INNOVATIVE PAIN *and* SPINE CENTER

Matthew Root D.O.

Welcome to our office! We are committed to providing the best care possible. We encourage you to ask questions and communicate openly with us. Please assist us by providing the following information. All information is confidential and will only be released with your consent.

PATIENT REGISTRATION FORM

General Information

Name (Last, First, MI): _____ Date: _____ Sex:____

Address (Street, City, State, Zip): _____

SSN:_____ Date of Birth: _____ Age:_____

Best phone # to reach you: (*circle: home, work, cell)*_____

Alternate phone #: (*circle: home, work, cell)* _____

Email:_____

Social Information

Marital Status: *S M W D* Spouse's Full Name:_____

Emergency Contact:_____ Relationship:_____ Phone #:_____

Healthcare Professionals

Have you seen other physicians for this issue?: ___ Yes ___ No

If yes: Specialty:_____ Name:_____

Specialty:_____ Name:_____

Specialty:_____ Name:_____

Primary Care Physician Name:_____ Phone #:_____

I authorize payment of medical benefits be made directly to **MATTHEW ROOT, D.O.** for services rendered.

Date: _____ Signature:_____

I authorize any insurance company, employer, physician to release any information to this claim and the expenses reported.

Date:_____ Signature:_____

INNOVATIVE PAIN *and* SPINE CENTER

Matthew Root D.O.

Questionnaire

Where is your pain localized? _____

When did your pain being? How did it occur? (ie. accident, fall, sudden onset, etc.)

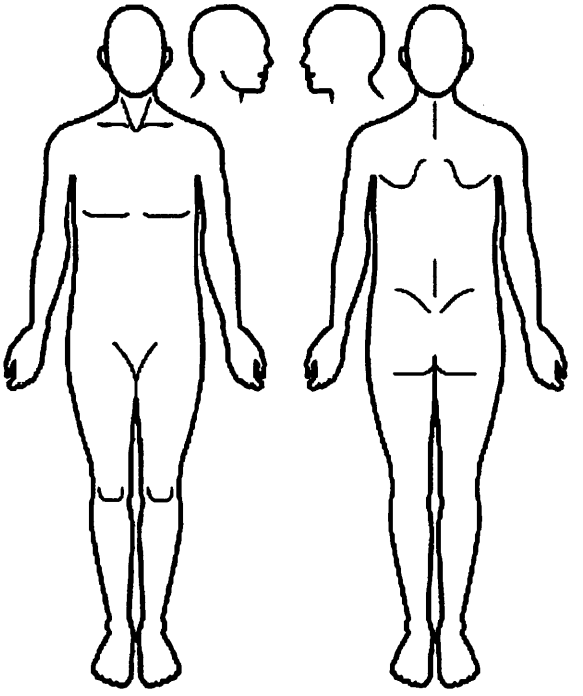
_____

_____

Does the pain radiate anywhere?

_____

Please indicate on diagram areas of pain:



The pain is described as:

__Sharp __Shooting
__Dull __Aching
__Throbbing __Constant
__Other: _____
_____

Do you experience any of the following?

__Numbness __Tingling __Pins/Needles
__Headaches __Nausea __Photophobia
__Muscle Spasms __Other:
_____
_____

Surgical History:

_____

_____

Have you had any imaging studies done?: __X-ray __MRI __CT

Facility Obtained (Name and City):_____

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Medications

Are you currently taking any of the following? *(write Yes or No)*:

Drug	Y/N	Specific Drug(s)	Dose	Reason
Blood thinners				
Aspirin				
NSAIDs (anti-inflammatories)				
Antibiotics/Antifungals				

Please list all **OTHER** medications, including: pain medication, vitamins, and/or herbal supplements you are taking:

Medication	Dosage (mg)	Frequency (1x/day, etc)

Have you stopped any previous pain medications? ___ Yes ___ No

Please list medications stopped and why? _____

ALLERGIES

Please mark if applicable: __No Known Drug Allergies __Sulfa Drugs __Iodine __Penicillin __NSAIDS __Steroids __Latex __Anesthesia

If not listed above, please document all other known allergies:

_____

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Medical History

Do you currently have or have had any of the following medical conditions?:

