Pain & Healing INSTITUTE

PATIENT INFORMATION: **DATE:**

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 #:_____

RECORD RELEASE:

My signature below bears authorization for Pain and Healing Institute to obtain my medical records for my medical care.

Signature: _____ Date:_____

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.

Signature: _____ Date: _____

OTHER INFORMATION:

In the event of emergency or illness, I grant permission to the following individuals to discuss my medical condition:

Name: _____Phone:_____Relation:_____

Name: _____Phone:_____Relation:_____

Name: _____Phone:_____Relation:_____

Signature: _____ Date:_____

Pain & Healing INSTITUTE

REVIEW OF SYSTEMS: Please check if you have or had any of the following:

General	**Hematological**	**Musculoskeletal**	**Head/Neck**
☐ Severe fatigue	☐ Anemia	☐ Arthritis	☐ Headaches
☐ Recent Fevers	☐ Easy bruising	☐ Osteoporosis	☐ Visual changes
☐ Recent Antibiotic	☐ Bleeding disorder	☐ Muscle Wasting	☐ TMJ
Cardiac	☐ On blood thinners	☐ Fractures	**Pulmonary**
☐ Chest pain	☐ Blood Transfusion	**Gastrointestinal**	☐ Difficult breathing
☐ Irregular heartbeat	☐ Cancer	☐ Abdominal Pain	☐ Cough
☐ Heart murmur	**Neurologic**	☐ Nausea/vomiting	☐ Asthma/Bronchitis
☐ Blood Pressure	☐ Numbness	☐ Constipation	☐ Lung Disease
☐ Circulation problem	☐ Weakness	☐ Diarrhea	**Infectious Diseases**
☐ Ankle swelling	☐ Stroke	☐ Ulcers	☐ Hepatitis A/B/C
Skin	☐ Seizures	**Endocrine**	☐ HIV/AIDS
☐ Rash	☐ Alzheimers/Dementia	☐ Diabetes	☐ Shingles
☐ Bumps/Nodules	☐ Loss of balance	☐ Thyroid problems	☐ PostherpeticNeuralgia

SURGICAL HISTORY: Please list any surgical procedures you have had

Year	Describe	Hospital	Doctor

MEDICAL PROBLEMS: Pleas list any medical conditions you have

List	Beginning Date	List	Beginning Date

CURRENT MEDICATIONS:

List all medications you are currently taking for medical and problems including prescribed, over-the-counter, herbs, and vitamins. You may use the back of this sheet if needed.

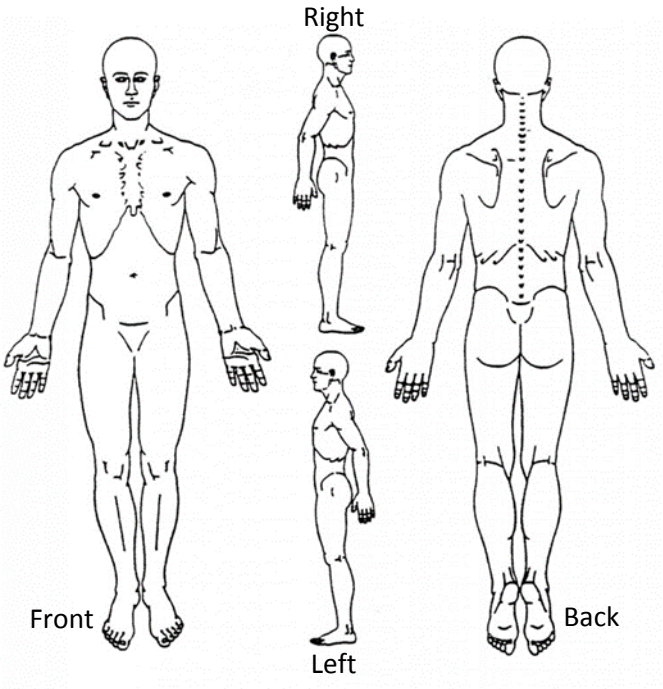
Medication Name	Dose	Schedule	Prescribing Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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 check mark the areas of your 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 ☐: _____

Pain & Healing INSTITUTE

PRACTICE POLICIES

Name: _____ Date: _____

REFERRALS/AUTHORIZATIONS: I understand that depending on my insurance, I may need a referral from my provider to see a specialist. My insurance may also 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: _____

FEES FOR PATIENT'S HEALTH INFORMATION: I hereby understand I may be charged a cost-based fee when requesting copies of my health information, including copying (supplies and labor) and postage (if information is to be mailed).

Initials: _____

FEE FOR FORMS: I understand, that if I request to have any forms completed by my physician that are not directly related to patient care I will be required to pay a fee. Examples of the forms include but are not limited to: jury duty excuse, Family Leave Act applications, accident reports, and school and camp forms. There may be other forms with associated fees.

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. My physician(s) attempt to maintain an "on-time" schedule, but I understand that urgent or complex needs for patients with prior appointments may cause my physician to be late for my appointment.

Initials: _____

NO-SHOW POLICY: I understand that if I miss an appointment with less than 24-hours prior notice, I will be charged a $50.00 fee for a missed visit. Multiple no shows will not be rescheduled.

Initials: _____

MEDICATION REFILLS: I understand that in order to receive a refill I must have a current opiate prescribing agreement, recent toxicology screening as mandated by law, and must be seen monthly and / or have an agreement with the physician to be seen regularly for my refills to be provided to me.
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 to 48 hours to complete prior authorization for medications (if needed) and that may insurance has 3 days to review after that. I further understand that prior authorization for my insurance are a courtesy that the office is providing me and that once this is completed; the time frame that it takes the insurance to review is not controlled by the provider's office. I also agree and understand that refills of NARCOTICS ARE NOT REFILLED ON FRIDAYS AND AFTER HOURS. If refills are needed, a call is to be made to the pharmacy so a fax can be generated to our office and a decision will be made during normal business hours. Medication refills are NOT AN EMERGENCY.

Initials: _____

Patient signature: _____

Pain & Healing INSTITUTE

HIPAA AGREEMENT

THIS NOTICE DESRCRIBES 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 at 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: _____

Pain & Healing INSTITUTE

PAYMENT POLICY OF NADIV SAMIMI MD. / FAISAL LALANI MD.

Thank you for choosing us as your physicians office. We are committed to providing you with quality and companionate care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. Paying your deductible.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. I f your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party/ Date Name