Elite Pain Management Inc.
2010 E. First St., #100, Santa Ana CA 92705 - 4086
PHONE : 714 556-7246
FAX: 714 556-7247

_____ _____ Date:
Signature of patient Print Name

Patient DATE OF BIRTH: _____

I authorize _____ to release health information to:

Elite Pain Management Inc.
2010 East First St. Suite 100
Santa Ana, CA 92705
Tel: 714 556-7246 Fax: 714 556-7247

Please specify the health information you authorize to be released:

( ) MEDICAL
( ) MENTAL HEALTH ( ) HIV ( ) Drug/Alcohol

Date(s) of treatment: _____

The purpose of this release is for (check one or more):
( ) At the request of the patient/patient representative.
( ) Other (state reason)_____

Elite Pain Management Patient Name: _____

Patient Information Sheet

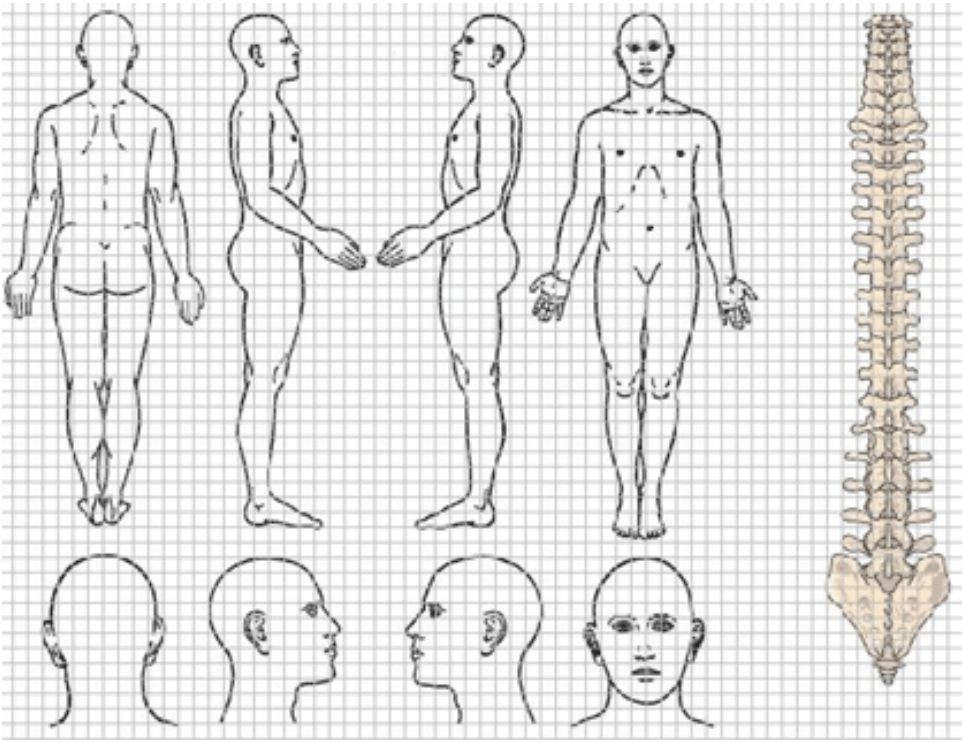
Email Contact:		Driver's License/ID Number	
Name (Last, First)		Home Telephone ( )	Cellular Telephone ( )
❑ Text message reminder for your appointments. ❑ Voice messages on your phone.			
Address	City	State	Zip Code
Social Security No.		Date of Birth	
Employer		Work Telephone ( )	
Employer Address	City	State	Zip Code
Spouse Name		Work Telephone ( )	Cellular Telephone ( )
Please list any persons you authorize to have access to your appointment, billing, and protected health information: ❑ Include my spouse		Relationship	Telephone

Referring Physician		Family Doctor		Other Doctor
Primary Insurance Name	Subscriber ID	Subscriber Name	Date of Birth	Social Security Number
Primary Insurance Name	Subscriber ID	Subscriber Name	Date of Birth	Social Security Number

Elite Pain Management Patient Name: _____

Date: _____

Please place an "X" on location of your pain:



Name:				Age:	
Systolic:	Diastolic:	Height:	Weight:	Heart Rate:	Resp. Rate:
Medical Problems: ❑Diabetes	❑Hypertension	❑Heart Disease		❑Lung Disease	❑Stroke

Do you have an Advanced Directive: ❑ Yes ❑ No (Please provide a copy if applicable)

List **ALL** Surgeries in the past:

Drug Allergies and reaction: _____

Please list all your Medications

Social History

Smoking status: ❑Never ❑Former ❑Currently everyday ❑Currently some days	
Do you use alcohol ❑Yes ❑No ❑1-5 times per week ❑Once a month ❑Once a year ❑Socially	
Do you use recreational drugs	❑Yes ❑No

What is your current occupation? _____

Education: ❑Grade School ❑High School ❑College ❑Post-Graduate ❑Vocational

Marital Status: ❑Single ❑Married ❑Divorced ❑Separated ❑Widowed

Family History			Age	Health Problem
Mother	❑Living	❑Deceased		
Father	❑Living	❑Deceased		
Brother(s)	❑Living	❑Deceased		
Sister(s)	❑Living	❑Deceased		

HPI: What is the reason you are coming to see the doctor?

