PATIENTS' NOTICE OF PRIVACY PRACTICES

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. <u>Please review it carefully</u>.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you that may identify you and that relates to your past, present, or future physical, mental health, and/or any condition related to health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms in our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. We will provide you with any revised Notice of Privacy Practices, upon request. This may be done by accessing our website, calling our office, and requesting that a revised copy be sent to you in the mail, or by asking for one at the time of your appointment.

Uses and Disclosures of Protected Health information

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation ofyour physician's practice.

The following are some examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make and may be made by our office.

<u>Treatment</u>: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. Your protected health information may be provided to a physician to whom you have been referred to in order to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (i.e. a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

<u>Payment</u>: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

<u>Health Care Operations</u>: As needed, we may use or disclose your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party business associates that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will enter a contact that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you will information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

PATIENTS' NOTICE OF PRIVACY PRACTICES

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

Other Permitted and Required Uses and DisclosuresThat May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you theopportunity to agree or object

Required by Law: We may use or disclose your PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury, or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI I we believe that you have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your PHI to a person or company required by the FDA for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products, to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (I) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties unauthorized by law. We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral direct to carry out their duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaveric organ, eye, or tissue donation purposes.

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and immense threat to the heat or safety of a person or the public. We may also disclose PHI if it is necessary or law enforcement authorities to identify or apprehend an individual.

Military Activit y and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including or the provision of protective services to the Present or others legally authorized.

Workers' Compensation: We may disclose your PHI as authorized to comply with workers' compensation laws and other similar legally-established programs.

PATIENTS' NOTICE OF PRIVACY PRACTICES

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

Uses and Disclosures of Protected HealthInformation Based upon Your Written Authorization

Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your PHI for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your PHI in the following instances: You have the opportunity to agree or object to the use or disclosure ofall or part of your PHI. If you are not present or able to agree or object to the use or disclosure of the PHI, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, relative, a close friend, or any other person you identify, your PH1 that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care of your location, general condition, or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Your Rights

You have the right to inspect and copy your protected health information. You may inspect and obtain a copy of PHI about you for so long as we maintain the PHI. You may obtain your medical records that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to PHI. Depending on the circumstances, a decision to deny access may be reviewable.

You have the right to request a restriction of your PHI. You may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or health care operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your Request must be written and must sate the specific restriction requested and to whom you want the restriction to apply. This must be delivered to our office and directed to the Privacy Officer.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specifications of an alternative address or other method of contact. We will not request an explanation from you as the basis for the request. Please make this request in writing and deliver to our directed to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of PHI about you in a designated record set for so long as we maintain this information. ln Certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment, or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions, and limitations.

PATIENTS' NOTICE OF PRIVACY PRACTICES

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

File a complaint if you feel your rights have been violated. You can complain if you feel that we have violated your rights by contacting us using the following information:

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by:

Sending a letter to **200 Independence Avenue, S.W., Washington, D.C. 20201**

Calling **1-877-696-6775**

Visiting **www.hhhs.gov/ocr/privacy/hipaa/complaints/**

We will not retaliate against youforfiling a complaint.

This notice was published and becomes effective on: **11/14/2016**

If you have any questions or concern about this Notice, please contact our Privacy Officer:

Officer Number : 714-375-1122

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,________________________________, (the patient) hereby acknowledge that I have reviewed and received a copyof Westside Pain Management, Inc.'s Notice ofPrivacy Practices explaining:

- ❖ How the office will use and disclose my protected health information
- ❖ My privacy rights with regard to my protected health information
- ❖ The office's obligations concerning the use and disclosure ofmy protected health information

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive acopy ofany revised Notice of Privacy Practices upon request.

I also understand that ifl have any questions or complaints, I may contact:

You may also contact the Secretary of the U.S Department of Health and Human services with any concerns regarding privacy and security policies and procedures. Please refer to the high-lighted contact information under the Notice of Privacy Practices.

FOR OFFICE USE ONLY

We made a good-faith effort to obtain an acknowledgement of________________________________ receipt of our Notice of Privacy of Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgement ofreceipt or the following reasons (check all that apply):

- o Patient refused to sign (date ofrefusal) _ _ _ _ _ _ _ _ _ _ _
- 0 Communications barriers prohibiting an acknowledgement
- o An emergency satiation prevented from obtaining an acknowledgement
- o Other

Attempted was made by:______________________________ Date: ______________________

! Patient Signature: ____________________________________ I Date__________________________

WESTSIDE
PAIN MANAGEMENT

Patient Financial Responsibility Consent

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policies. If you have any questions about the policy, please discuss them with a member of our management team. Please understand that payment is expected for services rendered. Please read, sign and date the agreement prior to treatment.

