Pacific
PAIN & REGENERATIVE MEDICINE

PATIENT DEMOGRAPHICS

FULL NAME: _____ DOB: _____ SSN: _____

ADDRESS: _____

PHONE: _____ _____ Ok to leave message? _____
Home Mobile

EMAIL: _____PREFERRED METHOD OF CONTACT? _____

PHARMACY: _____ _____
Name/Zip Phone Number

16405 Sand Canyon Ave Suite 215
Irvine, CA 92618

431 S Hewitt St
Los Angeles, CA 90013

Pacific
PAIN & REGENERATIVE MEDICINE

PATIENT HISTORY

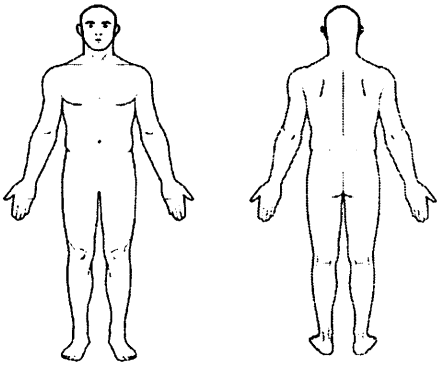
PATIENT NAME: _____ DOB: _____ DATE: _____

PHONE NUMBER: _____ ADDRESS: _____

OCCUPATION: _____ HOW DID YOU HEAR ABOUT US? _____

Chief Complaint (reason for visit): _____

On the Diagram below, please indicate the areas where you feel pain?



1. **When did your symptoms start?** _____
2. **Are they getting:** o WORSE o BETTER o STABLE
3. **Please describe your symptoms:**

   How often is your pain: o Intermittent o Continuous o Occasional o Rare

   How severe is your pain: o Mild o Moderate o Severe o Unbearable

   Describe sensation of pain: o Throbbing o Dull o Aching o Shooting o Stabbing o Burning

4. **Pain level today is** (0= no pain 10= unbearable) 0 1 2 3 4 5 6 7 8 9 10

Over the last 2 weeks, please identify your pain levels below:

5. Severe pain level: 0 1 2 3 4 5 6 7 8 9 10
6. Average pain level : 0 1 2 3 4 5 6 7 8 9 10
7. **Do you experience:** o Numbness o weakness o Tingling o pins/needles o Swelling

8. **What activities increase your symptoms:**

o sitting o lifting o bending to the right o bending to the left o walking o standing

o bending backward o bending forward o driving o cold/damp weather o coughing/sneezing

9. **What helps decrease your symptoms:**

o nothing o sitting o standing o walking o stretching o heat o ice o medication o lying down

o massage o physical therapy o chiropractic treatment o acupuncture o rest

10. What have you tried:

o Physical Therapy o Chiropractic Treatment o Massage o Acupuncture

o Injections/Nerve Blocks : _____

o Surgical intervention: _____

o Medications: _____

11. Past Medical History:

Hypertension	High Cholesterol	Asthma
Diabetes	Drug/Alcohol Abuse	Gout
Heart Disease	Bleeding/Clotting Disorder	HIV
Stroke	Cancer (type:_____)	Dementia
Seizures	Hepatitis	Chronic Infections
Multiple Sclerosis	Radiation/Chemotherapy	Respiratory Problems
Ulcers	Depression OR Psychological Problems	Parkinson's Disease

