PAINCARE
PROVIDERS
REDISCOVERING RELIEF
TEL: 949 872 2400 | FAX: 949 872 2401 | WWW.PAINCAREPROVIDERS.COM

NEW PATIENT LETTER

Dear Patient;

Your appointment is scheduled on_____ at _____AM/PM. (***Please, Arrive at*** _____AM/PM)

O Irvine Office: 113 Waterworks Way #345, Irvine, CA 92618

O Fountain Valley Office: 18035 Brookhurst Ste #1700, Fountain Valley, CA 92708

O Santa Ana Office: 801 N Tustin Ave #203, Santa Ana, CA 92705

Welcome to our pain management center at Pain Care Providers. Please, allow us to provide you with some useful important information about your upcoming appointment to ensure we can serve you to the best of our abilities.

1- You may download and complete the **"New Patient Questionnaire"** from our website prior to your scheduled appointment. Otherwise, please arrive at least 40 minutes ***before*** your appointment time in order to complete the required paperwork and check-in process. This will minimize any delays and/or need to reschedule your appointment. You can also ask us to mail the paperwork to you, at least a week before your appointment.

2- Please, notify our office in advance of your appointment if there are any relevant prior records regarding your pain symptoms; including previous consultations and/or imaging studies. The availability of those records will enable our physicians to review them prior to your visit, help facilitate your treatment, and avoid unnecessary delay due to lack of baseline information. If there are any imaging studies related to your pain complaint; please bring at least the official radiology report. Please, be advised that a taking blood thinners (anticoagulants) affect the timing and/or feasibility of specific procedures.

3- Please, bring your **Pictured ID** and valid **Insurance Card**.

4- Your initial visit is only for consultation purposes including discussion of recommended therapies and/or needed diagnostic studies. We do not guarantee continuation of your current analgesic regimen. Your treatment plan is completely dependent on your pain management physician's evaluation and recommendation. Please, be prepared to provide a urine sample as part of initial visit evaluation.

5- If an image-guided procedure is recommended, it will be done at a Medicare Certified Surgery Center. If indicated, you may have the opportunity to ask for conscious sedation for your procedure.

6- PPO, Workers Compensation, and HMO health plans now require a consultation report prepared by treating physician and an **authorization** for procedures submitted by the Performing Physician. This process might take up to 10 business days.

7- Co-payments are due before services are rendered. For your convenience, cash, check and major credit cards (Visa - MasterCard) are accepted.

We take pride in providing an individualized and effective chronic pain management solutions using the highest standards of care in a friendly, comfortable, and professional environment. We look forward to seeing you soon!

Reminder: Cancellation of office visits less than **24 hours** prior to your appointment will be subjected to a $75.00 cancellation fee.

SINCERELY,

PAIN CARE PROVIDERS

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NEW PATIENT QUESTIONNARIE

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First Name | Date of Birth

Last Name | Male Female | Age

Home Address

City | State | Zip Code

Primary Phone Number | Home | Cell | Work | Secondary Phone Number

E-mail Address

Emergency Contact / Phone Number | Contact's Name | Contact's Relation to Patient

Preffered Pharmacy | Pharmacy Number | How did you find out About us?

Primary Insurance | Name of Subscriber

Insurance Phone Number | Group Number

Member / Policy Number

Secondary Insurance | Name of Subscriber

Insurance Phone Number | Group Number | Member / Policy Number

WORKMAN'S COMPENSATION (W/C) INFORMATION

Client's File Number | Date of Accident | W/C Contact Person | Phone Number

Reffering Physician | Address | Phone Number

Primary Care Physician | Address | Phone Number

SIGNATURE Patient | Guardian | **DATE**

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Main Complaint(s) _____

_____

How did it happen ? _____

_____

_____

How long ago it started ? _____

Please, mark the appropriate locations for your pain and Indicate where the pain goes with arrows.