I understand and agree that I will be financially responsible for any and all charges for services rendered if not paid by my insurance. This includes any medical service, Injections and any other services performed by physician or physician staff.

- I understand and agree that it is my responsibility and not the responsibility of the physician or staff to know if my insurance will pay for such medical services that includes injections, office visits and surgeries.
- I understand that it is my responsibility to know if my insurance is out of network, has any deductible, Copayment, Co-insurance, and or unusual and customer a limit or any other type of benefit limitations for the service I receive.
- I understand that it is my responsibility to know if the medical care professional and /or physician I am saying is contracted in network provider recognized by my insurance company or plan.
- **___(Initials)**
- If the physician I am seeing is not a contracted in-network provider, it may result in claims being denied or higher out of pocket expense for me and I understand this and agree to be financially responsible and make full payment at Self Pay Services rates. **___(Initials)**

I understand that in the event, that my insurance is not valid, or my coverage was terminated at the time the services are rendered, I will be responsible for the full amount at Self Pay rates of my office visit and or any procedures rendered. Additionally, I understand that certain medical appointments with certain diagnosis can trigger a medical necessity or more depending on services rendered by the physician or physician staff. I understand that if my insurance rejects or denies their monetary responsibility to medical necessity that I am responsible for payments of the Self Pay rates. **____ (Initials)**

Or Additionally, I understand that certain medical appointments with certain diagnosis can trigger a medical necessity or more depending on services rendered by the physician or physician staff. I understand that due to the historic denials by Insurances like mine, Physician's office will collect the payments at Self Pay rates at the time of visit. **___ (Initials)**
I fully understand should my account become delinquent, can be subject to further action like collections.

For your convenience, or practice accepts Visa, MasterCard, Discover, and Cash

I have read and agree to the above financial responsibility.

____
Signature

____
Name

____
Date

PATIENT FINANCIAL STATEMENT OF INFORMATION

Thank you for choosing Westside Pain Management as your pain provider. All providers are committed to providing patients with the utmost quality of care and innovative pain management services.

Due to differences in each patients' insurance policy and coverage, we have developed this payment policy regarding patients and their insurance responsibility for services rendered by our practice. Please read it, ask us any questions you may have, and sign in the space provided below. A copy will be provided to you upon request.

Insurance and Billing

- As your provider, please remember that our relationship is with you and not your insurance company. Your benefit coverage is a contract between you and your insurance carrier. Please be aware that not all medical services are covered benefits under all insurance contracts.
- We encourage you to be familiar with your insurance benefits and limitations. If you have any questions about your insurance coverage, please contact your insurance carrier directly.
- All doctors are Preferred Provider or many insurance plans. It is your responsibility to check with your insurance carrier to ensure that we participate in your insurance network.
- As a service to you, our office will bill your health insurance company. Providing us with the accurate information at the time services are rendered will facilitate in the timely filing of claims. Changes in your information should be reported to our office In a timely manner. Your cooperation in keeping your account Information current is greatly appreciated.

Co-payments, Co-insurance, and Deductibles

All copayments, coinsurance, and deductibles are due at the time of service.

- **Co-payments** are a flat fee paid each time a medical service is accessed and must be paid before any policy benefit is payable by an insurance company. Copayments differ depending on your insurance coverage.
- **Co-Insurance** is a percentage of the allowed charge that the patient pays after the deductible has been met.
- **Deductibles** are amounts which must be paid out-of-pocket before an Insurance carrier will pay any expenses. The deductible must be paid by the patient before the benefits of the insurance policy can apply.

Westside Pain Management INC including the providers within the clinic, is in-network with most insurance companies and the insurance company will require that we collect these fees per the terms of your health care contract. Failure to pay any amounts due, including past due balances, will result in your appointment being rescheduled or other collection activity.

For your convenience, we accept cash, checks, debit or credit cards (MasterCard, Visa, Discover, American Express.) A fee of $35.00 will be charged for all returned checks.