Other: _____

Past Surgical History: _____

12. Please list all current medications:

_____ _____ _____

_____ _____ _____

13. Please list any allergies and reaction to each:

_____ _____ _____

_____ _____ _____

14. Family Medical History: o None o Unknown Please list all medical conditions in your family:

o Father o Mother o Brother o Sister o Other: _____ _____

15. Social History:

A. Do you use tobacco/smoke? _____ If so, how often? _____

B. Do you drink Alcohol? _____ If so, how often? _____

C. Describe your physical activity/type and frequency: _____

16. Review of Symptoms- Problems you are experiencing at the present time:

Fatigue	Shortness of breath	Urinary Incontinence	Depression
Fever	Chest Pain	Weakness	Anxiety
Headache	Constipation	Rash	Substance Abuse
Sleep Disturbance	Diarrhea	Tingling/Numbness	Alcohol Abuse
Itching	Nausea	Memory Loss	Stress
Blurred Vision	Heartburn	Seizures	Nervousness
Hot/Cold Intolerance	Vomiting	Balance Difficulty	Mental Illness

Other (Please Describe): _____

_____ _____

Patient Signature Date

Pacific
PAIN & REGENERATIVE MEDICINE

Hasan Badday MD
Board Certified in Physical Medicine& Rehabilitation
Board Certified in Pain Medicine

Name of Patient _____
Date(s) of Service _____
Date of Birth _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

PATIENT INFORMATION IS NEEDED FOR:
Continuing Medical Care

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):
TO:
Pacific Pain and Regenerative Medicine – Dr. Hasan Badday

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.)

Phone Number: 949-485-4257 Fax: 949-258-5011
16405 Sand Canyon Ave Suite 215 Irvine, CA 92618

Address (Street, City, State and ZIP)

FROM:

Phone Number :

Address (Street, City, State and ZIP)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

Date: _____ Signature: _____

Interventional Pain Management

Pain Medication Agreement

Name: _____ **DOB:** _____ **Date:** _____

The objective of this agreement is to prevent misunderstandings and clarify misconceptions about certain medications the patient will be taking for pain management. This agreement is helpful to both the patient and the doctor to comply with laws regarding controlled pharmaceuticals.

Please Initial Each Item Indicating Full Understanding and Agreement:

_____ 1. I understand that if I violate this agreement, my doctor will stop prescribing me these pain controlling medications.

_____ 2. If my doctor stops prescribing my medications, my doctor may taper off the medications over a period of several days, as necessary, to avoid withdrawal symptoms. A drug dependence program may be recommended.

_____ 3. I will not use any illegal controlled substances including but not limited to methamphetamine, cocaine, heroin, etc.

_____ 4. The use of THC (marijuana) may warrant my doctor to discontinue or adjust my opioid regimen.

_____ 5. My provider does not prescribe opioids with benzodiazepines (Valium, Ativan, Xanax, Klonopin). The FDA is warning patients and their caregivers about the serious risks of taking opioids along with benzodiazepines or other central nervous system (CNS) depressant medications, including alcohol. Serious risks include unusual dizziness or lightheadedness, extreme sleepiness/fatigue, slowed/difficult breathing, coma, and death. These risks are because opioids and benzodiazepines both impact the CNS, which controls most of the functions of the brain and body.

_____ 6. I understand that I may receive a prescription of EVZIO through a mail order pharmacy if authorized by my insurance. This is a medication for administering naloxone during an opioid emergency, such as an accidental overdose. If you decline to receive EVZIO, please sign here: _____

_____ 7. I will not share, sell, or exchange/trade my medication with ANYONE. I may be subject to a pill count at the request of my doctor or staff.

_____ 8. I will not attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other source without notifying my doctor.

_____ 9. I will safeguard my pain medications from loss or theft. Lost or stolen medications will NOT be replaced.

_____ 10. I understand and agree that refills of my prescriptions for pain medications will be made only at the time of an office visit and during regular business hours. No refills will be available during evenings, weekends, or holidays.

_____ 11. My doctor is NOT REQUIRED to release medications early due to my vacation/absence. I understand that in the event of a vacation or absence, I will provide appropriate verification and documentation in advance at my office visit and the provider will review this for further care.

_____ 12. I authorize my provider and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize my provider to provide a copy of this agreement to my pharmacy and other treating providers. I agree to waive any applicable privilege/privacy rule and confidentiality with respect to these authorizations.

