PATIENT INFORMATION

Please take a moment to fill out all the information below. Thank you!

Name_______________________________Date___________S.S.#___________________

Address____

City _____________________ State _______________ Zip code _______________

Home phone _________ Cell _________ Other_________E-Mail_________________

Date of Birth _________________Age ___________Sex: ▫ Male ▫ Female

Business/Employer ____

Address ____

Type of Work _____________________ Years Employed ___________ Retired (Date) ______

Check One: ▫ Married ▫Single ▫ Widowed ▫ Separated ▫ Divorced ▫ with Children (if so ages) __________

Name of Emergency Contact _____________ Relation ___________ Phone ______________

Who is responsible for your bill? ▫ Self ▫ Spouse ▫ Workmans' Comp ▫ Medicare ▫ Medicaid ▫ Auto ▫ Commercial

▫ Personal Health Insurance ▫ Other ____

Please answer the following Government Question:

What is your race: ▫ Caucasian ▫ Black ▫ Asian ▫ Pacific Islander ▫ Hispanic ▫ REFUSE TO ANSWER

What is you Religion: ______________________ What is your Native language? ______________________

Who is your Primary Care Physician? ____

Phone #: ____________________________ Fax #: _______________________________

Who is your referring physician? (If different than your PCP) _______________________

Phone #: ____________________________ Fax #: _______________________________

What pharmacy do you use? _______________ City: _____________ Phone #: ____________

<u>INSURANCE INFORMATION</u>

Do you have health insurance? ▫ Yes ▫ No

Primary Insurance: ________________________ ID #: ________________________

Secondary Insurance: ______________________ ID #: ________________________

Patient Name: ____ **Date of Birth:** ________________________________
Gender: Male/Female **Height:**______________ **Weight:**______________

What is your main concern today? ____

Where is your pain? (Describe & use diagram below)____

***Quality* of pain** Please circle all that apply. Dull, aching, gnawing, shooting, burning, electric, throbbing, rhythmic, Other____

Pain Level today (1-10)____________Average__________At it's worst______________________________________

When did it start and what where you doing ?____

What makes it **better?** (i.e. medication, rest, change in position, heat/cold packs)___________________________________

What makes it **worse?** (i.e. twisting, coughing, bending, walking, lifting, straining)__________________________________

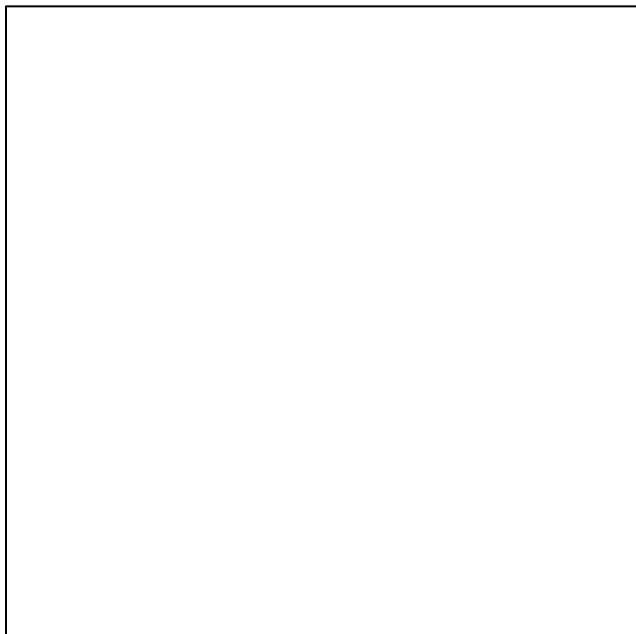
Have you tried any of the modalities below to improve your condition? Did it help? How much?
Physical Therapy ___________# weeks/sessions____(Y/N)_____%
Massage/Chiropractic ________# weeks/sessions____(Y/N)_____%
Injections? Type? How Many & When?____(Y/N)_____%
Past Pain medications?____(Y/N)_____%
Any hardware or implants in your body? (Y/N)___Where?____