Self-Pay

If you are uninsured and are in need of care, we can see you on a self-pay basis and payment is due at the time services are rendered.

Referrals/Authorizations

Many of the services we provide require referrals, authorizations, and pre-authorizations. Your insurance company may require documentation prior to authorizing services and we will do our best to comply in a timely fashion with their requests. This process can take time and we appreciate your patience while we work with your insurance company to obtain approval. We reserve the right to refuse or reschedule services to any patient who does not have a valid referral in our office at the time ***of*** their appointment.

I have read and understand the above financial responsibility policy.

I hereby authorize Westside Pain Management to file claims on my behalf and for payment to be rendered directly to Westside Pain Management for benefits otherwise payable to me by any third party. If my insurance does not cover services rendered, I agree to be personally and fully responsible for payment. The above authorization is in effect permanently or until canceled by myself in writing.

Patient Signature: ______________________________ **Date:** ______________________________

ACKNOWLEDGEMENT OF CONTROLLED SUBSTANCE PRESCRIPTION USE

This agreement between ______________ (the patient) and Westside Pain Management, Inc. (the physician) is for the purpose of establishing an agreement between the doctor and patient on clear conditions that the patient agrees to in order to receive pain management and/or pain medication(s). This may include the care from multiple disciplines, including diagnostic and/or therapeutic interventions, behavioral medicine (psychology, psychiatry, coping strategies, biofeedback), alternative therapies, physical therapy, weight management, and the prescription use of medications. The doctor and patient understand that this agreement is an essential factor in maintain the trust and confidence necessary in a doctor/patient relationship. Pain medication may not completely eliminate your pain, but is expected to reduce it enough that you may become more functional and improve your quality of life.

Your initials are required next to each of the following statement in the space provided.

I agree to and accept the following conditions for my pain management:

__ 1. I understand that strong medications, which may include opioids and other controlled substances, may be prescribed for pain relief, if my physician determines it would be of benefit. I understand that there are potential risks and side effected involved with taking any medications, including the risk of addiction. Overdose of opioid medication may cause injury or death. Other possible complications include, but are not limited to, constipation, which could be severe enough to require medical treatment, difficulty with urination, fatigue, drowsiness, nausea, itching, stomach cramps, loss of appetite, confusion, sweating, flushing, depressed respiration, and reduced sexual function. Men may have decreased testosterone from chronic opioids.

__ 2. I understand that it is my responsibility to keep others and myself from harm. This includes the safety of my driving and the operation of machinery. If there is any question of impairment of my ability to safely perform any activity, I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have stopped the medication long enough for the side effects to resolve. This applies to all medications prescribed to me. Prescriptions and bottles of medications must be safeguarded from loss and out of reach of children.

__ 3. I realize that all medications have potential side effects and interactions. I will inform the office of any adverse effects I am experiencing when they are of a nature to cause me concern. I understand and accept that there may be unknown risks associated with the long-term use of the substances prescribed.

__ 4. I understand that if I am pregnant or become pregnant while taking medications, my child could be physically dependent on the opioids and withdrawal can be life threatening for a baby. If a female of child bearing age, l certify that *I* am not pregnant, and I will use the appropriate contraceptive measures during the course of treatment, with medications. Many medications could harm the fetus or cause birth defects.

__ 5. I understand I must contact my physician before taking newly prescribed tranquilizers or prescription sleeping medications. I understand that the combined use of various drugs, opioids, as well as alcohol, may produce confusion, profound sedation, respiratory depression, blood pressure decrease, and even death.

__ 6. I understand that opioid analgesics could cause physical dependence within a few weeks of starting opioid therapy. If *I* suddenly stop or decrease the medication, I could have withdrawal symptoms (including nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24-48 hours of the last dose.

ACKNOWLEDGEMENT OF CONTROLLED SUBSTANCE PRESCRIPTION USE

__ 7. Withdrawal from other medications can also have serious consequences, including the risks of injury or death. I will not discontinue any medication I take regularly without consulting my physician.

__ 8. I agree that continued treatment and/or refill of medication(s) may be contingent upon compliance with other pain treatment modalities recommended by my doctor.

__ 9. I am responsible for keeping my scheduled appointment. Prescription renewals are contingent upon keeping each scheduled appointment. Requests for refills of medications due to rescheduled or missed appointments are prohibited, except in emergency circumstances as determined by and at the Physician's discretion and will only be bridged until the next available appointment.