Condition(s)	Y/N	Specify
Bleeding problems *(e.g. hemophilia, clotting disorders)*		
Cancer *(e.g. prostate, breast, colon)*		
Heart disease *(e.g. hypertension, CAD, hyperlipidemia)*		
Respiratory problems *(e.g. asthma, COPD, sleep apnea)*		
Gastrointestinal disorders *(e.g. GERD, IBS, Crohn's)*		
Liver disease *(e.g. hepatitis, cirrhosis)*		
Kidney disorders *(e.g. CKD, ESRD, kidney stones)*		
Endocrine disorders *(diabetes, thyroid disorder)*		
Psychiatric *(e.g. anxiety, depression, bipolar, addiction)*		
Nerve disorders *(e.g. stroke, MS, neuropathy)*		
Infections *(e.g. frequent UTIs, HIV, sinusitis, common cold)*		
Rheumatologic disorders *(e.g. Lupus, RA)*		
Headache disorder *(e.g. migraines, cluster headaches)*		

Social History

Do you currently smoke? *(circle) Y N*

Have you ever smoked? *circle: Y N* Packs/day:_____

Do you currently use illicit drugs? *(circle) Y N*

Any history of drug abuse? *(circle) Y N* Time sober:_____

Do you currently use marijuana? *(circle) Y N*

Have you ever used marijuana? *(circle) Y N*

Do you drink alcohol? *(circle) Y N*

If yes, how many drinks per week?:_____

Any history of alcohol abuse? *(circle) Y N*

Time sober:_____

Are you currently working? *(circle) Y N*

Work status: *(circle) part-time full-time modified retired*

Family History

Are there any of the following illnesses in your family?:

Condition(s)	Y/N	Relationship
Neurologic disorders *(e.g. MS, etc)*		
Diabetes		
Depression		
Heart disease		
Stroke		
Rheumatologic disorders *(e.g. lupus, RA)*		
Thyroid disease		
Blood disorders *(e.g. anemia, etc)*		
Autoimmune disorders		
Addiction		

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FOR PHYSICIAN USE ONLY

Motor Testing:

Bicep	R: 4* 4+ 5	L: 4* 4+ 5
Tricep	R: 4* 4+ 5	L: 4* 4+ 5
Wrist Ext.	R: 4* 4+ 5	L: 4* 4+ 5
Hand Int.	R: 4* 4+ 5	L: 4* 4+ 5
APB	R: 4* 4+ 5	L: 4* 4+ 5
Hip Flex	R: 4* 4+ 5	L: 4* 4+ 5
Hip Abd.	R: 4* 4+ 5	L: 4* 4+ 5
Knee Ext.	R: 4* 4+ 5	L: 4* 4+ 5
Knee Flex	R: 4* 4+ 5	L: 4* 4+ 5
Dori-Flex	R: 4* 4+ 5	L: 4* 4+ 5
EHL:	R: 4* 4+ 5	L: 4* 4+ 5
FHL:	R: 4* 4+ 5	L: 4* 4+ 5

Special Test:
SLR: (-) or (+): (B) (L) (R)
Axial Compression: (-) or (+): (B) (L) (R)
Hoffman's: (-) or (+): (B) (L) (R)
Spurling's: (-) or (+): (B) (L) (R)
Extension Loading Test: (+): (B) (L) (R)
Neer (+): (B) (L) (R)
Knee Test's: (+): (B) (L) (R)
CMC Grind (+): (B) (L) (R) Finkelstein's (+):
Faber's (+): Gaenslan (+):
Fortin's (+): Tinel's (+):
Drawer (+): Varus Stress (+):

Other:

Diagnosis: (1): Left (2): Right

__M79.18 Myalgia/Myofascial Pain __M54.12 Cervical Radiculopathy __M47.812 Cervical Spondylosis
__M48.02 Cervical Spinal Stenosis __M50.10 Cervical disc disorder with radiculopathy
__M54.16 Lumbar Radiculopathy __M51.26 Lumbar Intervertebral Disc Displacement
__M47.816 Lumbar Spondylosis __M48.061 /__M48.062 Lumbar Spinal Stenosis
__Z79.891 Long-term __M75.40/__.41/__.42 (Impingement Syndrome, unspecified shoulder
__M65.819 Tendinopathy, unspecified shoulder __M77.10/__.11/__.12 Lateral epicondylitis, unspecified elbow
__G56.03 Carpal tunnel syndrome, bilateral upper limbs __M53.3 Sacroiliac Joint Disorder
__M17.9 Knee Osteoarthritis
__Other:

Treatment Plan:

Injection:

___ SI INJ /___Ganglion Impar __SI Joint Disorder
___ C ILESI __Cervical Radiculopathy
___ C MBB __Cervical Spondylosis Levels:
___ C RFA __Cervcial Spondylosis Levels:
___ L MBB __Lumbar Spondylosis Levels:
___ L RFA __Lumbar Spondylosis Levels:
___ L ILESI __Lumbar Radiculopathy
___ L TFESI __Lumbar Radiculopathy Levels:
___ CAUDAL __Lumbrosacral Radiculopathy
___ TPI __Myalgia/Myofascial Pain Regions:
___ GON/LON
___ JOINT INJ __KNEE: __HIP: __ SHOULDER:
__Knee Osteoarthritis __ HIP OA __Shoulder OA
__Meniscus Tear __Trochanteric Bursitis __Shoulder impingement

___ OTHER

DIRECTIONS:
_____ PRIOR AUTHORIZATION
_____ RADIANCE or STARPOINT
_____ HOSPITAL

INNOVATIVE PAIN *and* SPINE CENTER

Matthew Root D.O.

Patient Pain Management Agreement and Consent

I, _____ (patient name), and my physician, Matthew Root, D.O., agree to have a safe and controlled pain treatment plan. I understand that pain medications have a high potential for abuse, can be dangerous if used in the wrong way, and that there are risks that come from the use of pain medications.

NO-HARM AGREEMENT:

Due to the nature of the drugs prescribed and the harmful potential of these drugs if not monitored by a physician on an ongoing basis, it is essential that each patient be seen monthly to reduce any potential harm to our patients. It is also imperative that you see your primary care provider every three months or whenever you have a scheduled appointment and advise all of your physicians about the medications you're prescribed by Innovative Pain and Spine Center. Coordination of your care is critical to reducing risks to your health.

We will NOT accommodate "walk-in" patients, including but not limited to writing refills on medication for the following reasons:

1. Failure to show up for your scheduled appointment
2. Late for your scheduled appointment
3. Failure to schedule a next month appointment during your visit

Partial refills will only be written IF your scheduled appointment was AFTER your regular fill date due to our office scheduling.

POLICY GUIDELINES:

To minimize the risks and problems with taking pain medications, **I agree to ALL of the following listed policy guidelines :**

1. You must get a prescription for all controlled substances from the physician whose name appears below or, during his or her absence, by the covering physician, unless specific written authorization is obtained for an exception.
2.. You must inform our office of any new medications or medical conditions and of any adverse effects you experience from any of the medications that you take.
3. You must give the prescribing physician permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability and coordinating your care.
4. You may not share, sell or otherwise permit others to have access to these medications. You must take all medications exactly as prescribed, unless you develop side effects. If you develop side effects, you must consult with your doctor or local emergency providers.
5. You must not stop these medications abruptly or without consulting the prescribing physician, as an abstinence/withdrawal syndrome may develop.
6. You must agree that your urine may be tested for controlled substances before initiation of therapy and that random urine follow up testing may be done. You must cooperate in such testing, and you must agree that the presence of unauthorized substances, illicit substances or absence of prescribed medications may prompt referral for assessment for addictive disorder and possible tapering and discontinuation of the controlled substances immediately or in the future.
7. You will not give your prescriptions or bottles of these medications to anyone else. These substances may be sought by other individuals with chemical dependency and should be closely safeguarded. You will take the highest degree of care with your medications and prescriptions. You will not leave them where others might see or otherwise have access to them.
8. You must bring original containers of medication to each office visit.
9. You must keep all controlled substances in a secure area. Since the medications may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.
10. You must exercise extreme caution when taking these medications and driving or operating heavy machinery. The use of these medications may induce drowsiness or change your mental abilities, thereby making it unsafe to