Medical Conditions (Y/N)____
____

Surgeries - (Y/N) date, body part, location____
____

Working/retired/disabled?__________ **Nature of work** (past & present) _______________________________________
Do you smoke? (Y/N) _________ packs/day/yrs___________ Recreational Drugs?___________________________________
Alcohol (Y/N)________________ day/week? (Wine/Beer/Liquor) ____
History of Alcohol/Drug Abuse or Treatment? (Y/N)____
History of Depression/PTSD/physical/emotional/sexual abuse? (Y/N)____
Children? (Y/N) Number and Ages_______________________________ Marital Status___________________________
Family History of Cancer/Spine/Joint/Heart Disease? Who?____
Allergies? (Drug/Symptom)____
Current Pain Medications? (Dose and Frequency)

_______________________________________ _______________________________________
_______________________________________ _______________________________________
_______________________________________ _______________________________________



Please circle all that apply:

Constitutional: Chronic fatigue, fever or chills, night sweats, weight loss, loss of bladder or bowel function.

Specific Problems:
Ears ringing, hearing loss, hearing aid
Nose pain, discharge, sneezing
Mouth lesions, sore throat
Eyes blurry/double/change vision, redness
Cardiovascular chest pain, palpitation, leg swelling, high blood presure
Respiratory cough, wheezing, sputum, shortness of breath
Gastro-intestinal Nausea, vomiting, black stools, constipation
Genital urinary frequency, burning, impotence, pregnant
Skin rash, change in skin/nails
Neurological headache, seizures, tingling, numbness, weakness, dizziness, memory loss
Psychiatric anxiety, insomnia, depression, suicidal
Endocrine cold intolerance, low sex drive
Hematologic/Lymph bruising, bleeding, clots
Allergic/Immunologic sneezing, itching

Financial Agreement, Authorization for Assignment of Benefits & Patient Consent

Patient Name: ________________________ Date: ______________________

With the execution of this document, the undersigned, in consideration for services rendered, hereby agree to the following:

1. FINANCIAL AGREEMENT: I agree to pay for all services rendered to me by Desert Clinic, LLC. I understand that as a courtesy to its patients providing insurance/billing information, Desert Clinic, LLC will submit claims to my health care plan or insurance company. However, I further understand that I am responsible for payment of the balance owed. I agree that I am also responsible for any deductibles, co-insurance, charges for non-covered services, charges for services deemed "medically unnecessary" or charges for which I have not obtained a properly authorized written referral, if required by my health plan. In the event that I am not currently enrolled as a member of a health care plan, I am personally responsible for all charges incurred for services.

FOR MEDICARE PATIENTS ONLY
2. MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits due me be paid in my behalf to Desert Clinic, LLC, for any services furnished by Desert Clinic, LLC. I authorize any holder of medical or other information about me to release to any insurance carrier or to the Health Care Financing Administration and its agents, information needed to determine these benefits or any benefits for related services. I permit a copy of this authorization to be used in place of the original. I understand that I am responsible for the Medicare Part B deductible and the remaining 20% of charges.

3. **ASSIGNMENT OF BENEFITS:** I hereby assign to Desert Clinic, LLC those insurance benefit payments due Desert Clinic, LLC and hereby authorize my insurance company to make payment directly Desert Clini, LLC. I understand that regardless of this assignment, I remain primarily responsible to Desert Clinic, LLC for payment of all actual charges incurred. A carbon copy or photocopy of this assignment shall be as valid as the original.

4. RELEASE OF INFORMATION: I authorize Desert Clinic, LLC to disclose all or any part of my medical record to any insurance carrier, person or corporation which is or may be liable under contract to Desert Clinic, LLC or to me or to a family member or employer of mine, for all or part of Desert Clinic, LLC charges. This authorization includes, but is not limited to, worker's compensation carriers, Anthem (Blue Cross/Blue Shield), commercial insurance carriers, and the fiscal intermediary under Medicare and Medicaid.