- Refill request for medication requiring a written prescription must be called to the office 48 business hours prior to pick up. Written prescriptions must be picked up at the office. Written prescriptions will not be mailed or delivered by any other manner.
- Refills will not be made if I "run out early" or "misplace my medication" or if someone else has been taking some of my prescription. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
- Refills will only be made for a lost or stolen prescription if a police report has been filed.

__ I 0. I agree that I will use my medication at a rate no greater than the prescribed amount unless it is discussed directly with my physician. I understand I can be asked to bring any or all of my prescribed medications to my office appointment or at a random time for a prescription compliance check (Pill Count).

__ 11. I will not use any illegal substances (cocaine, heroin, marijuana, etc.) while being treated with controlled substances. Violation of this will result in the cessation of the prescribing of any controlled substances and termination of my care.

__ I 2. I will not share, sell, or trade my medication or exchange medication for money, goods, or services.

__ 13. 1 understand that changing dates, quantity, or strengths of medication or altering a prescription in any way is against the law. Forging prescriptions or physician's signature is also against the law. Our office cooperates fully with the law enforcement agencies in regards to infraction involving prescription medications.

__ 14. I will discontinue all previously used pain medication, unless told to continue them by my physician. I will keep this office informed of all medications I may receive from other physicians.

_ 15. I agree that I will submit to random urine, blood, saliva toxicology test if requested to determine my compliance with this agreement and my regimen of pain control medication. Tests may include screens for illegal substances.

- I understand that I will be financially responsible for the charges for any urine, blood, or saliva test.
- I understand that I will be financially responsible for the charges for any urine, blood, or saliva test that has to be sent out to an outside lab for testing or confirmation.
- Presence of unauthorized substances or the lack of prescribed medications may necessitate a referral to an addiction specialist, as well as, dismissal from this practice.

ACKNOWLEDGEMENT OF CONTROLLED SUBSTANCE PRESCRIPTION USE

__ 16. I will not attempt to get pain medication from any other health care provider without telling them that Jam already taking pain medication prescribed by this office.

__ 17. I understand that my medication regimen may be continued for a definitive time period as determined by my physician. My case will be reviewed periodically. lf there is not significant evidence that I am improving or that progress is being made to improve my functioning or quality of life, the regimen might be tapered or possibly discontinued and my care referred back to my primary care physician.

__ 18. Jwill keep all scheduled follow-up appointments as outlined in my treatment plan.

__ 19. I understand that the main treatment goal using pain medications is to improve my ability to function and/or to work and/or to reduce pain. In consideration of that goal, and the fact that I may be given potent medication to help me reach that goal, I agree to help myself by following better health habits. This may include exercise, weight control, and avoiding the use of nicotine. I must comply with the treatment plan as prescribed by my doctor.

__ 20. I authorize my physician to provide a copy of this agreement to my pharmacy, other healthcare providers, and any emergency department upon request. I give my permission to allow sharing of medical history in regards to medication use with other health care agencies.

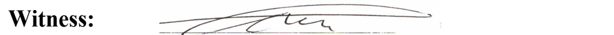
__ 21. I agree that this agreement is important to my doctor's ability to treat my pain effectively and that my failure to comply with the agreement may result in the discontinuation of prescribed medication by my doctor and termination of the doctor/patient relationship.

I have thoroughly read, understand, and accept all of the above provisions. Any questions I had regarding this agreement have been answered to my satisfaction. I understand all the policies regarding the prescribing and use of opioids and other medications. I agree to comply with the pain management program. I also agree to testing physiological, toxicology, and/or psychological and detoxification if indicated.

Your physician understands that emergencies can occur and under some circumstances, exceptions to these guidelines may be made. Emergencies will be considered on an individual basis.

Lack ofstrict adherence lo any provision ofthis agreement by your physician in no way invalidates any other provisions ofthis agreement.

Patient Signature ____________________ **Date** ____________________

Witness:  ____________________ **Date** ____________________

WESTSIDE PAIN MANAGEMENT Inc.

