Advanced Pain Specialists *of Southern California*

Gary L. Baker, M.D., Director 5750 Downey Ave, Suite 306 Lakewood, CA 90712 Ph (562) 408-4636
James A. Kim, M.D. Fax (562) 408-6491

Consent for Treatment and Release of Information and Payment Authorization

Medicare Patients Only
I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I authorize and request that payments of authorized Medicare benefits be made directly to *Advanced Pain Specialists of Southern California*, or its representative, for all services rendered.

All Other Insurance Companies and/or Third Party Payers
I hereby authorize *Advanced Pain Specialists of Southern California* and/or its representative to submit a claim to my insurance carrier or its intermediaries for all services rendered by the physician(s). I authorize and direct my insurance carrier or its intermediaries to issue payment directly to *Advanced Pain Specialists of Southern California*, or its representative. I authorize the release of any and all medical information to my insurance carrier or its intermediaries regarding services rendered. I authorize the use of this signature on all insurance submissions.

Guarantee of Payment
I understand that filing a claim with my insurance company or other third party payer, under any circumstance, does not relieve me from my responsibility for the payment of all charges. I further acknowledge that I am responsible for the payment of all charges for services rendered by *Advanced Pain Specialists of Southern California*, to me or the patient as indicated. By signing this document I personally guarantee the payment of these charges for medical services rendered. This includes, but is not limited to, claims filed for Workers' Compensation and/or claims due to personal injury.

Pharmacy and Prescription Information
I give permission for *Advanced Pain Specialists of Southern California* to access my pharmacy benefits data electronically through *SureScripts* health information network. This consent will enable *Advanced Pain Specialists of Southern California* to determine the pharmacy benefits and drug co pays for my health plan, check whether a prescribed medication is covered (in formulary) under my plan, display therapeutic alternatives with preference rank (if available) within a drug class for medications, determine if my health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies, and download a historic list of all medications prescribed for me by any provider. Formulary information, and information about prescriptions prescribed by other providers may be obtained using *SureScripts.*

I hereby authorize the staff to perform any necessary services needed during diagnosis and treatment of the diseases and/or conditions for which I have consulted this practice.

I understand that a 48-hour notice of cancellation is required. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

______________________________	________________
Patient Name (please print)	Date of Birth
______________________________	________________
Patient Signature	Date
______________________________	________________
Responsible Party Signature (if other than the patient)	Relationship to Patient

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Controlled Substance (Narcotic) Agreement

The decision to start or continue controlled substance therapy (also referred to as narcotics or pain medicine) was made because your condition is serious or other treatments have not helped control your pain. The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

The use of such medication has certain risks associated with it, including, but not limited to: sleepiness or drowsiness, dry mouth, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, problems with sex, physical dependence, tolerance to analgesia, depression, confusion, addiction and possibility that the medicine will not provide complete pain relief. If you use too much pain medicine or mix these medications with others (including alcohol or street drugs) you can end up with worsening of the above health problems or even death. If you suddenly stop pain medicine you may experience withdrawal symptoms (with most opioid medications this is similar to having a severe flu).

The use of medication is not designed to completely eliminate the pain. The goal is too significantly reduce the pain so that you maybe able to perform many activities of daily living as well as social activities. It is hoped that the use of these medications will improve the quality of life but is not expected that the pain relief will be complete.

Your physician is electing to provide pain medications based on the understanding that if directed you agree to attend physical therapy, counseling, and all scheduled office appointments. You will also follow directions for all treatment.

The long-term use of such medications is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

(**Males Only**) Chronic narcotic use has been associated with low testosterone levels in males. This may affect mood, stamina, sexual desire and physical and sexual performance.

(**Females Only**) If you plan to become pregnant or believe that you have become pregnant while taking narcotics or any prescription medication, you will immediately call your obstetric doctor and this office to inform them. Should you carry a baby to delivery while taking these medications the baby maybe physically dependent upon narcotics or develop birth defects. The use of opioid narcotics 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 your child may have a birth defect while you are taking a narcotic.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the prescribing physician to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

1. All pain medications must only be prescribed by our office, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment).

2. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.

3. You are expected to inform this office if you went the emergency room for any reason or if the emergency department provided you with any prescription pain medication. You are to notify any emergency department or other healthcare provider that you have a pain medication agreement.

4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.

5. You are expected to get past health records from other offices within one month when needed. You are responsible to pay for these records if needed, and hand deliver to this office if needed.

6. Unannounced random urine or serum toxicology screens may be requested to determine compliance with this agreement and medication regimen. Presence of unauthorized substances may prompt referral for assessment for addictive disorder.

