NEW PATIENT PACKET

Pain & Rehabilitative
CONSULTANTS MEDICAL GROUP

1335 Stanford Ave
Emeryville, CA 94608
Phone: (510) 647-5101 Fax: (510) 647-5105

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Dear prospective patient,

The following forms must be completed before you arrive to your scheduled appointment. Please turn in the following **completed** forms to the front desk receptionist when you check in on the day of your appointment. Unfortunately, the physician may reschedule your New Patient visit for another day if any of the following forms are not fully completed.

Please note that there is parking on Stanford Ave across the street from our building. Please park at your own discretion.

Thank you,
Pain and Rehabilitative Consultants Medical Group

NEW PATIENT PACKET

PERSONAL INFORMATION

Name: _____ SSN: _____
Last First Middle Initial

Address: _____
Street City State Zip

Phone: (_____) _____ Email Address: _____

Fax: (_____) _____ Birthdate: _____ Sex: ___ Driver's License #: _____

RESPONSIBLE PARTY

If patient is under 18 or if the responsible party is different from the patient, please complete the following section.

Name: _____ Relationship: _____
Last First Middle Initial

Address: _____
Street City State Zip

Phone: (_____) _____ SSN: _____

Birthdate: _____ Age: _____ Sex: _____ Driver's License #: _____

REFERRING PROVIDER

Name: _____ Degree: _____

Address: _____
Street City State Zip

Phone: (_____) _____ Fax: (_____) _____

EMPLOYER INFORMATION

Employer: _____ Phone: (_____) _____

Address: _____
Street City State Zip

Occupation: _____ Supervisor: _____

Employer Email Address: _____ Fax: (_____) _____

INSURANCE INFORMATION

Primary Insurance: _____ Phone: (_____) _____

Address: _____ Date of onset: _____

Insured: _____ ID #: _____ Policy/Group: _____

Relationship to Patient: _____ SSN: _____ Date of Birth: _____

Secondary Insurance: _____ Phone: (_____) _____

Address: _____ Date of onset: _____

Insured: _____ ID #: _____ Policy/Group: _____

Relationship to Patient: _____ SSN: _____ Date of Birth: _____

General Medical Consent: The patient or the patient's legal representative hereby consents to general and medical care, including but not limited to x-ray examinations, laboratory procedures, and medical services rendered to the patient under the general and special instructions of the physician. It is understood that the patient is under the care and supervision of his or her attending physician. **Release of Information:** To the extent necessary to determine insurance benefits, liability for payment, and to obtain reimbursement, we may disclose portions of the patient's medical record and account file to any person or corporation which may be liable for all or any portion of the patient's charges, including but not limited to insurance companies, healthcare service plans, or worker's compensation carriers. **Assignment of Insurance Benefits**: I authorize the filing of insurance claims on my behalf for services rendered. I also authorize payments to be made directly to this office for any benefits, both basic and major medical, otherwise payable to or on behalf of the patient for all services rendered.

_____ _____

Signature of patient, parent, legal guardian, or legal representative **Date**

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HIPAA CONSENT FORM

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), established a "Privacy Rule" to help ensure that personal healthcare information is protected for privacy. The "Privacy Rule" was also created in order to provide a standard for certain healthcare providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment, or healthcare operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We always strive to take reasonable precautions to protect your privacy. When it is appropriate or necessary, we provide the minimum necessary information only to those we feel are in need of your healthcare information regarding treatment, payment, or healthcare operations in order to provide healthcare that is in your best interest.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not patients), and may have to disclose personal health information for purposes of treatment, payment, or healthcare operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your Personal Health Information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our Privacy Notice (Compliance Assurance Notification to Our Patients), to request restrictions and revoke consent in writing.

I, the undersigned, understand and agree to the contents above.