drive or operate heavy machinery. The effects of these medications are particularly problematic during any dose changes. If you are the slightest bit impaired, you must refrain from these activities.
11. You must discuss the long-term use of controlled substances with your physician. Prolonged opioid use can be associated with serious health risks. You need to understand these risks.
12. You must agree that medications will not be replaced if they are lost, flushed down the toilet, destroyed, left on an airplane, etc. If your medication has been stolen and you complete a police report regarding the theft and present that report to the prescribing physician, an exception may be made at the discretion of your treating physician.
13. You must agree that early refills will not be given.
14. You understand that prescriptions may be issued early only if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date.
15. You agree that, if the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.
16. You agree that failure to adhere to these policies may result in tapering and cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.
17. You agree that prescription renewals are contingent on keeping scheduled appointments. Do not phone for prescriptions after hours or on weekends. If you receive any controlled substances in an ER, you must report the incident to your prescriber, in writing, within 48 hours.
18. You recognize that any medical treatment is a trial, and that continued prescription is contingent on evidence of benefit and improved functionality.

WHEN USING A PHARMACY, I WILL:

- Use the same pharmacy for all of my medications. This is the pharmacy that I have chosen: _____
- If my chosen pharmacy does not have my medication, I will inform the office of the alternative pharmacy filling my medications.
- Not ask for early refills or more pain medications, even if I lose my medications.

You acknowledge that the risks and potential benefits of therapy with controlled substances have been explained to you and that you have had the opportunity to ask any questions that you may have. You understand and agree that failure to adhere to these policies will be considered noncompliance and may result in cessation of opioid prescribing by your physician and possible dismissal from this clinic. You affirm that you have full right and power to sign and be bound by this agreement. You further affirm that you have been given the opportunity to ask any questions you may have and that you have read, understand, and accept all of its terms.

I understand this is the policy of Innovative Pain and Spine Center (IPSC) that all patients prescribed potentially addictive medications must sign and agree to follow the conditions described in this *"Pain Medication Agreement and Consent"*

Patient Name:_____
Patient Signature:_____ Date:_____

Pain Physician:_____

INNOVATIVE PAIN *and* SPINE CENTER

Matthew Root D.O.

Patient Financial Agreement

Thank you for choosing us as your healthcare provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, checks, credit cards, and pre-approved insurance for which we are a contracted provider.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the InNetwork rate.

Worker's Compensation	Personal Injury
If your claim is denied, you may be responsible for payment in full.	We bill your attorney for charges incurred associated with personal injury cases. We require a signed Lien for all personal injury cases.

I have read the financial policies contained above, and my signature below serves as an acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Signature of Patient/Responsible Party: _____ Date: _____

Name of Patient/Responsible Party: _____ Relationship:_____

INNOVATIVE PAIN *and* SPINE CENTER

Matthew Root D.O.

Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have been given the opportunity to review and request a copy of the Innovative Pain and Spine Center Privacy Act on the date indicated. If you have any questions regarding the information in Innovative Pain and Spine Center Notice of Privacy Practices, please do not hesitate to contact our office located at 4418 Vineland Ave Suite 218 North Hollywood CA 91602.

The following individuals may have access to my medical records (family/friend(s)/caregiver(s):

_____

*I understand that ONLY the above named individuals will have access to my medical information upon their request. I understand that I may update this information at any time that I am physically in your office.

Patient Name/ Responsible Party (Printed):

_____

Relationship to Patient (Printed):

_____

Signature of Patient/Responsible Party:

_____

Date Notice Received:

_____

INNOVATIVE PAIN *and* SPINE CENTER

Matthew Root D.O.

Authorization for Release of Medical Record Information

Patient Name:_____ D.O.B.:_____

Home/Cell Phone:_____

Email:_____

Address:_____

PLEASE NOTE: COPY FEE MAY BE CHARGED FOR MEDICAL RECORDS

Above listed patient authorizes the following healthcare facility to send and receive record disclosures:

Facility Name:_____

Facility Address:_____

Facility Phone:_____ Facility Fax:_____

Dates and Type of Information to Disclose:

___ 2 years prior from last date seen

___ Dates Other:_____

___ Specific Information Requested:_____

_____

Purpose of Disclosure (check all that apply):

___ Change of Insurance of Physician

___ Continuation of Care

___ Referral

___ Other:_____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndromes (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release to: Innovative Pain and Spine Center (Matthew Root, D.O.)