17822 Beach Blvd Suite 300
Huntington Beach, CA 92647
Tel: 714-375-1122
Fax: 949-863-8581
Email : info@wspainclinic.com

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION
Failure to provide **ALL** information may invalidate this authorization

Patient's Name: ____________________ Date of Birth____________________
Phone: ____________________
Address: ____
City: ____________________ State:__________ Zip Code:____________________

I Authorize Westside Pain Management Inc. to release/request my medical records for the following:

___ Continued care
___ Legal
___ Personal use
___ Other________________

Send Via Fax ____________________
Picked up by Patient ________________
Email ____________________
Verbal ____________________
(name of person to speak to)

Release to :____________________ Release From :____________________

Person/Organization:____
Address:____
City:____________________ State:__________ Zip:____________________
Phone:____________________ Fax____________________

___ Progress Notes/Procedure
___ MRI/CT/XRAY Reports
___ Other (specify)____

Patient sign:____________________ Date:____________________

Staff co-sign:____________________ Date:____________________

ALL RECORDS THAT ARE LARGER THEN 5 PAGES PICKED UP BY PATIENTS -MUST BE ON A FLASH DRIVE PROVIDED BY PATIENTS AND SEALED IN ORIGINAL PACKAGING <u>NO EXCEPTIONS</u>

Based on Health Insurance Portability and Accountability Act (HIPAA) Privacy & Security Rule, 45 CFR 160 _164.524, California Confidentiality of Medical Information Act, California Civil Code Section 56 - 56.16 ,Medicare Conditions of Participation, 42 CFR Sections 482.24 ,Title 22 California Code of Regulations, Sections 70749, 70751, 71527, and 71549

NEW PATIENT INFORMATION FORM

PATIENT INFORMATION						
Last Name: First: Middle:			☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss		Marital Status (circle) Sin / Mar / Div / Sep / Wid	
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?		Date of Birth: i.e. MM/DD/YYYY ____/ ____/_______		Age:	Sex: ☐ Female ☐ Male
Social Security #: _____ -- _____ -- _____	Email Address:				Home Phone #: ( ) --	
Street Address:	City:	State:	Zip Code:		Cell Phone #: ( ) --	
Preferred Method of Contact: (circle) Email / Cell / Home / Work	Occupation:	Employer:			Employer Phone #:	
Referred to office by (Please check one box):	☐ Dr.___________	☐ Family ☐ Friend ☐ Yellow Pages	☐ Insurance Plan ☐ Adjuster		☐ Hospital ☐ Website ___________ ☐ Other ___________	
Referring Physician's Name:	Address:			Telephone #: ( ) --		
Primary Care Physician's Name	Address:			Telephone #: ( ) --		

INSURANCE INFORMATION					
Primary Insurance:			Address:		
Subscriber's Name	Subscriber's SS #:	Date of Birth: ____/___ _/ ____	Policy/Claim #:	Group #:	Co-Payment:
Relationship to Subscriber:	☐ Self	☐ Spouse	☐ Child		☐ Other:

17822 Beach Blvd., Suite 300 Huntington Beach, CA 92647 • (Tel) 714 375 1122 • (Fax) 949 863 8581 • info@wspainclinic.com

NEW PATIENT INFORMATION FORM

Secondary Insurance:			Address:		
Subscriber's Name	Subscriber's SS #:	Date of Birth: ____/____/____	Policy/Claim #:	Group #:	Co-Payment:
Relationship to Subscriber:	☐ Self	☐ Spouse	☐ Child		☐ Other:

Is injury related to ____ Work _____ Auto Accident? If yes, please fill out below (where applicable)		
Auto Accident Claim #:	Attorney's Name:	Address:
Email:	Telephone:	Fax:
Workers' Compensation Claim #	Adjuster's Name	Address:
Email:	Telephone:	Fax:

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at the same address):	Relationship to patient:	Home Phone #: ( ) --	Work Phone #: ( ) --

PREFERRED PHARMACY			
Pharmacy's Name	Address:	Telephone: ( ) --	Fax: ( ) --

AUTHORIZATION & ASSIGNMENT OF BENEFITS: The above information is true to the best of my knowledge, I authorize my insurance benefits to be paid directly to Westside Pain Management, Inc. I understand that I am financially responsible for any co-payments, deductibles, or uncovered amounts. I also authorize Westside Pain Management, Inc. or insurance company to release any information required to process my claims. I consent to the performance of examinations and diagnostic procedures my physician considers to be medically necessary. I authorize Westside Pain Management, Inc. to disclose health information necessary to process claims related to my care and to other health care providers for continuing care and treatment. I have received a Notice of Privacy Practices and have been provided an opportunity to request restrictions to the use and disclosure of my health information.