Patient Name (PRINT): _____ Date of Birth: _____

Patient Signature: _____ Date: _____

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MEDICATION MANAGEMENT AGREEMENT

I agree to and accept the following conditions for the management of pain medication (opioids) prescribed by my pain management "provider":

1. I understand that a reduction in my pain and an improvement in my quality of life are the goals of my treatment with pain medication. I will accurately report pain relief, changes in my quality of life, and side effects caused by my pain medication.
2. I understand that the use of pain medications carry risks, including those from side effects and complications, and that these have been discussed with me to my satisfaction by my doctor. I understand that one of the risks of using pain medication is becoming addicted to them.
3. Pain medications may be prescribed for me only by my physician. Examples of pain medications are: morphine, MS Contin, Oramorph Codeine, Tylenol #3, OxyContin, Percocet, Percodan, hydrocodone, Vicodin, Lortab, Norco, methadone, Dolophine, meperidine, Demerol, hydromorphone, Dilaudid, propoxyphene, Darvocet, Darvon, and others.
4. The prescription of pain medication by my physician will require follow-up appointments at this office as determined by my physician.
5. I agree to allow my physician to communicate with other doctors and pharmacists concerning his or her prescription of my medications.
6. I understand that no pain medications will be refilled early, including those that are lost, stolen, or misplaced.
7. **Only a physician may increase your dose of pain medication**. If you choose to increase your pain medication usage on your own, we will not refill it.
8. Inquiries regarding your pain medications should be made during normal business hours (i.e. Monday through Friday, 8:00 am to 5:00 pm) at 510-647-5101, extension 104 or 162.
9. In the event that your treatment with your pain medication is unsuccessful and you have been compliant with the treatment, care will be provided during any required medication taper. Referral to facilities specializing in medication detoxification may be necessary.
10. It is understood that emergencies do arise, and under special circumstances exceptions may be made to these policies. Individual cases will be reviewed and modified as necessary.
11. Please be advised that you may request a written prescription to fill at the pharmacy of your choice in lieu of having your medication dispensed directly from our office.

PLEASE NOTE: We have a 5 business day period in which we respond to all refill requests. This does not include weekends or holidays.

CAUTION: OPIOID MEDICATIONS MAY CAUSE DROWSINESS. ALCOHOL SHOULD NOT BE CONSUMED WHILE TAKING MEDICATIONS. USE CARE WHEN OPERATING A CAR OR DANGEROUS MACHINERY. FEDERAL LAW PROHIBITS THE TRANSFER OF THESE DRUGS TO ANY PERSON OTHER THAN THE PATIENT FOR WHOM THEY WERE PRESCRIBED.

I, the undersigned, understand and agree to comply with the above guidelines.

Patient Name (PRINT): _____ Date of Birth: _____

Patient Signature: _____ Date: _____

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CONDITIONS OF TREATMENT

RELEASE OF INFORMATION

In general, medical information concerning the patient's procedure is treated as confidential by Pain and Rehabilitative Consultants Medical Group, its personnel, and members of its medical staff. The Confidentiality of Medical Information Act (Part 2.6 of Division 2 of the California Civil Code, Section 56) sets forth those instances where Pain and Rehabilitative Consultants Medical Group may lawfully release such information to others without written consent. Under the act, Pain and Rehabilitative Consultants Medical Group is permitted without my written consent to release such medical information to the patient's healthcare insurance company or other legal entity providing healthcare coverage to the extent necessary in order to determine that entity's liability for payment.

I authorize all my prior healthcare givers to provide pertinent medical records (including psychology and psychiatric evaluation) to Pain and Rehabilitative Consultants Medical Group.

I authorize Pain and Rehabilitative Consultants Medical Group to send copies of my evaluation and treatment to the medical personnel, whom I have listed on this questionnaire, as well as further medical personnel who I request receive this information, or to whom I am referred from Pain and Rehabilitative Consultants Medical Group. I also release Pain and Rehabilitative Consultants Medical Group to send copies of my reports to insurance providers.

FINANCIAL RELEASE

In consideration for the services rendered, I, the patient, hereby individually obligate myself to pay the account of Pain and Rehabilitative Consultants Medical Group in accordance with the regular rates and terms of Pain and Rehabilitative Consultants Medical Group, even if I have insurance. In the event it should become necessary to refer my account to any attorney or collections agency for collections, I hereby agree to pay reasonable attorney fees and collection expenses. All delinquent accounts at Pain and Rehabilitative Medical Group's option bear interest at the legal rate.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign all medical and/or surgical benefits to which I am entitled, including private insurance and other health plans to: Pain and Rehabilitative Consultants Medical Group. This assignment will remain in effect until revoked in writing by me. A photocopy of this agreement is to be as valid as the original. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I hereby authorize said assignee to release all information necessary to secure payment.