5. PATIENT CONSENT: Based on physician's referral for Desert Clinic, LLC services, I request and give consent to Desert Clinic, LLC, its physicians and staff, to provide diagnostic and therapeutic radiology services, contrast administration and related care. This includes treatment of any life-threatening condition that may arise during the course of my Desert Clinic, LLC examination(s) or while present at Desert Clinic, LLC.

MY SIGNATURE BELOW ACKNOWLEDGES THAT I HAVE BEEN GIVEN THE OPPORTUNITY TO READ OR HAVE HAD THE ABOVE INFORMATION EXPLAINED TO ME AND THAT I FULLY UNDERSTAND THE STATEMENTS IN THIS DOCUMENT AND CONSENT TO EACH OF THEM. I CERTIFY THAT I AM THE PATIENT OR AM DULY AUTHORIZED BY THE PATIENT TO EXECUTE THE ABOVE AND ACCEPT THE TERMS.

____ ______________________________

Patient Signature Patient's Agent/Representative Date

AUTHORIZATION TO RELEASE/REQUEST HEALTHCARE INFORMATION

Patient's Name: ____________ Date of Birth: ____________

Previous Name: ____________ Social Security #: ____________

I authorize **Desert Clinic Pain Institute** to

Release and Request healthcare information of the patient named above to:

Name: ____________

Address: ____________

City: ____________ State: ____________ Zip Code: ____________

This request authorization applies to:

□ Healthcare information relating to the following treatment, condition, or dates:

____

____

____

___

□ All healthcare information

□ Other: ____________

Patient Signature: I authorize the release/request of any records to the person(s) listed above.

Patient Signature ____________________ Date ____________

Notice of Privacy Practices

Desert Clinic Pain Institute

Effective April 29, 2012

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Health Information

Each time a Desert Clinic, LLC., staff interacts with you, a record of the visit is made in your health record.

- Health, family, social, educational, and other information provided by you is maintained in your health record.
- Your record may also contain your screening and test results, immunization record, diagnoses, treatment, and a plan for your ongoing care. Medical and hospital reports, and other information obtained with your written permission may be part of your record.
- Your health record serves as the basis for:
  - Planning your care and treatment;
  - Communicating with other health professionals involved in your care;
  - Documenting the care you receive;
  - Assessing and continually working to improve the care we provide; and
  - Verifying that the services billed to your health insurer were actually provided.

Your Health Information Privacy Rights

Although your health record is the physical property of Desert Clinic, LLC., the information belongs to you. You have the right to:

- See and get a copy your health information;
- Receive this notice that tells you how your health information may be used and shared;
- Obtain a written report on when and why your health information was shared for certain purposes;
- File a complaint with Desert Clinic Pain, LLC., or the U.S. government without fear of retaliation if you believe that your privacy rights are being denied or your health information isn't being protected;
- Ask to have corrections added to your health information;
- Ask that certain health information not be shared for particular reasons; however, Desert Clinic, LLC., may not be required to agree with your request; and
- Ask Desert Clinic, LLC., to communicate with you about your health information in a different way or at a different location.

Desert Clinic, LLC., Responsibilities

Desert Clinic, LLC., is required to:

- Ensure the privacy of your health information;
- Provide you with this notice which describes our legal duties and privacy practices regarding information we collect and maintain about you; and
- Abide by the terms of this Notice of Privacy Practices currently in effect.

Should our privacy practices change, we reserve the right to make the new provisions effective for all health information we maintain. Any significant change will be reflected in a revised Notice of Privacy Practices which will be available on or after the effective date of the change.

Even if you have agreed to receive this notice electronically, you may receive a paper copy on request.

How Desert Clinic, LLC., Permitted to Use or Share your Information?

***With your Authorization*:** You may give written permission or authorize Desert Clinic Pain Institute to share your information with any person or entity you choose, such as your insurance company, certain members of your family, your attorney, or your employer.