_____ 13. I agree to submit to a urine test, mouth swab, or other form of verification if requested by my provider to determine my compliance with my program/regimen of pain control medication.

_____ 14. I agree that I will use my medication at a rate no greater than the prescribed rate. Use of prescribed medication at a greater rate will result in my being without medication for a period of time and may result in withdrawal symptoms which can be life-threatening.

_____ 15. I understand that many medications can cause drowsiness and decrease ability to safely operate motor vehicles and heavy machinery. Opiate medications can cause impairment while driving. Combining my medication with sedatives, alcohol, over the counter medications, other prescription medications, and/or illegal substances can intensify/amplify this impairment. I will never drive if I feel at all impaired. I should minimize driving in general. Driving under the influence of pain medications can be a criminal offense, even if my drugs are prescribed.

_____ 16. I understand that many medications including opioid pain medications have potential for addiction.

_____ 17. I will take my medication as prescribed. I will not break or crush or divide my medication unless directed to do so by my doctor.

_____ 18. I understand that overdose of medication can result in difficulty breathing, loss of consciousness, and even death.

_____ 19. I understand the goals of prescription pain medication are: 1) Improve functioning; 2) Decrease Pain; 3) Avoid serious side effects. If these goals are not being met, my doctor may wean these medications and discontinue use.

_____ 20. If I become pregnant or plan to become pregnant, I will notify my doctor immediately.

_____ 21. I understand that the office does not provide physical triplicate prescriptions. All prescriptions must be sent to an electronic enabled pharmacy. I understand that at the time of visit, the discussed prescription will be electronically sent by the END OF THE BUSINESS DAY.

_____ 22. I agree that in the event of medication changes, I will return previously prescribed unused medication to the office to be accounted for with proper disposal protocol.

_____ 23. I understand that I will not engage in unprofessional or disrespectful behaviors, such as yelling, using aggressive language or profanity, calling the office multiple times per day, and other actions toward my doctor or staff.

_____ 24. These guidelines have been fully explained to me and I agree to follow them completely. All of my questions and concerns regarding treatment and treatment guidelines have been answered. Failure of compliance of this agreement can result in withdrawal of all prescribed medications by the doctor or termination of the doctor patient relationship. A copy of this document can be given to me at my request.

Patient Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____

Witnessed By: _____ **Date:** _____

Pharmacy Name: _____ **Date:** _____

Pacific
PAIN & REGENERATIVE MEDICINE

YOU AND YOUR INSURANCE ARE SOLELY RESPONSIBLE FOR YOUR BILL. KNOWING YOUR INSURANCE BENEFITS PLAN IS YOUR RESPONSIBILITY

I understand that these services are my financial responsibility. As a courtesy you will submit a claim to my insurance. I agree to pay for these services if my insurance fails to pay.

PAYMENT IN FULL for non insurance services is expected at the time of service. Co-payments for services are REQUIRED at the time of registration. Please be advised that we are contractually obligated by your insurance carrier to collect your co-payment at the time of service. If you arrive without the ability to pay for your services or your co-pay you will not be seen and your visit will be rescheduled.

Pacific Pain and Regenerative Medicine is committed to providing the highest quality care for our patients and we charge what is usual and customary for our area. You are ultimately responsible for all clinic and surgery fees relating to your care. **You are responsible for payment regardless of your insurance company's arbitrary determination of usual and customary rates.** Your insurance policy is a contract between you and your insurance company. Any disagreement you have concerning the amount your insurance pays should be directed to your insurance company.

Initial_____

For services that are not covered by insurance, the practice requires payment of 100% of the total **estimated charges** unless prior payment arrangements have been set up with our office.

Insured individuals electing to be self-pay. The patient has the right to elect not to file their health insurance and elect to be a self-pay patient for services provided. The patient will be financially responsible for charges incurred and payment will be due at the time of service. After services have been rendered, the patent will not be able to file their health insurance for the services due to insurance claim submission requirements. Pacific Pain and Regenerative Medicine will not file insurances for any services where the patient elected to be self-pay. The patient's election to not file the services to their insurance company does not affect or reduce any out of pocket financial responsibility for future services as determined by their insurance plan.

