ADVANCE COMPREHENSIVE PAIN CARE

MUNISH LOOMBA, M.D.

ADVANCE COMPREHENSIVE PAIN CARE

4244 Riverwalk Pkwy Suite 220
Riverside, CA 92505
Ph: 951-208-7714
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10807 Laurel St., Suite 210
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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR THE TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

Patient Name:______________________________________ DOB: ___/___/___ Date: ___/___/___
(Last Name) (First Name)

Advance Comprehensive Pain Care has implemented all the HIPPA (Health Insurance Portability and Accountability) guidelines recommended by the Federal Government. For more information, please ask to see our Notice Of Privacy Practices.

We have implemented the following to protect and safeguard your health information:

- Ongoing training for all our employees on privacy policy and procedures.
- Established safeguards to protect all electronically stored data.

Advance Comprehensive Pain Care will only use personal information for:

- Planning your care and treatment.
- Communicating with other health care professionals who may contribute to your care.
- Communicating with your insurance care provider.

We do request your permission to have a:

- Sign-in sheet at the front desk.
- To call out your name at the time of your appointment.
- We will get your written permission if we were to use your personal information for any other reasons.

You have the right:

- To revoke this consent in writing, except to the extent that Advance Comprehensive Pain Care has already taken action in reliance thereon.
- To inspect and copy your medical information.
- Get information about the disclosures, we have made on your behalf.

Please outline any other restrictions that you would like us to place in the disclosure of your health information:

____________Accepted ____________Denied

Patient Signature: ________________________________ Date: ____________

Witness Signature: ________________________________ Date: ____________

I also authorize the person(s) listed below to receive information regarding my appointments or treatments while a patient at the Advance Comprehensive Pain Care.

NAME	RELATIONSHIP
____________________	____________________
____________________	____________________

Patient Signature: ________________________________

Please print your name: ________________________________

Date: ________________________________

PATIENT HEALTH QUESTIONNAIRE (**PHQ-9**)

NAME: ______________________________ DATE: ______________

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

	Not at all	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble failing or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

FOR OFFICE CODING ______+______+______

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL:

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	
Not difficult at all	______
Somewhat difficult	______
Very difficult	______
Extremely difficult	______

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OPIOID RISK TOOL

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates high risk of opioid abuse.

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal Drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal Drugs	4	4
Rx drugs	5	5
Age between 16-45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

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Cancellation of an Appointment

Please notify our office at least 24 hours in advance if you are unable to keep your scheduled office appointment. If you must cancel a scheduled procedure, we require that you call at least three working days (72 hours) in advance. Appointments and procedure times are in high demand, and early cancellation will give another person the possibility to have access to timely care.

How to Cancel Your Appointment

To cancel an appointment, please call **Moreno Valley (951) 208-7700, Riverside (951) 208-7714, Rancho Cucamonga (909) 222-6903.** You may leave a detailed message on the voice mail if you are unable to speak directly with a receptionist.

Late Cancellation or No Show

Patients failing to cancel their office appointment as indicated above (at least 24 hours in advance) will be billed a cancellation fee of $25.

Patients failing to cancel their scheduled procedure as indicated above (at least 72 hours in advance) will be billed a cancellation fee of $50.

On-Time Arrivals

If you are more than 15 minutes late to your appointment, you will have to reschedule your appointment for another day. This will be considered a missed appointment.

Patient Name: (Please Print) ______________________________

Patient Signature: ______________________________

Date: ______________________________

Welcome to Advance Comprehensive Pain Care

1. Please provide the front desk with a copy of your driver's license and current insurance cards.
2. It is your responsibility to know your insurance. Due to the exactitude of insurances, you will not be seen until all insurances have been verified and referrals have been received. If you have more than one insurance, please let us know immediately as it can take up to two hours to verify insurance.
3. Please do not leave anything blank in the patient packet.
4. Do not use the term N/A (not applicable); instead use "none" or "no" where it is needed.
5. Please ask us for help if something needs to be clarified. We are here to help you.

Today's Date ____________________

Patients Name ________________________________ Birth Date ______________
First Middle Last

Social Security Number ________________ Home Phone ____________ Cell ____________

Address ________________________ Apt # _____ City __________ State _____ Zip ________

Preferred contact method: ☐ Phone ☐ Text ☐ Email ______________________________

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Employer ______________________ Employer Phone __________________ Ext ______

Employer Address __________________________ City__________ State _____Zip ______

Spouses Name ______________________________ Spouses Cell ______________

Referring Doctor ________________________ Phone ______________ Fax __________

Primary Care Physician ____________________ Phone ______________ Fax __________

Emergency Contact (not living with you) ______________ Relationship _________Phone __________

Primary Insurance ______________________ Phone ______________ Fax __________

Claims Address __________________________ City __________ State _____ Zip ______

Policy Holder Name __________________ Birth Date _______ ID# ____________ Group #________

Effective Date ______________ Relationship to Patient ________________

Secondary Insurance ______________________ Phone ______________ Fax __________

Claims Address __________________________ City __________ State ____ Zip ________

Policy Holder Name ______________________ Birth Date _______ ID# __________ Group #_______

Effective Date ______________ Relationship to Patient ______________

Is this an on the job or other work related injury? □ Yes □ No

If so, please complete the following:
Employer Name: ______________________________ Phone ________________________________
Case Worker's Name ____________________________Case Worker's Phone ____________________________
Date of Injury _________________________