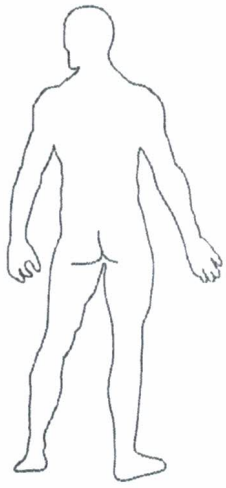
Nature of Pain ◯ Constant ◯ Intermittent

Qualities of Pain

◯ Throbbing	◯ Cramping	◯ Gnawing
◯ Aching	◯ Shooting	◯ Stabbing
◯ Sharp	◯ Hot-burning	◯ Heavy
◯ Tender	◯ Splitting	◯ Sickening

Intensity of Pain

	No Pain									max imaginable pain	MAX
At Worst condition	0	10	20	30	40	50	60	70	80	90	100
At Best condition	0	10	20	30	40	50	60	70	80	90	100
Overall feeling	0	10	20	30	40	50	60	70	80	90	100



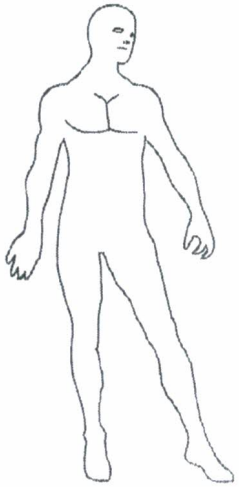
Pain Increased by

◯ Bending	◯ Lifting	◯ Coughing
◯ Sneezing	◯ Defecation	◯ Walking
◯ Sexual Intercourse	◯ Twisting of spine	
◯ Prolonged Sitting	◯ Prolonged Standing	

Worst Pain at ◯ Early Morning ◯ Late Evening

Pain Decreased by

◯ physical therapy	◯ Massage	◯ Heat
◯ Rest	◯ Medication	◯ Cold
◯ Lying on your back	◯ Lying in a fetal position	



TREATMENT HISTORY

Please mention all of the health care providers you have consulted and their treatment plan

◯ Orthopedic/Spine Surgeon _____

◯ Neurologist _____

◯ Rheumatologist _____

◯ Pain Management _____

◯ Pain Injections/Procedures _____

Alternative measures: ◯ Physical Therapist ◯ Acupuncturist ◯ Chiropractros

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Occupation | Education | Marital Status

◯ On Disability?

◯ Use of TOBACCO? How Often? How Long?

◯ Use of ALCOHOL? How Often? How Long?

◯ Use of Recreational DRUGS? How Often? How Long?
Type of DRUG ?

REVIEW OF SYSTEMS

Constitutional	◯ Fever	◯ Fatigue	◯ Weigh Loss	
Eyes	◯ Blurred Vision	◯ Redness	◯ Double vision	◯ Vision loss
Ear / Nose / Throat	◯ Trouble Hearing ◯ Ear Discharge	◯ Loss of Balance ◯ Ringing in the ear	◯ Dizziness/Vertigo	
Cardiovascular	◯ Fainting	◯ Chest pain/angina	◯ Limb Swelling	◯ Irregular Heart beat
Respiratory	◯ Chronic cough	◯ Coughing blood	◯ Trouble breathing	
Gastointestinal	◯ Indigestion ◯ Heart burn	◯ Nausea ◯ Constipation	◯ Vomiting ◯ Bloody stools	◯ Diarrhea
Genitourinary	◯ Incontinence	◯ Blood in Urine	◯ Pain on Urination	
Musculoskeletal	◯ Muscle pain ◯ Joint swelling	◯ Muscle cramp ◯ Joint pain	◯ Neck pain ◯ Stiffness	◯ Back pain
Skin & Breast	◯ Numbness	◯ Hair loss	◯ Discoloration	
Neurologic	◯ Headache ◯ Blackouts	◯ Weakness ◯ Trouble with memory/concentration	◯ Tremors	◯ Seizures
Psychiatric	◯ Hallucinations ◯ Suicidal thoughts	◯ Feeling down ◯ Inappropriate crying / laughing	◯ Trouble sleeping	
Hematologic/Lymphatic	◯ Anemia	◯ lumps/swellings	◯ Abnormal Bleeding	
Allergic/Immunologic	◯ Rash	◯ Joint pain	◯ Dry eyes / mouth	
Endocrinologic	◯ Excessive thirst	◯ Excessive urination	◯ heat/cold intolerance	

Other Symptoms :

To be Completed After Examination | Blood Pressure | Height | Weight

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List Your **Current** Pain Related Medications

1 _____ 2 _____ 3 _____ 4 _____

5 _____ 6 _____ 7 _____ 8 _____

Medication(s) that have been tried **Before** and its Effectiveness (1 to 10)