7. You may not share, sell, or otherwise permit others to have access to these medications.

8. You will not use any alcohol or street drugs (cocaine, heroin, marijuana, crystal meth, ecstasy, ketamine, etc.) while taking controlled substances. Violation of this may result in the cessation of the prescribing of any controlled substances and possible termination of care. You agree to take responsibility if you overdose yourself or on purpose.

9. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.

10. It may be requested that original containers of medications be brought in to the office at each visit for inspection.

11. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.

12. You should not be involved in any activity that may be dangerous to yourself or someone else if you feel drowsy or not thinking clearly. Be aware that even if you do not notice it, 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 him or herself.

13. Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made. You agree to keep medications in a secure place at all times.

14. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.

15. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.

16. Early refills will generally not be given. Medication is to be taken only as prescribed.

17. Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.

18. It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit.

19. Upon request your physician will provide a prescription for the emergency reversal drug Naloxone for you or a family member/caregiver to use in case of an opioid drug overdose. Opioid pain medications include but are not limited to Vicodin, Norco, Percocet, Hydrocodone, Oxycodone, Oxycontin, Tylenol with Codeine, Methadone, Fentanyl, Dilaudid, Morphine, Opana, and Nucynta. You have been provided with information about Naloxone and how to recognize an opioid overdose. If you are taking an opioid pain medication, you will share this information with appropriate family members/caregivers. You are aware that this medication can also be obtained from a pharmacist without a doctor's prescription in an effort by the state of California to encourage widespread public availability.

I have read this form or have had 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 controlled substance and accept all the terms of this agreement.

______________________________	______________________________
Patient Signature	Date
______________________________	______________________________
Patient Name (Printed)	Witness

Advanced Pain Specialists *of Southern California*

Gary L. Baker, M.D., Director
James A. Kim, M.D.
Jaime Guerrero, PA.
M. Jabeen, PA-C
Dean X. Nghiem, PA-C

5750 Downey Ave, Suite 306
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Authorization to Release Medical Records/Information

Patient Name: ____ Date of Birth: ____________

I authorize and request the below named institution or treating professional to provide medical and/or psychological records pertaining to my medical history, mental or physical condition, services rendered, or treatment provided during the period from initial visit to present.

Name: ____
Address: ____
City: ________________________________State: _______ Zip Code: ________
Fax: ________________________________

Please send or fax all records to:

Advanced Pain Specialists of Southern California
5750 Downey Ave, Suite 306
Lakewood, CA 90712
Fax: (562) 408-6491

I agree that a photocopy or facsimile of this authorization is as valid as the original.

This authorization is valid for 1 (one) year from the date of signature. I understand that I may revoke this authorization at any time by notifying Advanced Pain Specialists of Southern California in writing at the address listed above. I further understand that any such revocation does not apply to information already released in response to this authorization.

I have read and understand this information. I may receive a copy of this form if requested. I am the patient or am authorized to act on behalf of the patient to sign this document verifying authorization for the use or disclosure of the protected health information under the about stated terms.

____ ________________
Signature of Patient Date

____ ________________
Signature of Legal Guardian/Representative Relationship

\

____
Signature of Witness

Advanced Pain Specialists *of Southern California*

Patient Information

Patient Information					
Patient Name				Today's Date	
Date of Birth	Sex Male Female	Age		Drivers License or State ID Number	
Social Security Number		Marital Status Single Married Divorced Widowed			
Address					
City		State		Zip	
Home Telephone	Mobile Telephone			Spouse	
Primary Language You Speak English Spanish Other:			Primary Language You Read English Spanish Other:		
Emergency Contact					
Name		Relationship		Telephone	
Referral Information					
Name				Telephone	
Name				Telephone	
Attorney					
Name		Telephone			Fax
Address					
City				State	Zip

Employment

Current Work Status

Employed Full-Time	Employed Part-Time	Unemployed	On Disability
Retired	Student	Home Duties/Family	Other

Current Employer	Current Occupation

Current Employers Address

City	State	Zip	Telephone

Previous Employer	Previous Occupation

Previous Employers Address

City	State	Zip	Telephone

Insurance Information

Who Is Responsible For This Account	Relationship To Patient	Date of Birth

Primary Insurance Company	Telephone
Policy/Group Number	Case Manager
Secondary Insurance Company	Telephone
Policy/Group Number	Case Manager

Work Comp, Personal Injury, Third Party, or Other Information

Insurance Company	Telephone

Case Manager	Telephone	Fax
WCAB Number	Claim Number	Date of Injury

Other Information

Medical History

Do you have a family physician? Yes No
If yes, whom? ____________________
Office address: ____________________
Office telephone: ____________________

Do you have allergies or adverse reactions to any medications? Yes No
If yes, please list allergies: ____________________

Are you taking blood thinning medication? Yes No
If so, please list: ____________________