Is this an injury from a Slip and Fall or Auto related injury? □ Yes □ No

Date of Injury _______________ Attorneys Name ______________________ Phone ____________________

MEDICAL HISTORY

Past surgeries or hospitalizations

Patient Name ____________________

1. Are there any other symptoms associated with your pain?
   ☐ Numbness ☐ Bowel Incontinence ☐ Tenderness of affected area
   ☐ Weakness ☐ Urinary Incontinence ☐ Pain with light touch

2. Are you depressed because of your pain? ___ Yes ___ No

3. Have you ever considered suicide to end your pain? ___ Yes ___ No

4. Has your pain affected any of the following? (Check all that apply.)
   ☐ Sleep ☐ Routine Activities ☐ Work

5. What other treatments have you had in the past to treat your pain?

Date	Type of Treatment	Pain Relief (%)

PAST MEDICAL HISTORY:

Please check any of the following conditions you have had or presently have:

☐ Diabetes ☐ Kidney disease
☐ Cancer ☐ Thyroid disease ☐ HIV/AIDS
☐ Heart Problems ☐ Ulcer ☐ Hepatitis
☐ High blood pressure ☐ Bleeding problems ☐ Stroke
☐ Asthma, Emphysema ☐ Seizures ☐ Other

PERSONAL AND SOCIAL HISTORY:

1. What is your current martial status?
   ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow/widower
2. Do you smoke? ___ Yes ___ No
3. Do you drink alcoholic beverages? ___ Yes ___ No
4. Do you use recreational drugs? ___ Yes ___ No
5. Present employment status:
   ☐ Full Time ☐ Unemployed ☐ Leave of absence ☐ Student
   ☐ Part Time ☐ Retired ☐ Homemaker

FAMILY HISTORY: (Check all that apply)

☐High blood pressure ☐ Heart Attack ☐Heart Disease
☐Hepatitis ☐ Asthma ☐Lupus
☐Diabetes ☐Seizures ☐Multiple Sclerosis
☐Depression ☐ Schizophrenia ☐ Alcoholism
☐Cancer ☐Thyroid disease ☐ Bleeding disorder
☐Other

ALLERGIES: ☐ Yes ☐ No

If yes, please list: ______________________________

MEDICATIONS:

Medications	Medications	Medications

DIAGNOSTIC STUDIES:

Test	Date	Facility Where Test Was Done
X-rays		
CT Scan		
MRI		
EMG/NCV		

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• PMR / Pain Management Clinic
New Patient Evaluation Form

Please complete this form so we can better help you.

What is your goal/purpose of visit? ______________________________

Please circle one of the numbers on the scale below to point out how intense your pain is today:

1 2 3 4 5 6 7 8 9 10

No Pain — Moderate Pain — Unbearable Pain

The pain is ___Constant___Nearly constant (50-80%) ___Intermittent (25-50%) ___Occas. (<25%)

Where is your worst pain?	
When and how did it start?	

The Pain is::	Pain is worsened by:	Pain is helped by:	Over time, the pain is::	Are you having any: (check any + location)
☐ Sharp	☐ Sitting	☐ Ice or ☐ Heat	☐ Getting better	☐ Numbness + tingling
☐ Dull	☐ Standing	☐ Walking	☐ Getting worse	☐ Weakness
☐ Aching	☐ Walking	☐ Medication	☐ Staying the same	☐ Urinary Incontinence
☐ Burning	☐ Lying down	☐ Lying down		☐ Morning Stiffness
☐ ____________	☐ Bending/ twist	☐ Bend forward		☐ Depression
☐ ____________	☐ ____________	☐ ____________		☐ Sleep disruption

Have you had any of the following tests, where and when?

☐ X-rays
☐ MRI or CT
☐ EMG / Labs

Financial Policy and Assignment of Benefits

***Payments for medical services rendered are due at the time of service unless prior arrangements have been made.**

Our office verifies eligibility and benefits with your health insurance company. If we are unable to accomplish this, you will be asked to pay for services rendered until we can confirm your status. We will do all we can to assist you with your insurance claims; however, the insurance is a contract between you and your insurance carrier. Final responsibility for payment of your account rests with you.

Prior authorizations obtained for procedures by this office on your behalf do not guarantee payment but rather are based on medical necessity. Claims are subject to policy provisions, and your insurance carrier determines final payment. A deposit is required if you are being scheduled for a procedure.

Having read the above, I hereby authorize payment by my insurance carrier, Medicare, Medicaid, or other designated payers of medical benefits to Advance Comprehensive Pain Care for services furnished to me. This assignment will remain in effect until revoked by me in writing. I hereby accept financial responsibility for all charges incurred whether or not I have insurance coverage. A photocopy of the assignment is considered as valid as the original.

I also authorize Advance Comprehensive Pain Care to release to my insurance carrier or their agents any medical information about me needed to determine these benefits payable for service.

I understand that if my account becomes delinquent and is assigned to an outside collection agency, that an additional mark up of 100% will be added to the amount I owe. I understand the adding of this collection fee as well as the accrual of interest at the statutory rate should by account be assigned to a collection agency. I agree to pay Advance Comprehensive Pain Care for the medical services provided, collection fees if added and interest.

I hereby consent to and authorize medical treatment, tests, and procedures performed in this office that my physician deems advisable and necessary based on his judgment. I understand that I may ask whatever questions needed to understand the necessity for and expected outcomes of the recommended care.

I have read and understand the above statements:

____ ______________________________

Patient Signature Date

____

Please Print Your Name