Patient's Name:	
Patient's Signature:	Date: _____/_____/______

MEDICAL HEALTH QUESTIONNAIRE

PAST MEDICAL HISTORY
Please check all that apply

☐ AIDS/HIV	☐ Aneurysm	☐ Arthritis	☐ Asthma
☐ Bleeding Disorder	☐ Cancer	☐ Chem. Dependency	☐ CA Colon
☐ CA Lung	☐ CA Breast	☐ CA Prostate	☐ CA Cervical
☐ COPD	☐ Depression	☐ Diabetes	☐ Fibromyalgia
☐ Heart Attack	☐ Heart Disease	☐ Hepatitis	☐ Hypercholesterolemia
☐ Hypertension	☐ Hypothyroidism	☐ Jaundice	☐ Kidney Disease
☐ Liver Disease	☐ Murmur	☐ Osteoarthritis	☐ Pacemaker
☐ Peptic Ulcer Disease	☐ Peripheral Neuropathy	☐ Peripheral Vascular	☐ Post/-op Nausea/Vomit
☐ Acid Reflux	☐ Rheumatic Fever	☐ Seizure Disorder	☐ Sleep Apnea
☐ Stroke	☐ Other (please list):		

PAST SURGICAL HISTORY
List all previous surgeries:

DATE (MM/YYYY)	PROCEDURE

FAMILY HISTORY
Check if any of your BLOOD relatives have had any of the following:

DISEASE	RELATIONSHIP TO YOU
Asthma	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease (Stroke)	
High Blood Pressure	
Kidney Disease	
Neurologic Condition	
Bleeding Disorder	
Other (please list):	

SOCIAL HISTORY
Please check all that apply

Smoker Status (Meaningful Use)

☐ Current every day smoker ☐ Occasional Smoker ☐ Former Smoker
☐ Never smoked

Do you drink alcohol? ☐ Yes ☐ No ☐ Former

MEDICAL HEALTH QUESTIONNAIRE

How frequently do you drink alcohol?

☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Occasionally ☐ Rarely ☐ Socially ☐ Never

Do you use recreational drugs? ☐ Yes ☐ No ☐ Former

☐ Never ☐ Rarely ☐ Occasionally ☐ Often

What: ______________________________ *How often:* ______________________________

Exercise?

☐ Never ☐ Rarely ☐ Occasionally ☐ Often ☐ 2-3 times/ week ☐ 3-4 times/week ☐ Daily

ALLERGIES

Allergy	Reaction

MEDICATION HISTORY

Please list pharmacy if it differs from your preferred pharmacy with our office.

Medication Name	Dose	Frequency	Pharmacy

Have you taken any medications in the past for your current pain problem, even if they didn't work?
If yes, please list (be sure to include non-prescription medications such as Tylenol, topical analgesic cream, etc.)

NAME	WHY STOPPED

I, the undersigned, have completed this form to the best of my knowledge. The information that I have provided is true and accurate to the best of my knowledge. I understand that this information is used in the care and treatment plan while under the care of Dr. Arash Esmailzadegan and Westside Pain Management, Inc.

______________________ ______________________ ______________________

Patient's Name Patient's Signature Date

REVIEW OF SYSTEMS

Patient's Name:	DOB:

Please review the following list and check any that apply to you. Please start with the left panel and move downward

CONSTITUTIONAL
- ☐ fever
- ☐ night sweats
- ☐ chills
- ☐ cold intolerance
- ☐ fatigue
- ☐ daytime somnolence
- ☐ weight gain
- ☐ weight loss
- ☐ polydipsia
- ☐ anorexia
- ☐ other:

EYES
- ☐ change in vision
- ☐ loss of vision
- ☐ blurred vision
- ☐ diplopia
- ☐ eye redness
- ☐ eye pain
- ☐ tearing
- ☐ purulent discharge
- ☐ other:

EARS
- ☐ difficulty hearing
- ☐ hearing loss
- ☐ ear pain/ear ache
- ☐ ear drainage
- ☐ tinnitus
- ☐ other:

NOSE
- ☐ nasal congestion
- ☐ nasal discharge
- ☐ epistasis
- ☐ sneezing
- ☐ snoring
- ☐ other:

MOUTH/THROAT/VOICE
- ☐ lip sores
- ☐ mouth sores
- ☐ tongue sores
- ☐ sore throat
- ☐ dysphagia
- ☐ odynophagia
- ☐ gum bleeding
- ☐ dental problems
- ☐ hoarse voice
- ☐ change in voice quality
- ☐ other:

NECK
- ☐ neck pain
- ☐ neck stiffness
- ☐ neck lumps
- ☐ neck swelling
- ☐ other:

RESPIRATORY
- ☐ dyspnea
- ☐ cough
- ☐ cough productive of sputum
- ☐ hemoptysis
- ☐ wheezing
- ☐ other:

CARDIOVASCULAR
- ☐ chest pain
- ☐ palpitations
- ☐ dyspnea at rest
- ☐ dyspnea with activity
- ☐ orthopnea
- ☐ paroxysmal nocturnal dyspnea
- ☐ lower extremity edema
- ☐ varicosities
- ☐ other:

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REVIEW OF SYSTEMS

GASTROINTESTINAL
- ☐ abdominal pain
- ☐ rectal pain
- ☐ nausea
- ☐ vomiting
- ☐ vomiting blood
- ☐ flatulence
- ☐ decreased frequency of BMs
- ☐ constipation
- ☐ increased frequency of BMs
- ☐ diarrhea
- ☐ fecal incontinence
- ☐ clay-colored stools
- ☐ greasy stools
- ☐ tarry stools
- ☐ blood in stool
- ☐ foul smelling stool
- ☐ other:

URINARY
- ☐ dysuria
- ☐ hematuria
- ☐ urinary hesitancy
- ☐ difficulty initiating urine stream
- ☐ difficulty maintaining urine stream
- ☐ urine dribbling
- ☐ increased urinary frequency
- ☐ decreased urinary frequency
- ☐ polyuria
- ☐ oliguria
- ☐ increased nighttime urination
- ☐ urge symptoms
- ☐ urinary incontinence
- ☐ urinary incontinence with cough
- ☐ other:

MUSCULOSKELETAL:
- ☐ muscle pain
- ☐ back pain
- ☐ tender points
- ☐ muscle cramps
- ☐ muscle weakness
- ☐ decreased muscle strength
- ☐ limb paralysis
- ☐ difficulty walking
- ☐ limp
- ☐ other:

DERMATOLOGIC
- ☐ dry hair
- ☐ brittle hair
- ☐ hair loss
- ☐ dry sky
- ☐ itching
- ☐ hives
- ☐ rash
- ☐ bruising
- ☐ new mole(s)
- ☐ skin sores
- ☐ skin lumps
- ☐ other:

BREAST
- ☐ breast lump (past or present)
- ☐ breast pain
- ☐ nipple discharge
- ☐ other:

NEUROLOGICAL
- ☐ headaches
- ☐ vertigo
- ☐ lightheadedness
- ☐ fainting
- ☐ blackout(s)
- ☐ numbness
- ☐ tingling
- ☐ tremor
- ☐ lack of coordination
- ☐ weakness
- ☐ difficulty speaking
- ☐ memory loss
- ☐ difficulty concentrating
- ☐ other:

PSYCHIATRIC
- ☐ change in mood
- ☐ depression
- ☐ sadness interfering with function
- ☐ anxiety
- ☐ nervousness
- ☐ sleep disturbance
- ☐ suicidal ideation
- ☐ hopelessness
- ☐ worthlessness
- ☐ delusions
- ☐ hallucinations
- ☐ other:

REVIEW OF SYSTEMS

Patient's Name:	DOB:

Please complete the following questionnaire to provide us information as to how your pain has affected your ability to manage in everyday life. ***Please answer every section.*** *Mark only ONE number in each section that is the most accurately described for you.*

Section 1 – Pain Intensity
- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 – Personal Care
- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself, but it is very painful.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help, but can manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed, I was with difficulty and stay in bed.