For women:
Are you taking birth control? Yes No
Are you nursing? Yes No
Are you pregnant? Yes No If so, how many weeks? ___________

List all prior serious injuries None

Date	Injury	Hospital/Doctor

List all prior surgeries None

Date	Surgery	Hospital/Doctor

List all current medications including nonprescription drugs and supplements None

Drug	Dose	How Often

Do you have or have you ever had? (circle)

High Blood Pressure Yes No
Heart Attack Yes No
Mitral Valve Prolapse Yes No
Psychiatric Disorder Yes No
Seizures Yes No
Emphysema Yes No
Glaucoma Yes No
Thyroid Disorder Yes No
Depression Yes No
Liver Disorder / Hepatitis Yes No
Hiatal Hernia Yes No
Peptic Ulcer Yes No
Bladder Incontinence Yes No
Cancer Yes No

Angina/Chest Pain Yes No
Heart Murmurs Yes No
Heart Failure Yes No
Stroke/TIA Yes No
Asthma Yes No
Multiple Sclerosis Yes No
Diabetes Yes No
Kidney Disorder Yes No
Bleeding Disorder Yes No
HIV/AIDS Yes No
Esophageal Reflux Yes No
Bowel Incontinence Yes No
Arthritis Yes No
Other: ___________________________

Do you have or have you ever had? (circle)

Fevers Yes No
Recent weight loss Yes No
Skin rash Yes No
Skin discoloration Yes No
Mouth sores Yes No
Sore throats Yes No
Chest pain Yes No
Palpitations Yes No
Stomach pain Yes No
Diarrhea Yes No
Burning on urination Yes No
Difficulty starting urine Yes No
Joint swelling Yes No
Excessive thirst Yes No
Depressed mood Yes No
Anxiety or nervousness Yes No
Sense of doom Yes No

Decreased appetite Yes No
Easy fatigue Yes No
Skin flaking Yes No
Breast pain or lumps Yes No
Difficulty swallowing Yes No
Shortness of breath Yes No
Loss of consciousness Yes No
Daily coughing Yes No
Black or red stools Yes No
Constipation Yes No
Discolored urine Yes No
Joint stiffness Yes No
Numbness or weakness Yes No
Frequent urination Yes No
Difficulty sleeping Yes No
Irregular menses Yes No
Pregnant Yes No

Social History

Do you smoke? Yes No
If yes, number of cigarettes per day? ______________________

Do you drink alcohol? Yes No
If yes, how much? Rare Occasional Moderate Fequent Heavy

Do you take any illicit drugs? Yes No
If yes, what? ______________________

Highest level of education you have completed:
Less than high school High school Vocational school
College Graduate school Other:

With whom do you live? ______________________ Relationship? ____________

Are there any substance abuse issues in the household? Yes No
If yes, please explain. ______________________

Are you able to take care of yourself? Yes No
If not, please enter name of your caregiver. ______________________

Do you have children: Yes No
If yes, list their ages: ______________________

What is your current employment status?
Employed full-time Employed part-time Self-Employed Homemaker
Retired Unemployed due to pain/injury Unemployed due to other reasons

Where you happy with your job/occupation before being injured? Yes No
If no, please explain. ______________________
____

Are you on disability? Yes No
If yes, date disability started: __________ Date last worked: ______________

Family History

Member	Deceased or Living	Age	Medical Problems
Father			
Mother			
Siblings			
Spouse			

Psychological History

How would you describe your emotional health? (check all that apply)

Happy/Cheerful Optimistic Anxious Worried Angry Frustrated
Depressed Suicidal Compulsive Indifferent Hopeless Panicked

Do you have a history of physical, mental, or sexual abuse? Yes No

Are you currently in psychotherapy? Yes No
If yes, with whom? Name: ____________________________________ Telephone: ________________

Pain History and Questionnaire

Describe in *your own words* the pain problem(s) you would like help with (where it is, how it feels, is it constant, does it come and go, etc.)**:**

____
____
____
____
____

What do you think is causing your pain?

____
____

When did your current pain start? ____

Was there a precipitating event or cause of the pain? Yes No
Work injury Sports injury Auto accident Routine/household activity After surgery
Other: ____
If yes, when did your condition / injury / accident occur? ______________________________

Is your condition getting worse? Yes No Constant Comes and goes

How often does your pain occur?
Continuous (100% of the time) Near Constant (60-95% of the time)
Intermittently (30-60% of the time) Occasionally (less than 30% of the time)

In general, over the past month, when has your pain been the worst? (check one)
Morning Afternoon Evening Night No typical pattern

In the last year have you been treated at the emergency room for pain? Yes No
If yes, how many times? 1 2 3 4 5 More than 5

Below is a list of words that may describe your pain. Please rate each word by circling the number in the corresponding column that describes the intensity of that type of pain.