If you do not have insurance coverage for the service, are self-pay, or have insurance that Pacific Pain and Regenerative Medicine does not participate in or accept, payment is expected at the time of service. Pacific Pain and Regenerative Medicine has established a discounted self-pay rate for our services. Prior financial arrangements must be made and approved before your visit if you cannot pay 100% at the time of service.

No discount of assigned insurance patient liability (co-pay, deductibles, co-insurance) will be made to comply with federal insurance regulations and law. **This office collects deductible, co-pay and co-insurance up front.**

If financial arrangements have not been made and you arrive without the ability to pay for the services you will not be seen and you visit will be rescheduled.

Out of Network insurance-Some insurance plans require you to pay different out-of-pocket amounts based on the provider and/or location where the service is performed. Deductibles, co-insurance and co-payments may also apply according to you insurance plan. By law, you are responsible for these amounts, as well as any non-covered services outlined in you health plan. It is your responsibility to inquire about any plan specific coverage limitations with you insurance company. You can choose to have the services performed as "Out of Network" or as self pay. You may also apply for financial hardship review if the "Out Of Network" patient liability exceeds you ability to pay.

Insurance information provided after the services have been provided will be billed or not billed at the discretion of Pacific Pain and Regenerative Medicine. Due to the insurance contractual requirements for referrals, authorization of services and timely filing limitations insurance must be presented prior to services being provided. If our office agrees to bill your insurance you will be held liable for the charges if the insurance denies your claim as untimely because of late presentation of coverage or for lack of timely authorizations or referrals.

Patients who request payment arrangements and/or financial hardship adjustments are required to supply financial documentation to support their request. Financial documentation will include income and expenses as outlined on our financial assistance application. Failure to supply the required documentation will result in normal collection activity being adhered to.

In the event your account/s must be turned over for outside collections, you will be billed and are responsible for all fees involved in the collection process. Returned checks are subject to a handling of **$30.00.**

Patients with a history of presenting for their appointment without the ability to pay their co-pay, short notice (less than 48 hours) cancellation of appointment or not showing up for their appointments will be subject to reviewed for dismissal from our practice.

There is a minimum charge of **$50.00** complete FMLA paperwork, forms for disability claims, accident or injury claims, attorney verification of medical condition or any other non medical services reimbursement paperwork. Payment must be made at the time the forms are complete. Some third party forms requests must be paid for prior to the forms being completed.

There is a fee of **$50** if you no show an office visit, and there is a charge of **$150** for anyone who no shows a procedure.

We realize that temporary financial problems do occur. If such problems do arise, we encourage you to contact us promptly for assistance. If you have any questions about the above information, or any uncertainty regarding you insurance coverage, PLEASE do not hesitate to ask us.

Authorization: I hereby authorize Pacific Pain and Regenerative Medicine to administer treatment, diagnostic testing and perform procedures as may be deemed necessary or advisable in my diagnosis. I further authorize the release of any medical information necessary to process my insurance claim and request payment of medical services to be assigned directly to Pacific Pain and Regenerative Medicine . In the event my insurance makes payments directly to me for services I will immediately endorse and assign the payment to Pacific Pain and Regenerative Medicine. If my insurance does not cover services rendered, I agree to be personally and fully responsible for payment. I give doctor permission to appeal any denials by my insurance for services rendered on my behalf. I will assist the office with follow up of timely payment, requests for information and appeals to my insurance as necessary to ensure full and timely payment for services received.

I have read the Financial Policy and understand and agree to its terms. This authorization is to remain in full force unless I revoke the same in writing.

_____ _____

(Patient/Responsible Party Signature) **Printed name**

_____

Date