◯ Tylenol	0	1	2	3	4	5	6	7	8	9	10
◯ NSAID's: Motrin / Advil / Ibuprofen,etc	0	1	2	3	4	5	6	7	8	9	10
◯ Opioids: Vicodin / Norco / Oxycodone, etc	0	1	2	3	4	5	6	7	8	9	10
◯ Oral Steroids / Medrol dose pack	0	1	2	3	4	5	6	7	8	9	10
◯ Amitriptyline (Elavil), Nortriptyline (Pamelor), etc	0	1	2	3	4	5	6	7	8	9	10
◯ Neurontin/Topamax / Tegretol, etc	0	1	2	3	4	5	6	7	8	9	10
◯ Other Medications	0	1	2	3	4	5	6	7	8	9	10

Past Medical History

_____ Name of illness / Duration

_____ Name of illness / Duration

_____ Name of illness / Duration

_____ Name of illness / Duration

Surgical History

_____ Name of Surgery / Date

_____ Name of Surgery / Date

Allergies

Allergies: _____

Non-Pain-Related Medications

_____ Name / Dosage / Frequency

_____ Name / Dosage / Frequency

_____ Name / Dosage / Frequency

_____ Name / Dosage / Frequency

Do you take any ***blood thinners*** (anti-coagulants) , What kind? _____

☐ *By checking and signing this document I hereby promise that provided information is correct and complete.*

SIGNATURE Patient I Guardian _____ **DATE** _____

TREATMENT AND PAYMENT AUTHORIZATION

I have completed this form fully and completely, and certify that I am authorized to furnish the information requested and authorize related treatments. It is the policy of PAIN CARE PROVIDERS to receive payment in full at the time of services that are rendered, unless other arrangements have been made in advance.

If you wish our office to bill an insurance company instead, a copy of the insurance card and/or complete insurance billing information is required and must be presented before services are rendered. Enrollment in an insurance plan is not a guarantee of payment. Deductibles, co-payments, and doctor participation amounts are due at the time of service.

PAIN CARE PROVIDERS does not assume the responsibility for verification of insurance benefits and/or coverage. Please contact your insurance company to verify your benefits and doctor participation in your plan ***before*** services are rendered.

Any portion of the balance that is not paid by the insurance company due to patient co-pays or deductible amounts, non-covered services, deemed by the insurance company as not medically necessary, Doctor's non-participation in a plan, or any other reason for non-payment or reduced payment is the responsibility of the patient or responsible party.

HMO's and some other insurance plans require an authorization for treatment from a specialist and for the most procedures. Referrals are submitted to your or IPA following your visit and may take 10-14 days for approval. You will be notified by mail or a phone call unless your Primary Care Physician deems the referral as urgent. A statement of charges will be sent to the patient each month showing the patient's due balance. Delinquent balances may be referred to an outside agency for collection.

I have read the above policy and understand that I am financially resposible for all medical services rendered.

SIGNATURE Patient I Guardian _____ **DATE** _____

Thank you for choosing Pain Care Providers. Please fax or bring printed forms with you to office.

IRVINE OFFICE 113 WATERWORKS WAY Suite #345, IRVINE, CA 92618 TEL: 949 872 2400 FAX: 949 872 2401
FOUNTAIN VALLEY 11190 WARNER AVE #305, FOUNTAIN VALLEY, CA 92708 TEL: 714 546 0149 FAX: 949 872 2401
LAGUNA HILLS 24411 HEALTH CENTER DR #320 LAGUNA HILLS CA 92653 TEL: 949 716 8752 FAX: 949 872 2401

You can also follow us on facebook or sign up for our newsletter facebook NewsLetter

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113 WATERWROKS WAY #345
IRVINE, CALIFORNIA 92618
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AUTHORIZATION AND CONSENT FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

I, _____ (**DOB**:), hereby authorize and consent to your release of any and all records and information in your possession which relate to my medical history to:

PAIN CARE PROVIDERS
113 WATERWORKS WAY SUITE 345
IRVINE, CA. 92618
PH: (949)872-2400
FAX: (949)872-2401

I agree that this authorization and consent shall remain valid and in full force and effect until specifically withdrawn by me in writing.

I agree that a photocopy of this document will serve as a duplicate original.

_____
Name (please print name clearly)

_____
Signature

_____
Date

TO OUR PATIENTS

Have you heard of the Health Insurance Portability and Accountability Act? This act is to protect your privacy. If we need to contact you with test results, or leave instructions from your doctor, we need your permission to leave a message at the phone numbers on file.

