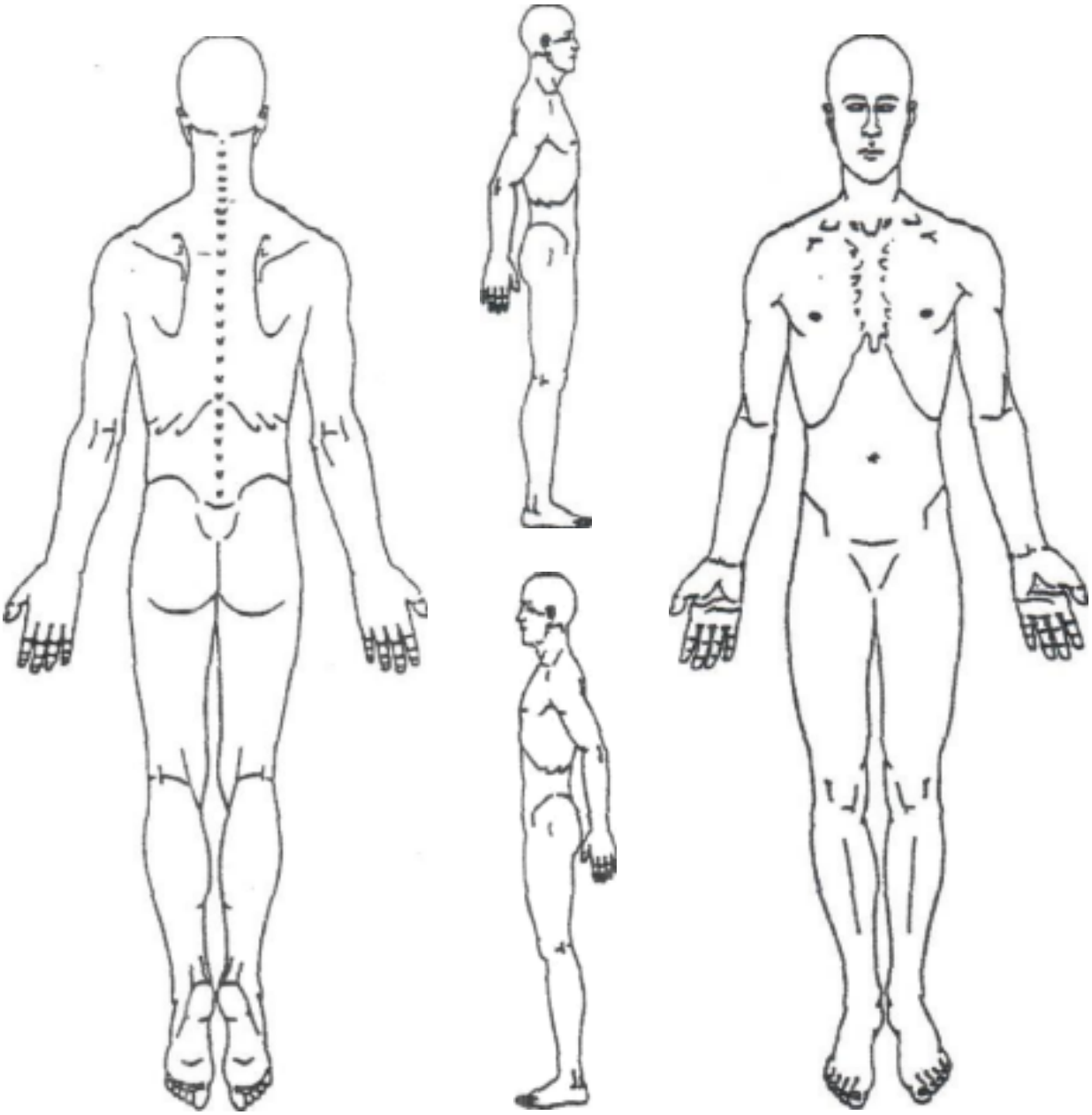
Pain Assessment

Patient Name:_____

Height:_____Weight:_____ **Please mark below where you are experiencing symptoms**



NEW PATIENT PAIN ASSESSMENT INFORMATION

NAME_____HEIGHT_____WEIGHT_____

WHERE IS THE WORST PAIN LOCATED?_____

HOW LONG HAVE YOU HAD THE PAIN?_____

1. Is your pain related to an accident or acute injury? If yes, please explain_____

_____

_____

_____

2. From 0 to 10: What is your current pain level?_____
What is your lowest pain level?_____
What is your highest pain level?_____