To do this, you must complete, sign, and date an **Authorization Form**. You may cancel your authorization in writing at any time; however, your cancellation will not apply to the actions already taken by Desert Clinic Pain Institute, LLC., when your authorization was in effect.

***Without your Authorization*:** Current privacy laws allow Desert Clinic, LLC., to use and share your health information without first obtaining your written permission for the following purposes:

For your treatment. For example, Desert Clinic, LLC., may use your health information to remind you about a health appointment. Most importantly, your information may be used and shared with the members of your health care Treatment Team to determine the best course of care for you.

For payment activities related to services we provide for you. For example, a bill may be sent to your health insurer which may include information that identifies you, your diagnosis, as well as the type of health care services that you received.

For administrative health care operations. For example, members of the Desert Clinic, LLC., Quality Improvement Team may use your health information to assess the care and outcomes in your situation and others like it. This information may then be used to continually improve the quality and effectiveness of the services we provide.

For public health activities. Desert Clinic, may share your health information with public health authorities charged with preventing or controlling disease, injury, or disability.

When required by law. For example, the law requires Desert Clinic, LLC., to report gunshot wounds to the police.

To report suspected abuse or neglect. The law requires Desert Clinic, LLC., to report suspected abuse or neglect to Child or Adult Protective Services or the police. The report may contain health information.

For judicial purposes. For example, Desert Clinic, LLC., may share specific health information in response to a court order, administrative tribunal request, subpoena, or discovery request.

To law enforcement officials. Desert Clinic, LLC., may share health information relating to crime victims, suspicious deaths, crime suspects, about crimes that occur on its premises, or as required by law.

To avert a serious threat to health or safety. For example, Desert Clinic, LLC., may in good faith provide information to the police when faced with a person who is threatening to use a dangerous weapon to harm himself and others.

For care and notification purposes if you agree and do not object: For example, Desert Clinic, LLC., may share your treatment plan with your daughter who takes care of you, or notify the Red Cross of your location during a disaster.

About deceased persons. Desert Clinic, LLC., may share health information with the medical examiner seeking to identify a person and the cause of death; and with funeral directors to carry out their official duties.

For organ, eye, or tissue donation Desert Clinic, LLC., may share health information for transplantation for tissue donations only.
For research purposes. Desert Clinic, LLC., may share health information with researchers after an Institutional Review Board has ensured the research proposal protects the privacy of your health information.

For health oversight activities. For example, Desert Clinic, LLC., is required to provide health information requested by the U.S. Dept. of Health and Human Services during an investigation.

For specialized government functions. For example, Desert Clinic, LLC., may share health information with a correctional institution to ensure the health and safety of inmates or others in the facility.

To other government agencies or organizations. Desert Clinic, LLC., may share your health information with another government agency to coordinate public benefits you may receive.

For all other purposes: Desert Clinic Pain, LLC., may share your health information only if you provide us with your written authorization, or as required or permitted by law.

Note about other Federal and State laws: *Specially protected health information.* The rules for sharing mental health, alcohol/substance abuse, HIV/AIDS, and developmental disabilities health information may differ due to stricter Federal or State laws.

Questions or Complaints?

If you have **questions or concerns,** or if you wish to **file a complaint** because you believe that your privacy rights are being denied or your health information isn't being protected, please contact Desert Clinic Pain Institute, LLC., at:

Desert Clinic Pain Institute Medical Director

3857 Birch St Ste 605

Newport Beach, CA 92660

Phone: (949) 783-3600 Fax: (949) 783-3602

You may file a privacy complaint without fear of threat, coercion, discrimination or other retaliatory action from Desert Clinic Pain Institute, LLC.