-----You may not leave a message

-----You may leave a message on my answering machine/and or voice-mail at this number:

-----You may leave a message with a family member at this number

_____
Name (please print name clearly)

_____
Signature

_____
Date

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PAIN CARE PROVIDERS PATIENT CONTRACT
Opioid and Controlled Substances Agreement and Informed Consent

Opioid medications are used judiciously in the treatment of benign or malignant pain conditions. The following is an agreement and explanation of issues related to treatment of painful disorders through the use of opioid medications and/or other controlled substances. These medications include but are not limited to morphine (e.g. MS Contine, Kadian, MS IR), oxycodone (e.g. Percocet, Oxycontin, Roxicodone), Hydromorphone (dilaudid), Hydrocodone (e.g. Vicodin, Lortab, Norco), propoxyphene (e.g. Darvocet), fentanyl (e.g. Duragesic patch, Actiq), methadone, codeine (e.g. Tylenol No. 3), benzodiazepines (e.g. Valium, Xanax), stimulants (e.g. Adderall, Ritalin), Barbiturates (e.g. Fioricet, Fiorinel), etc.

Side Effects & Risks:

Because these medications are potentially dangerous, as are all medications, the side effects and risks are discussed with you at the beginning of the treatment and periodically thereafter. Side effects/risks include but are not limited to allergic reactions, sedation, somnolence, respiratory depression (i.e. slow breathing), dizziness, confusion, nausea, vomiting, urinary retention, suppression of menstrual cycle, hormonal imbalance, constipation, itching, physical dependence, tolerance, addiction, or death.

Caution:

Opioid medications may cause drowsiness. Alcoholic beverages should be avoided or be used with extreme caution and sparingly after approval of your pain physician while taking these medications. Driving a car or operating dangerous machinery may not be allowed initially until a stable dose of these medications are obtained.

Usually, most side effects of opioid use disappear over time and with continued use, except for constipation. Bowel maintenance should be addressed seriously and treated if necessary.

If decision is made to terminate opioid therapy, a weaning manner rather than abrupt discontinuation of treatment should be exercise to prevent withdrawal symptoms (e.g. increased pain, agitation, nausea, diarrhea…)

The following conditions must be followed and agreed upon as long as the patient is receiving treatment at Pain Care Providers Center. Noncompliance with any one of these conditions may result in discharge from the practice.

- Pain Care Providers Center must be the only source for the medications that were reviewed above. The patient may not obtain these medicines from any other source or physician except when it is explicitly allowed and approved by Pain Care Providers Center.
- The patient understands that the treatment goal is to improve the quality of life and ability to function and/or work. These parameters will be assessed periodically to determine benefits of opioid therapy and adjust the dosage accordingly.
- The patient understands that he/she must take the medications as instructed and prescribed. Any change in dosing must be approved by a Pain Care Providers Center physician.
- The patient agrees to use only one pharmacy whose contact information and address the patient would provide to Pain Care Providers Center. If for any reason another pharmacy is to be used (e.g. unavailability of a certain medicine), the patient should notify Pain Care Providers Center.
- **Lost or stolen prescriptions or medications will NOT be replaced.** It is the patient's responsibility to ensure that prescriptions are filled correctly at the pharmacy. If the patient realizes a medication is lost, stolen, or misplaced, a police report must be filed, and the case number should be given to Pain Care Providers Center.
- To ensure efficacy of treatment and for monitoring purposes, the patient should keep all recommended appointments.
- ***Narcotic prescriptions will not be given over the phone, after hours, during the weekends, or holidays.*** If there is a need to change any narcotic prescription a new appointment will be made.
- Pain Care Providers Center has the right to directly communicate with other healthcare providers and pharmacies regarding the patient's use of controlled substances.
- Opioid therapy usually is only part of the overall treatment plan. The patient shall comply with all other treatments as outlined by their physician at Pain Care Providers Center.