3. What does your pain feel like/what is the sensation you experience?_____

_____

_____

4. What makes the pain worse?_____

5. What makes the pain better?_____

6. What treatments have you tried for the pain?_____

_____

6. Are there physical activities you can't do because of the pain?_____

7. Does pain affect your sleep?_____

8. Does pain affect your relationships?_____

9. Is there anything else you would like us to know about your condition or the treatment you would like to receive?_____

_____

NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE

1. **WHAT ARE YOUR CURRENT MEDICATIONS?** If you have a list please attach.

a._____e._____

b._____f._____

c._____g._____

d._____h._____

ARE YOU ALLERGIC TO ANY MEDICATIONS? IF SO, WHAT IS THE MEDICATION AND THE REACTION?_____
_____
_____

3. **HAS ANYONE IN YOUR FAMILY HAD ANY OF THE ABOVE MEDICAL PROBLEMS?**
_____
_____

4. **Do you use tobacco products?** Smoke, Chew, Vape? How much per day? _____

5. **Do you drink alcohol?** How much per day or month or year? _____

6. **Female patients:** Could you be pregnant? _____ Do you use contraception? _____

7. **Please list all of the operations you have had or provide you may attach a list.**

a._____e._____

b._____f._____

c._____g._____

d._____h._____

Patient Signature_____ Date_____

Pain Influence Scale

1 – Not At All

2- Very Seldom

3 - Half of the Time

4 – Most of the Time

5 – All the Time

Question 1: Does the pain cause you to stay inside your house?

1 2 3 4 5

Question 2: Does your pain cause you to miss socializing with other people?

1 2 3 4 5

Question 3: Does your pain cause you to miss work?

1 2 3 4 5

Question 4: Does your pain cause you financial hardship?

1 2 3 4 5

Question 5: Does your pain interfere with sexual activities?

1 2 3 4 5

Question 6: Does your pain hamper or prevent leisure time activities, such as hobbies, sports, etc.

1 2 3 4 5

Question 7: Does your pain cause you to feel like an outcast?

1 2 3 4 5

Question 8: Does your pain make you wonder whether your life is worth living

1 2 3 4 5

Question 9: Does your pain occupy most of your thoughts?

1 2 3 4 5

Question 10: Does your pain cause you to feel angry, frustrated, or depressed?

1 2 3 4 5

ATTENTION PATIENTS

FEE SCHEDULE UPDATED 04/18/22

Due to an increase in missed and last minute cancellation appointments, Balanced Pain Management must put in place a fee structure for such events. We must receive 24 hour notice for cancellation or reschedule of appointments, otherwise the fee schedule listed below will be enforced.

If you are late for your appointment you may reschedule and/or wait until the end of the morning or afternoon scheduled patients to be seen without penalty.

If you do not cancel or reschedule less than 24 hours of your original appointment time, the following applies:

15 minute follow up visit = $50

30 minute follow up = $100

30 minute procedure visit = $100

45 minute new patient appointment = $200

45 minute and longer, procedure appointment = $300

Please note that we require that unpaid copays and /or statement balances be paid prior to your next visit

These fees will need to be collected before we can reschedule any appointments. These guidelines are used to help Dr. DeLaney continue to provide the best care for her patients. We appreciate your understanding in the matter. If you have any questions please do not hesitate to ask.

Patient Signature_____

Balanced Pain Management Signature_____

Balanced Pain Management Financial Policy

Managed Care Coverage

The following financial policy applies to all patients that have managed care plans. Please carefully read and sign this agreement providing you agree with it. Let our staff know if you have any questions.

1. We have agreed to provide you service under your managed care plan. However, as you probably know, managed care plans carefully control and restrict your treatment
2. You will need to pay your copay as your portion of the charge at each visit. Our office policy does not allow us to extend credit.
3. You may also need to pay for services that your plan does not cover.
4. You can pay for your portion with your MasterCard or Visa card. You sign an authorization form and the amount you owe will be charged to your credit card at the time of your service.
5. We will need to verify your benefits by contacting your plan. After we verify your coverage, we will credit the amount you have paid to your portion of the bill. Using your credit for this purpose will be the easiest for you.
6. Your plan may request additional information from you. Please send the information to them right away. They will not pay your claim until they receive the information.

By signing below you agree to follow this policy.

