} levels that fall at or below what experts consider the low end of normal.
- B_{12} is a vital supplement for skin health! Treat eczema, dark spots, and dull or dry skin.
- B vitamins are essential for proper cellular respiration.

Individual B_{12} injections are $20. Please inquire with our front desk if you are interested.

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UPDATED PRICES AS OF FEBRUARY 1, 2019

DMV	$15
Completion of State EDD Disability Forms	$40
Completion of FMLA FORMS Completion	$40
of ALL Disability Forms Completion of	$30
Work Requirement Forms Copy of Patient	$30
Records-Minimum Charge	$25

(Subject to the size of the Record's)

Fees must be paid in advance by credit card

Or cash and cannot be billed to insurance.

Please allow at least 5 business days for completion

Of forms and documents requiring doctor's signature.

Patient Signature: _____ Date: _____