	None	Mild	Moderate	Severe
Throbbing	1	2	3	4
Shooting	1	2	3	4
Stabbing	1	2	3	4
Sharp	1	2	3	4
Cramping	1	2	3	4
Gnawing	1	2	3	4
Hot/Burning	1	2	3	4
Aching	1	2	3	4
Heavy	1	2	3	4
Tender	1	2	3	4
Tiring/Exhausting	1	2	3	4
Sickening	1	2	3	4
Fearful	1	2	3	4
Punishing/Cruel	1	2	3	4

Using the scales below, please rate your pain levels and effects. (circle the number)

1. **Your *highest pain intensity* over the past week.**

0	1	2	3	4	5	6	7	8	9	10

None Mild Moderate Severe Worst Ever

2. **Your *lowest pain intensity* over the past week**.

0	1	2	3	4	5	6	7	8	9	10

None Mild Moderate Severe Worst Ever

3. **Your *usual pain intensity* over the past week.**

0	1	2	3	4	5	6	7	8	9	10

None Mild Moderate Severe Worst Ever

4. **How much your pain has *interfered with your normal activities* over the past week.**

0	1	2	3	4	5	6	7	8	9	10

None Mild Moderate Severe Worst Ever

5. **How *distress or bothered* you have been in the past week about the pain.**

0	1	2	3	4	5	6	7	8	9	10

None Mild Moderate Severe Worst Ever

6. **How much pain has *interfered with your sleep* in the past week.**

0	1	2	3	4	5	6	7	8	9	10

None Mild Moderate Severe Worst Ever

During the past month, how much did pain interfere with the following activities? (circle the number for each item that best describes your situation)

	Not at All	A Little Bit	Moderately	Quite a Bit	Extremely
Going to work	1	2	3	4	5
Performing household chores	1	2	3	4	5
Doing yard work or shopping	1	2	3	4	5
Socializing with friends	1	2	3	4	5
Participating in recreation	1	2	3	4	5
Having sexual relations	1	2	3	4	5
Standing for 20 minutes	1	2	3	4	5
Sitting for 20 minutes	1	2	3	4	5
Walk for 20 minutes	1	2	3	4	5
Climb stairs	1	2	3	4	5
Drive a car	1	2	3	4	5
Ride in a car	1	2	3	4	5
Dress myself	1	2	3	4	5
Shower/bathe myself	1	2	3	4	5

What makes your pain *WORSE*? Please be specific.

____

____

What makes your pain *BETTER*? Please be specific.

____

____

Pain Diagram

On the diagrams below mark the areas on your body where you feel the described sensations.

Key Ache: ^ ^ ^ ^ ^ Pins/Needles: ● ● ● ● ● ● Burning: X X X X
Numbness: O O O O Radiating Pain: / / / / / / /

FRONT LEFT SIDE RIGHT SIDE BACK

List all previous pain medications you have taken/tried for pain control.

Name of Medicine	Dose	Date	Helpful?	Reason for Stopping
____________________	__________	_________	Yes / No	____________________
____________________	__________	_________	Yes / No	____________________
____________________	__________	_________	Yes / No	____________________
____________________	__________	_________	Yes / No	____________________
____________________	__________	_________	Yes / No	____________________
____________________	__________	_________	Yes / No	____________________

Have you ever had any of the following types of treatment for your pain and what was the result or benefit of that treatment? (circle the number that best describes your situation)

Treatment	Helpful	Minimal Benefit	No Significant Help
Occupational Therapy	1	2	3
Physical Therapy	1	2	3
Chiropractic	1	2	3
Deep Tissue Massage	1	2	3
Acupuncture	1	2	3
TENS Unit	1	2	3
Psychological / Psychiatric Care	1	2	3
Biofeedback	1	2	3
Pain Management Program	1	2	3
Injections			
Trigger Point Injections	1	2	3
Epidural Steroid Injections	1	2	3
Facet Blocks	1	2	3
Stellate Ganglion Block	1	2	3
Lumbar Sympathetic Blocks	1	2	3
Nerve Blocks	1	2	3
Surgery			
Cervical Spine Surgery	1	2	3
Lumbar Spine Surgery	1	2	3

Have you received or tried any other treatments for your pain problems? Yes No
If yes, what? ____

Have you ever been evaluated at a pain center? Yes No
If yes, which doctor/facility? ____

List all doctors you have seen for your pain problem.

Date	Name	Specialty	Treatment
____	______________________	______________________	___________________________
____	______________________	______________________	___________________________
____	______________________	______________________	___________________________
____	______________________	______________________	___________________________
____	______________________	______________________	___________________________
____	______________________	______________________	___________________________
____	______________________	______________________	___________________________

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient Signature: ____ Date: ________________