You may also file a privacy complaint with the U.S. government at:

Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103

Phone: (415) 437-8310 Fax: (415) 437-8329
TDD: (415) 437-8329
Website: www.hhs.gov/ocr (How To File a Complaint)

My signature below indicates that I have been provided with a copy of the Notice of Privacy Practices:

X____

Signature of Individual/ Parent/ Legal Representative

If signed by the Legal Representative, your relationship to the individual:

____

Date: X_______________________________

Desert Clinic***, LLC., use only***
Patient was provided a copy of the Notice of Privacy Practices, but refused to sign the acknowledgment.

Staff signature Date

Distribution: Original on file in health record. Copy to patient

Authorization for Release of Information to Family Members

Patient Name: ______________________________ Date of Birth: _____________________________

Many of our patients allow family members such as their spouse, parents or others to call and request medical/ billing information. Under the requirements if HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical/billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Desert Clinic Pain Institute to release my medical/billing information to the following individual(s):

1. ____________________________________ Relation to Patient: _____________________________
2. ____________________________________ Relation to Patient: _____________________________
3. ____________________________________ Relation to Patient: _____________________________
4. ____________________________________ Relation to Patient: _____________________________
5. ____________________________________ Relation to Patient: _____________________________

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any of the above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.

It is your responsibility to change/revoke this consent in writing.

Signature: _______________________________________ Date: ____________________________

OPIOID TREATMENT AGREEMENT

Patient Name: _____________________________ Date: __________________

Desert Clinic Pain Institute will keep a copy in your file and give a photocopy to you, the patient.
Recommended to be renewed at least every 12 months.

Opioid (narcotic) treatment for chronic pain is used to reduce pain and improve what you are able to do each day. Along with opioid treatment, other medical care may be prescribed to help improve your ability to do daily activities. This may include exercise, use of non-narcotic analgesics, physical therapy, psychological counseling or other therapies or treatment. Vocational counseling may be provided to assist in your return to work effort.

I, _______________________________, understand that compliance with the following guidelines is important in continuing pain treatment with Dr. ______________________.

1. I understand that I will consent to random drug screening. A drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking.

2. I understand that I have the following responsibilities:

a. I will take medications only at the dose and frequency prescribed.
b. I will not increase or change medications without the approval of this doctor.
c. I will actively participate in RTW efforts and in any program designed to improve function (including social, physical, psychological and daily or work activities).
d. I will not request opioids or any other pain medicine from physicians other than from this doctor. This doctor will approve or prescribe all other mind and mood altering drugs.
e. I will inform this doctor of all other medications that I am taking.
f. I will obtain all medications from one pharmacy, when possible known to this doctor with full consent to talk with the pharmacist given by signing this agreement.
g. I will protect my prescriptions and medications. Only one lost prescription or medication will be replaced in a single calendar year. I will keep all medications way from children.
h. I agree to participate in psychiatric or psychological assessments, if necessary.
i. If I have an addiction problem, I will not use illegal or street drugs or alcohol. This doctor may ask me to follow through with a program to address this issue. Such programs may include the following:
   A) 12-step program and securing a sponsor
   B) Individual counseling
   C) Inpatient or outpatient treatment.

3. I understand that in the event of an emergency, this doctor should be contacted and the problem will be discussed with the emergency room or other treating physician. I am responsible of signing a consent to request records for this doctor. No more than 3 days of medications may be prescribed by the emergency room or other physician without this doctor's approval.

4. I will keep my scheduled appointments and/or cancel my appointment a minimum of 24 hours prior to the appointment.

5. I understand that this doctor may stop prescribing opioids or change the treatment plan if:

a. I do not show any improvement in pain from opioids or my physical activity has not improved.
b. My behavior is inconsistent with the responsibilities outlined in #1 above.
c. I give, sell, or misuse the opioid medications.
d. I develop rapid tolerance or loss of improvement from the treatment.
e. I obtain opioids from another doctor.
f. I refuse to cooperate when asked to get a drug screen.
g. If an addiction problem is identified as a result of prescribed treatment or any other addictive substance.
h. If I am unable to keep follow-up appointments.