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- **The patient may be asked for urine and/or blood screening tests as well as random pill count. Failure to comply with this results in immediate discharge from the practice.**
- The patient understands that sharing of medications referred to above with anyone is absolutely forbidden and is against the law.
- Patient understands that the results of urine/blood testing can be given to the patient's other healthcare providers, insurance company, or other reimbursing agencies. The patient also authorizes any other healthcare provider, pharmacy, law enforcement, or judiciary body to release any pertinent information regarding the patient's prescription or urine/blood screen results.
- Patient agrees that any use of illicit substances (Marijuana, Cocaine, etc.) during treatment is strictly prohibited, and if identified during a urine test it will result in discharge. The only exception is marijuana used for medicinal purposes and only when prescribed by a US licensed physician.
- I, the undersigned, attest that above was discussed with me, and I fully understand and agree to all of the above requirements and instructions. I also understand that failure to comply with above can result in my discharge from Pain Care Providers Center.

HIPPA NOTICE OF PRIVACY PRACTICES

HEALTH INFORMATION THAT WE MAINTAIN ABOUT YOU

We maintain records of:

- Your name and (if different) the name and relationship of the person receiving Treatment. .
- Your address
- Your telephone number
- Your (or the patient's, if different) condition
- The date the doctor diagnosed the condition
- Clinical findings related to the condition such as results of blood tests, procedures, examinations, and diagnostic modalities.
- Your insurance and other coverage information such as billing records.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the right to:

- request restrictions on certain uses and disclosures (we are not required to agree to the restriction)
- **receive communications of protected health information by alternative means or at alternative locations such as home telephone numbers, cell phones, etc. We may leave messages at any or all telephone numbers listed by patient on the patient information form. We may contact any person left as an emergency contact listed on patient information form. We may contact the patient's spouse relaying any message regarding care, appointment or any necessary information deemed necessary for the patient's treatment or care.**
- inspect, copy and amend your protected health information held at Pain Care Providers.
- receive an accounting of certain disclosures (of your protected health information)
- receive a paper copy of this notice even if you have received it electronically.
-

HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

We only use or disclose your health information as state and federal laws require or permit. In some cases, the law requires that you authorize the disclosure. In other cases, the law allows us to disclose your health information without your authorization.

Use and Disclosure Not Requiring Your Authorization

Treatment: We may use your health information for our treatment activities, such as disclosing it to other healthcare providers as helpful to treat you.

Payment: We may use and disclose your health information for our payment and collection activities, such as sending claims to insurance companies for the payment of metabolic treatment products.

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Healthcare Operations: We may use and disclose your health information to manage our program operations, such as reviewing the quality of services you receive.

Business Associates: We may disclose your health information to organizations that help us with our work, such as the billing service we use to process claims to your health insurance company. We have a written agreement that requires these organizations to use your health information for only the reasons necessary to do the work, and protect it from other uses or disclosures, just like we do.

To Contact You: We may use the information in your health records to contact you if we have information about treatment or other health-related benefits and services that may be of interest to you.

Other Permitted Uses and Disclosures

HIPAA specifically permits us to use or disclose your health information for other purposes without your consent or authorization. In our experience such disclosures are rare, and the limited information we maintain is generally not applicable. However, when authorized by law, and to the extent we may have the information, HIPAA permits us to disclose it to:

- comply with the requirements of federal, state, or local laws, court orders or other lawful process and for administrative or court proceedings
- report a public health authority for the purpose of preventing or controlling disease, injury, or disability
- report to the FDA for the quality, safety or effectiveness of FDA-regulated products or activities
- notify a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition
- report abuse, neglect or domestic violence to a government authority
- provide necessary information to a health oversight agency for activities such as audits, investigations, inspections, licensure of the healthcare system, government benefit programs and regulated entities
- a law enforcement official for specified law enforcement purposes
- coroners or medical examiners for identification or determining cause of death
- funeral directors to carry out their duties with respect to the decedent
- organ procurement organizations for facilitating donation and transplantation
- researchers conducting studies approved by an Institutional Review Board
- prevent or lessen a serious and imminent threat to the health of safety of a person or the public
- authorized federal officials for specialized government functions such as military and veterans activities; national security and intelligence activities; protective services for the president; medical suitability determinations; correctional institutions; government entities providing public benefits and
- comply with workers' compensation laws

Uses and Disclosures with Your Authorization

Other uses and disclosures or your personal information require your written authorization. You may revoke your authorization at any time by doing so in writing.

By signing this form I acknowledge that I have read and understood the contract agreement and will follow these instructions during my treatment. I have also received a copy of this agreement for my files.

Patient Name : _____

Patient Signature: _____ **Date:** _____