I, the undersigned, understand and agree to the contents above.

Patient Name (PRINT): _____ Date of Birth: _____

Patient Signature: _____ Date: _____

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CONFIDENTIALITY INFORMATION SHEET

Name: _____ Date of Birth: _____

Address: _____
Street City State Zip

Where may we leave detailed confidential messages for you?

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____

Patient Signature: _____ Date: _____

EMERGENCY CONTACT

Local friend or relative (who does not live with you)

Full Name:_____ Relationship: _____

Phone: (_____) _____

Address: _____
Street City State Zip

MEDICATION PICK-UP CONTACT

If you want to authorize someone to pick up your medication for you, please fill out the form below.

Name of Person Picking Up Medication: _____

Driver's License Number of Person Picking Up Medication: _____

Relationship to Patient: _____

Patient Signature: _____ Date: _____

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AGREEMENT FOR OPIOID MAINTENANCE THERAPY FOR PAIN MANAGEMENT

The purpose of this agreement is to give you information about the medications you will be taking for pain management and to assure that you and your physician comply with all state and federal regulations concerning the prescribing of controlled substances. A trial of opioid therapy can be considered for moderate to severe pain with the intent of reducing pain and increasing function. The physician's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the physician/patient relationship and full agreement and understanding of the risks and benefits of using opioids to treat pain.

1. You should use one physician to prescribe and monitor all opioid medications and adjunctive analgesics.
2. You should use one pharmacy to obtain all opioid prescriptions and adjunctive analgesics prescribed by your physician.
    a. **Pharmacy Name and City**: _____
    b. **Phone Number**: _____ **Fax Number**: _____
3. You should inform your physician of all medications you are taking, including herbal remedies, since opioid medications can interact with over-the-counter medications and other prescribed medications, especially cough syrup that contains alcohol, codeine, or hydrocodone.
4. You will be seen on a regular basis and may be given prescriptions for enough medication to last from appointment to appointment, plus usually two to three days extra. This extra medication is not to be used without explicit permission of the prescribing physician unless an emergency requires your appointment to be deferred one or two days.
5. Prescriptions for pain medicine or any other prescriptions will be done only during an office visit or during regular office hours. No refills of any medications will be done during the evening or on the weekends unless it is a true and verifiable emergency.
6. You are responsible for keeping your pain medication in a safe and secure place, such as a locked cabinet or safe. You are expected to protect your medications from loss or theft. Stolen medications should immediately be reported to the police, and to your physician with proof that you have filed a police report. You agree to provide your physician with an official copy of this police report when it becomes available. If your medications are lost, misplaced, or stolen, your physician may choose not to replace the medications or to taper and discontinue the medications.
7. You may not give or sell your medications to any other person under any circumstances. If you do, you may endanger that person's health. It is also against the law.
8. Any evidence of drug hoarding, acquisition of any opioid medication or adjunctive analgesia from other physicians (which includes emergency rooms), uncontrolled dose escalation or reduction, loss of prescriptions, or failure to follow the agreement may result in termination of the doctor/patient relationship.
9. You will communicate fully to your physician to the best of your ability at the initial and all follow-up visits your pain level and functional activity level along with any side effects of the medications. This information allows your physician to adjust your treatment plan accordingly.
10. You should not use any illicit substances, such as cocaine, marijuana, etc., while taking these medications. This may result in a change to your treatment plan, including safe discontinuation of your opioid medications when applicable, or complete termination of the doctor/patient relationship.
11. The use of alcohol and opioid medications is contraindicated.
12. There are side effects with opioid therapy, which may include, but not exclusively, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, or the possibility of impaired cognitive (mental status) and/or motor ability. Overuse of opioids can cause decreased respiration (breathing) and possibly death.