RISKS:

YOUR SAFETY RISKS WHILE WORKING UNDER THE INFLUENCE OF OPIOIDS:

You should be aware of potential side effects of opioids such as decreased reaction time, clouded judgment, drowsiness and tolerance. Also, you should know about the possible danger associated with the use of opioids while operating heavy equipment or driving.

SIDE EFFECTS OF OPIOIDS:

- Confusion or other change in thinking abilities
- Nausea
- Constipation
- Problems with coordination or balance that may make it unsafe to operate dangerous equipment or motor vehicles
- Sleepiness or drowsiness
- Aggravation of depression
- Breathing too slowly – overdose can stop your breathing and lead to death
- Vomiting
- Dry mouth

THESE SIDE EFFECTS MAY BE MADE WORSE IF YOU MIX OPIOIDS WITH OTHER DRUGS, INCLUDING ALCOHOL.

Physical dependence- This means that abrupt stopping of the drug may lead to withdrawal symptoms characterized by one or more of the following:

- Runny nose
- Diarrhea
- Sweating
- Rapid heart rate
- Difficulty sleeping for several days
- Abdominal cramping
- Goose bumps
- Nervousness
- Psychological dependence- This means it is possible that stopping the drug will cause you to miss or crave it.

- Tolerance- This means you may need more and more drug to get the same effect.
- Addiction- A small percentage of patients may develop addiction problems based on genetic or other factors.
- Problems with pregnancy- If you are pregnant or contemplating pregnancy, discuss with your physician.

RECOMMENDATIONS TO MANAGE YOUR MEDICATIONS:

• Keep a diary of the pain medications you are taking, the medication dose, time of day you are taking them, their effectiveness, and any side effects you may be having.

• Use a medication box that you can purchase at your pharmacy that is already divided into the days of the week and times of the day so it is easier to remember when to take your medications.

• Take along only the amount of medicine you need when leaving home so there is less risk of losing all your medications at the same time.

I have read this document, understand and have had all my questions answered satisfactorily. I consent to the use of opioids to help control my pain and I understand that my treatment with opioids will be carried out as described above.

______________________________	__________	______________________________	__________
Patient Signature	Date	Physician Signature	Date

Consent for Chronic Opioid Therapy

My treating physician at Desert Clinic Pain Institute is prescribing opioid medicine, sometimes called narcotic analgesics to me for the diagnosis of:

____

This decision was made because my condition is serious or other treatments have not helped my pain.

I am aware that the use of such medicine has certain risks associated with, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and possibility that the medicine will not provide complete pain relief.

I am aware about the possible risks and benefits of other types of treatments that do not involve the use of opioids. The other treatments discussed were conservative treatment including physical therapy, heat/cold application, and non-opioid medications used to treat pain such as NSAID's, Tylenol, or antidepressants.

I will tell my doctor about all other medicines and treatments that I am receiving.

I will not be involved in any activity that might be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include, but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself.

I am aware that certain other medicines such as nalbuphine (Nubain), pentazocine (Talwin), buprenorphine (Buprenex), and butorphanol (Stadol), may reverse the action of the medicine I am using for pain control. Taking any of these other medicines while I am taking my pain medicines can cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of these medicines and to tell any other doctor that I am taking an opioid as my pain medicine and cannot take any of the medicines listed above.

I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine is very low. I am aware that the chance of becoming addicted to my pain medicine is very low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge.

I understand that physical dependence is a normal, expected result of using these medicines for a long time. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine use is markedly decreased, stopped or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening.

I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain; however, it has been seen and may occur to me. If it occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment.

(**Males only)** I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

(**Females only)** If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to deliver while taking these medicines; the baby will be physically dependent upon opioids. I am aware that the use of opioids is not

generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

I have read this form or have it read to me. I understand all of it. I have had a chance to have all of my questions answered to my satisfaction. By signing this form voluntarily, I give my consent for the treatment of my pain with opioid pain medicines.

Patient Signature____Date______________________