Section 3 – Lifting
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weight, but it gives me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on the table).
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Walking
- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than ¼ mile.
- ☐ Pain prevents me from walking more than 100 yards.
- ☐ I can walk only using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting
- ☐ I can sit in any chair as long as I like
- ☐ I can sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting for more than 1 hour.
- ☐ Pain prevents me from sitting for more than ½ hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Section 6 – Standing
- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want, but it gives me extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 1/3 hour.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 – Sleeping
- ☐ My sleep is never disturbed by pain.
- ☐ My sleep is occasionally disturbed by the pain.
- ☐ Because of pain, I have less than 6 hours of sleep.
- ☐ Because of pain, I have less than 4 hours of sleep.
- ☐ Because of pain, I have less than 2 hours of sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Social Life
- ☐ My social life is normal and causes me no extra pain.
- ☐ My social life is normal, but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests.
- ☐ Pain has restricted my social life and I don't go out often
- ☐ Pain has restricted my social life to home.
- ☐ I have no social life because of pain.

Section 9 – Traveling
- ☐ I can travel anywhere without extra pain
- ☐ I can travel anywhere, but it gives me extra pain.
- ☐ Pain is bad, but I manage journeys over 2 hours.
- ☐ Pain restricts me to journeys of less than 1 hour.
- ☐ Pain prevents me from traveling except to receive treatment.

REVIEW OF SYSTEMS

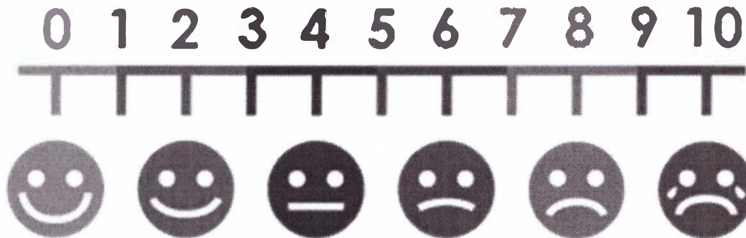
Patient's Name:	DOB:

In order to help us provide the best possible care for you, we ask for your cooperation in providing the following information.

Was this injury: ☐ At Work ☐ Auto Accident ☐ After Surgery ☐ Other
Onset of pain ☐ Sudden ☐ Gradual

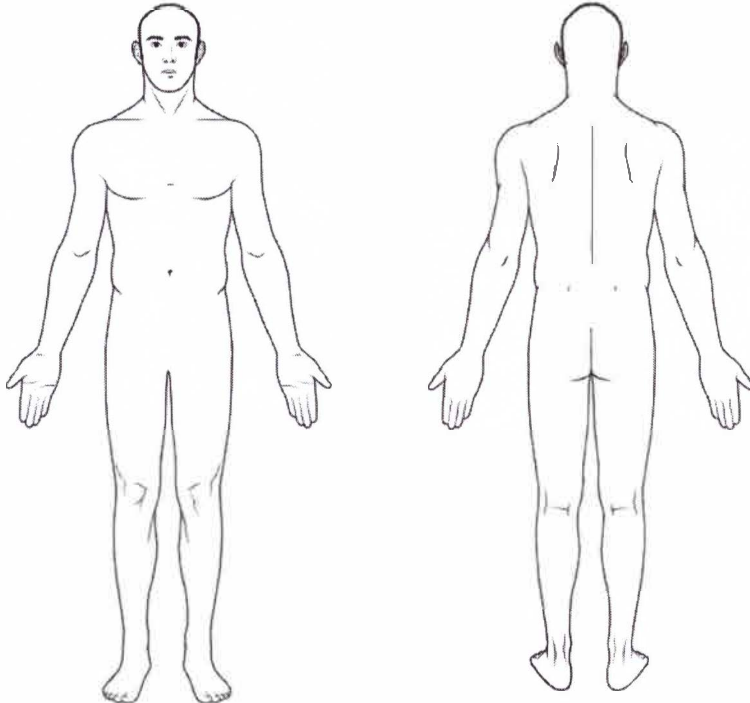
On a scale of 1-10, your pain is at its worst: _____ Pain at its best: ______ Pain right at this moment: _____

0 - no hurt
1-2 hurts a little bit
3-4 hurts a little more
5-6 hurts even more
7-8 hurts a whole lot
9-10 hurts the worst



LOCATION OF PAIN:

Indicate all areas of your pain on the human body outline



Associated with (check all that apply)

- ☐ Numbness/Tingling
- ☐ Night pain
- ☐ Weakness
- ☐ Loss of Control of Bowel
- ☐ Loss of Control of Bladder
- ☐ Fever/Chills
- ☐ Sexual Dysfunction
- ☐ Unexplained weight loss