_____

Patient Signature Print Name Date

_____

Staff Member Signature Print Name Date

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTHCARE INFORMATION

130 La Casa Via, Bldg 2 Suite 209
Walnut Creek, CA 94598

By signing this form, I_____, authorize the use and disclosure of my health

Information as described below:

1. You can disclose my health information as described below:

    • Leave messages on my answering machine (Y or N)

    • Leave messages with my spouse (Y or N)

    • Leave messages with anyone who answers the phone (Y or N)

    • Can fax information to my home (Y or N)

    • Can fax information to my work place (Y or N)

    • Can mail information to my home (Y or N)

    • Can mail information to my work place (Y or N)

1. You can leave messages confirming appointments as described below:

    • Leave messages on my answering machine (Y or N)

    • Leave messages with my spouse (Y or N)

    • Leave messages with anyone who answers the phone (Y or N)

Name or person(s) authorized to receive this information:

_____

I understand that have the right to revoke this authorization,in writing at any time, except where uses or disclosures have already been made based upon my original permission or the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or insurance policy.I understand the uses or disclosures already made based on original permission cannot be taken back. To revoke this authorization, I must do so in writing arid send it to: Balanced Pain Management at 130 La Casa Via, Bldg 2 Suite 209 Walnut Creek CA 94598

_____

Signature Print Name Date

Balanced Pain Management Notice of Privacy Practices

This notice describes how your health information may be used and disclosed, and how you can access this information. Please review it carefully.

At BPM, we are required to keep your health information secure and confidential, by law. Also by law, we need to give you this notice and follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of services. For example, we may send a report of your treatment or progress to your insurance company. We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your treatment information into our computer system. We may share your medical information with our business associates,such as a billing service.We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information to you.We may also call and remind you of your appointments. If you are not home,we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency,we may disclose your health information to a family member or another person responsible for your care. We will need to release some or all of your health information, when required by law. If this practice is sold, your information will become property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we do not use or disclose some or all of your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond normal uses.

You have the right to receive communication about your health information in the manner you prefer. We will also use whatever communication method, number or system you prefer to contact you.You have the right to transfer a copy of your health information to another practice. Notify us in writing or where you would like us to send a copy of your health information for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies.If you would like a digital copy of your records,let us know which type of file you would like and we will try to meet your needs.

You have the right to request an amendment or change to your health information in writing. If you wish to include a statement to your file, please give it to us in writing.We may or may not make changes to your request, but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a report of who we disclose your information to. If our privacy and security measures or systems are breached in any way,we will notify you.You have the right to receive a copy of this notice. If we change any of the details of this notice,we will notify the changes in writing.

You may file a complaint with the Department of Health and Human Services in writing (200 Independence Avenue, S.W,Room 509, Washington. DC20201). Online (hhtp:hhs.gov) or by email (OCRComplaint@hhs.gov).You will not be retaliated against for filing a complaint. Please contact our Privacy Officer. Dr. Leslie DeLaney, M.D., At (925) 988-9333 for more information, to make a request, file a complaint, or for more assistance regarding your health information privacy.

I have received a copy of the BPM Notice of Privacy Practice

_____

Patient Signature Print Name Date

If signing as a parent/guardian, please note the name of the patient._____

PATIENT CONSENT AND AUTHORIZATION

CONSENT FOR TREATMENT: I voluntarily consent to the sending of care including treatments, administration of anesthetics and performance of diagnostic and/or surgical procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instruction of such physician(s).

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to the physician(s) accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the physician's regular charges. I understand that I am financially responsible for the charges not covered by this assignment or for any and all charges which the insurance carrier declines to pay. It is further agreed that my credit balance resulting from payment of insurance or other sources may be applied to any other amounts owed to said physician(s) by the insured or his/her family

RELEASE OF INFORMATION: The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician(s) or to the patient or to the Health Care Financing Administration and/or the patient's attorney, for all or part of the physician(s) charges, including but not limited to, patient insurance companies, worker's compensation carriers, welfare funds or the patient's employer if a worker's compensation cares.

LIFETIME AUTHORIZATION

MEDICARE AND MEDICAID PATIENT CERTIFICATION - PAYMENT CLASSIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: 1 certify that the information given by me in applying or payment under Title XVIII and or T itle XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release the Medicare, Medicaid, or other third party claim. I request that payment of authorized benefits be made on my behalf; I assign the benefits payable for the physician(s) services. I understand that I am responsible for my health insurance deductibles and co- insurance.

PLEASE NOTE

Insurance contracts are made between you and the insurance company. We do not render service on the assumption that the charges will be paid by your insurance company. Payments of any and all charges are presumed to be your responsibility. All charges are due in full upon receipt of our statement. A photocopy of this form shall be valid.

_____

Patient's Signature or Responsible Party Date