



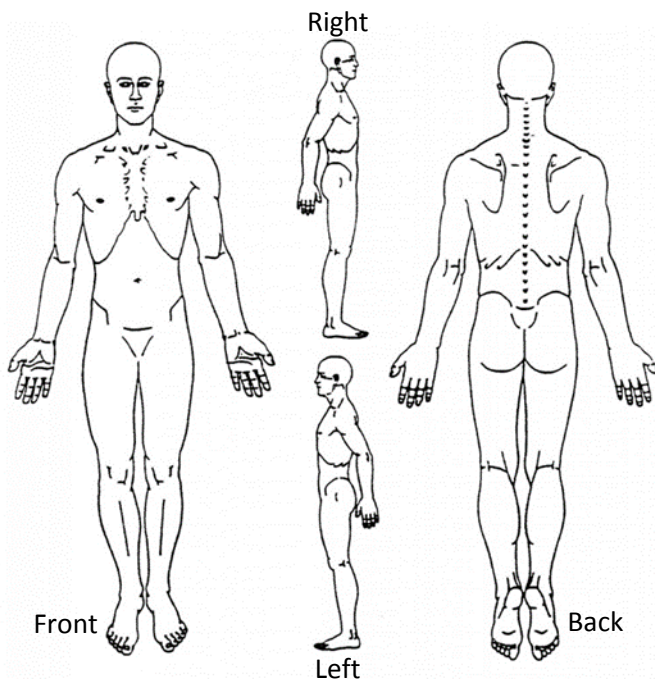
PATIENT INFORMATION:	DATE:
<p>Name: _____ Sex: _____ Age: _____ Date of Birth: _____ Social Security #: _____ Cell Phone: _____ Home Phone: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Email Address: _____ Occupation: _____ Emergency Contact: _____ Phone #: _____ Referring Physician: _____ Primary Care Physician: _____ Preferred Pharmacy: _____ Phone #: _____</p>	
RECORD RELEASE:	
<p>My signature below bears authorization for Pain and Healing Institute to obtain my medical records for my medical care.</p> <p>Signature: _____ Date: _____</p> <p>I authorize Pain and Healing Institute to release my records to my insurance carrier to process my claims for medical treatments received at Pain and Healing Institute.</p> <p>Signature: _____ Date: _____</p>	
OTHER INFORMATION:	
<p>In the event of emergency or illness, I grant permission to the following individuals to discuss my medical condition:</p> <p>Name: _____ Phone: _____ Relation: _____ Name: _____ Phone: _____ Relation: _____ Name: _____ Phone: _____ Relation: _____</p> <p>Signature: _____ Date: _____</p>	

**CURRENT PAIN:**

Throbbing     Shooting     Aching     Stabbing     Sharp     Tender

0	1	2	3	4	5	6	7	8	9	10
No pain		Mild pain			Moderate pain			Severe Pain		Worst pain Imaginable

Please shade in areas of pain:



What makes the pain **WORSE**: \_\_\_\_\_

What makes the pain **BETTER**: \_\_\_\_\_

When did your pain start? \_\_\_\_\_

Describe the pain in your own words: \_\_\_\_\_

**ALLERGIES:**  No Known Allergies

Medicine	Reaction	Medicine	Reaction

**SOCIAL HISTORY:**

Smoking: Yes  No  Quit  Packs per day: \_\_\_\_\_ Number of years: \_\_\_\_\_

Alcohol use: None  Occasional  Daily  Number per week: \_\_\_\_\_

Recreational drugs: No  Yes : \_\_\_\_\_





Name: \_\_\_\_\_

Date: \_\_\_\_\_

**FINANCIAL RESPONSIBILITY FOR SERVICES:** I hereby authorize my insurance benefits be paid directly to Pain and Healing Institute. I understand that I may have financial responsibility for all or a portion of the charges for the professional services rendered and am responsible for services not covered by my insurance. **If applicable, at the time of check-in, I will be required to pay a co-payment.** If I do not pay my co-payment, I understand that my visit may be cancelled. I understand that depending on my insurance, I may receive a separate bill for laboratory, x-ray, anesthesia or other ancillary services. I acknowledge that **it is my responsibility to understand the benefits and limitations of my insurance plan** and to contact my insurance carrier if I have questions. Initials: \_\_\_\_\_

**REFERRALS/AUTHORIZATIONS:** I understand that depending on my insurance may require approval for any and all procedures. If so, and my provider decides it is medically necessary, I will allow 7-10 working days for this process. I understand that if I choose to access services without prior authorization from my provider, or if I fail to notify if my insurance plan requires specific outside to perform services, I may be financially responsible for the services rendered. Initials: \_\_\_\_\_

**CREDIT CARD TRANSACTIONS:** All transactions that I authorize pain and healing institute to process have my signature or the signature of the authorized card holder. Pain and Healing Institute will provide me with a legible receipt that provides approval number and date of transaction for my records. This is a formal receipt for the visit for your records. Initials: \_\_\_\_\_

**FEE FOR FORMS:** I understand jury duty excuse, Family Leave Act applications, accident reports, and school and camp forms have fees associated with filling these out. Initials: \_\_\_\_\_

**ON-TIME ARRIVAL POLICY:** I understand that I must arrive for my appointment on time in order to check in. If I arrive late for my schedule appointment, I understand that it may be necessary to reschedule or wait until my physician is available. Initials: \_\_\_\_\_

**REFUNDS AND CREDIT POLICY:** I understand that there are no refunds given for consults, follow ups, procedures or ketamine infusions. I may be offered a credit for a follow up visit if my initial consult was scheduled in two sessions due to complexity of my consult and extent of records to review. Initials: \_\_\_\_\_

**MEDICATION REFILLS:** I understand that refills may take 24-48 hours to complete. I acknowledge that the best way to ensure my medications are filled in a timely manner is to come in for re-evaluation by my physician on a monthly basis. I agree to allow staff 24 hours to complete prior authorization for medications (if needed) and that my insurance has 3 days to review after that. Initials: \_\_\_\_\_

Patient signature: \_\_\_\_\_



**THIS NOTICE DESCRIBES HOW MEDICAL/HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION**

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The following circumstances may require us to use your health information:

1. To coordinate your care with your physical therapists, pharmacist, suppliers of medical equipment, referring/primary treating physician or in the event of an emergency.
2. To file claims with your insurance carrier for the purpose of billing and payment.
3. To comply with Worker's Compensation regulations.
4. At the request of public health oversight agencies that are authorized to collect information.
5. At the request of a law enforcement official.
6. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of others.
7. As legally required in the case of lawsuits or similar proceedings

Your rights regarding your health information:

1. Except as described in this notice, we will use and disclose your health information only with your written consent. You may revoke your consent to disclose at any time.
2. You can request a restriction in our use or disclosure of your health information. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records. You must submit your request in writing to Pain and Healing Institute.
4. You may ask us to amend your health information if you believe it is incomplete or incorrect, and as long as the information is kept by or for our practice. You must submit an amendment in writing to Pain and Healing Institute. You must provide us with a legitimate reason that supports your request for amendment.
5. You are entitled to receive a copy of this Notice of Privacy Practices. At any time, you may obtain a copy by asking the front desk.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing to Pain and Healing Institute. You will not be penalized for filing a complaint.

I hereby acknowledge that I have been provided a Privacy Notice and understand my rights as a patient.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_



### PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All claims must be arbitrated:** it is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to complete arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** Procedures and Applicable law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283,05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** A claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_