AGREEMENT FOR OPIOID MAINTENANCE THERAPY FOR PAIN MANAGEMENT

13. You agree and understand that your physician reserves the right to perform urine drug testing. If requested to provide a urine sample, you agree to cooperate. If you decide not to provide a urine sample, you understand that your doctor may change your treatment plan, including safe discontinuation of your medications when applicable, or complete termination of the doctor/patient relationship. The presence of a non-prescribed drug(s) or illicit drug(s) in the urine can be grounds for termination of the doctor/patient relationship. You understand there is a separate charge for urine drug testing for which you are responsible if it is not covered by your insurance or if you are a self-pay patient.
14. Physical dependence and/or tolerance can occur with the use of opioid medications. Physical dependence means that if the opioid medication is abruptly stopped or not taken as directed, a withdrawal symptom can occur. This is a normal physiological response. The withdrawal syndrome could include, but not exclusively, sweating, nervousness, abdominal cramps, diarrhea, goose bumps, and alterations in one's mood. It should be noted that physical dependence does not equal addiction. One can be dependent on insulin to treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to the insulin or prednisone. Addiction is a primary, chronic neurobiologic disease with genetic, psychosocial, and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more or the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases one's quality of life.

    Tolerance means a state of adaptation in which exposure to the drug induces changes that result in diminution of one or more of the drug's effects over time. The dose of the opioid may have to be titrated up or down to a dose that produces maximum function and a realistic decrease of the patient's pain.
15. If you have a history of alcohol or drug misuse/addiction, you must notify the physician of such history since the treatment with opioids for pain may increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one for opioid treatment of pain, but starting or continuing a program for recovery is a must.
16. You agree to allow your physician to contact any healthcare professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about your care or actions if the physician feels it is necessary.
17. You agree to a family conference or a conference with a close friend or significant other if the physician feels it is necessary.

I agree to the above terms so that Dr. _____ can provide quality pain management using opioid therapy to decrease my pain and increase my function.

Patient Name (PRINT): _____ Date of Birth: _____

Patient Signature: _____ Date: _____

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PATIENT DISCLOSURE STATEMENT

I, _____, understand that my physician has the ability to provide me with some of the medications that I may need for my treatment. However, I understand that I will always be given the option to receive a written prescription that I may have filled at a pharmacy of my choice.

Patient Name (PRINT): _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Yo, _____, entiendo que mi médico tiene la habilidad de darme algunas de las medicinas que puedo necesitar para mi tratamiento. Sin embargo, entiendo, que siempre tendré la opcion de recibir una receta escrita que puedo llevar a una farmacia de mi preferencia.

Nombre del Paciente: _____ Fecha de nacimiento: _____

Firma del Paciente: _____ Fecha: _____

(TO BE FILED IN PATIENT'S CHART)
CA Pharmacy Laws – Business & Professions Code
Article 12. Prescriber Dispensing Part 4170 (6)

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AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "Patient/Guardian" shall be understood to mean _____ (***insert name of patient or guardian)***.

"Physician" shall be understood to mean the ***Physicians and Physician Assistants of Pain and Rehabilitative Consultants Medical Group.***

Further, I understand that I am entering into a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Physician, I, the patient/guardian and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Physician.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use American Board of Medical Specialties ("ABMS") board-certified expert medical witness(es) in the same specialty as Physician. Furthermore, I agree that these expert witnesses will be members in good standing of and adhere to the guidelines and/or code of conduct defined for expert witnesses by the ***American Academy of Pain Management.***

In further consideration for this, Physician agrees to the same stipulations.

Patient/guardian and Physician *acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physician's reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief.*

Physician Name	Physician Signature
Patient/Guardian Name	Patient/Guardian Signature
Effective from Date of Treatment	Date of Signature

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FINANCIAL DISCLOSURE

Dear Patient,

Pain and Rehabilitative Consultants Medical Group is dedicated to providing comprehensive services to its patients in a friendly, efficient and high-quality manner. You may be referred to Bay Surgery Center for outpatient procedures. Drs. Jamasbi and Morley are partial owners of Bay Surgery Center. Although you may choose to have the procedure performed elsewhere, all referrals are made with your best care and convenience in mind.

Sincerely,

Drs. Jamasbi and Morley

I acknowledge that I may have the outpatient procedure prescribed by my doctor performed at any other facility providing similar services, but I agree to have the procedure performed at Bay Surgery Center.

Patient Name (PRINT): _____ Date of Birth: _____

Patient Signature: _____ Date: _____