Address: 4418 Vineland Ave Suite 218 North Hollywood CA 91602

Phone: (818) 621-0019 **Fax: (818) 671-5556** Please (check): ___ Mail ___ Fax Records

I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides the insurer with the right to contest a claim under my policy. **This authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient or Authorized Representative Signature:_____ Date:_____

Patient or Authorized Representative Name(printed):_____

Relationship to Patient:_____

Brief Pain Inventory (Short Form)

Date: _____ Time: _____

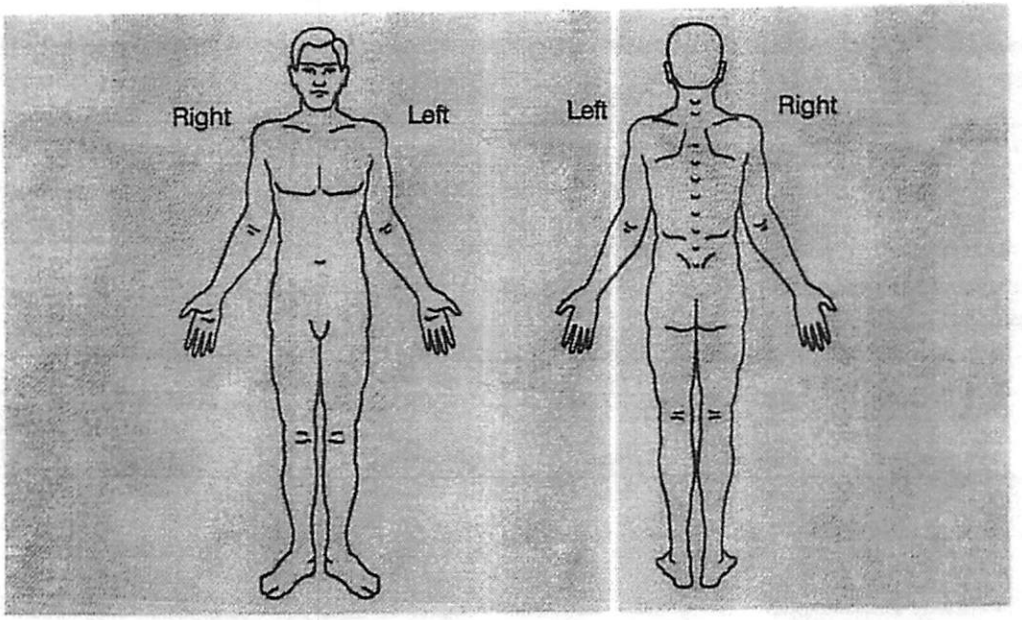
Name: _____

Last First Middle Initial

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

1. Yes 2. No

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3) Please rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its LEAST in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

7) What treatments or medications are you receiving for your pain?

8) In the past 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much RELIEF you have received.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
No relief										Complete relief

9) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General activity:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

B. Mood:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

C. Walking ability:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

D. Normal work (includes both work outside the home and housework):

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

E. Relations with other people:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

F. Sleep:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

G. Enjoyment of life:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

Questionnaire

Name: _____ Date:_____

No.	Question	Answer	Score
1	Are you basically satisfied with your life?	Y / N	
2	Have you dropped many of your activities of interest?	Y / N	
3	Do you feel your life is empty?	Y / N	
4	Do you often get bored?	Y / N	
5	Are you in good spirits most of the time?	Y / N	
6	Are you afraid that something bad is going to happen to you?	Y / N	
7	Do you feel happy most of the time?	Y / N	
8	Do you often feel helpless?	Y / N	
9	Do you prefer to stay at home, rather than going out and doing new things?	Y / N	
10	Do you feel you have more problems with memory than most people?	Y / N	
11	Do you think it is wonderful to be alive?	Y / N	
12	Do you feel pretty worthless the way you are now?	Y / N	
13	Do you feel full of energy?	Y / N	
14	Do you feel that your situation is hopeless?	Y / N	
15	Do you think that most people are better off than you are?	Y / N	
	For office use	Total:	