_____

_____

How long have you had the pain? _____

When did it start? _____

What were you doing when the pain started? _____

How long does the pain last? ❑Constant ❑Intermittent

Does the pain occur at specific times? ❑Yes ❑No
If Yes, describe when:

_____

Please check all that apply with your pain:

❑Aching	❑Burning (Hot)	❑Cramping	❑Fearful	❑Heavy
❑Gnawing	❑Punishing (Cruel)	❑Sharp	❑Shooting	❑Sickening
❑Splitting	❑Stabbing	❑Tender	❑Throbbing	❑Tiring (Exhausting)

Describe your pain at its **WORST** 0 1 2 3 4 5 6 7 8 9 10 (Most)

Describe your pain at its **BEST** 0 1 2 3 4 5 6 7 8 9 10

Describe your pain at its **AVERAGE** 0 1 2 3 4 5 6 7 8 9 10

What makes the pain WORSE?

❑Bending ❑Coughing ❑Standing a long time

❑Lifting ❑Sneezing ❑Sitting a long time

❑Defecation ❑Sexual Intercourse

What else makes it worse?

_____

_____

_____

_____

What makes it better? ❑Lying on your back ❑Lying on your side

_____

_____

_____

Other associated problems? i.e. ❑Difficulty sleeping? ❑Feeling depressed?

_____

_____

_____

_____

Treatment History

How many times have you visited a physician?

❑0-5 ❑6-10 ❑Cannot Remember ❑Too many to count

Which kind of doctor have you seen for the pain?

❑Pain Physician

❑Orthopedic Surgeon

❑Rheumatologist

❑Neurologist

❑Acupuncture

❑Chiropractor

Other_____

_____

_____

Studies? ❑MRI ❑CT Scan ❑X-ray ❑Other

Which medicine have you tried for this pain?

❑Tylenol/acetaminophen	❑Neurontin/Gabapentin	❑Norco
❑Motrin/Ibuprofen	❑Lyrica	❑Morphine
❑Flexeril/Soma/Zanaflex	❑Cymbalta	❑Other _____
	❑Oxycodone	

Have you taken any of the following for pain? ❑Marijuana ❑Other Illicit Drug (specify)

_____

Have you had any of the following procedures?

❑Epidural Injections	❑Discogram	❑Spinal Cord Stimulator
❑Trigger point injection	❑Ultrasound ❑TENS/nerve stimulator	❑Discogram
❑Facet Injections	❑Ultrasound	❑Physical Therapy
❑Sacroiliac joint injections		How many sessions (PT)?

Communication

Preferred Language	❑English ❑Spanish ❑ Other language (please specify)
What is your Race?	
What is your Ethnicity?	❑Non-Hispanic or Latino ❑ Hispanic ❑Other (please specify if Other)

Review of Systems Please check all that apply

Constitutional Symptoms	❑weight loss	❑appetite	❑fatigue
	❑physical strength		
Eyes	❑corrective lenses	❑changes in vision	
HEENT	❑headache	❑dizziness	❑deafness/hearing loss
			❑change in smelling sense
Cardiovascular	❑ hypertension	❑limb swelling	❑arrhythmia
	❑heart attack	❑phlebitis	❑difficulty breathing laying down
Respiratory	❑chronic cough	❑shortness of breath	❑asthma
	❑COPD/Emphysema		
Gastrointestinal	❑nausea	❑ diarrhea	❑constipation
	❑reflux	❑bloating	
Genitourinary	❑ blood in urine	❑kidney stones	❑ difficult urination
Musculoskeletal	❑ joint swelling	❑abnormal joint	❑fractures
	❑arthritis	❑joint limitation	❑muscle wasting
	❑muscle weak	❑muscle pain	❑night cramps
	❑atrophy	❑posture abnormal	
Skin and Breast	❑rash	❑scar	❑mass
	❑discoloration	❑hair loss	
Neurological	❑ blackouts	❑gait disturbance	❑stroke
	❑ seizures	❑headaches	❑loss of coordination
	❑memory loss	❑involuntary movement	❑spasticity
Psychiatric	❑depressed	❑anxiety	❑trouble sleeping
Hematologic	❑abnormal bleeding	❑ anemia	❑easy bruising
Allergies	❑medications	❑latex	❑other allergies
Endocrine	❑excessive thirst	❑heat or cold intolerance	❑excessive urination

NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date: _____

By signing below I acknowledge that I have been advised of the Notice of Privacy Practice and consent to the use and release of my medical information per the office Privacy Practice.

Signature: Relationship of Witness (if not the patient):

_____ _____

(Patient or Appropriate Representative) (Name) (Title/Office Position)

Release of Information: The physician office may disclose all or any part of the patient's protected health information, with certain limits and protections, for **treatment** (providing, coordinating, or managing health care and related services), **payment** (reimbursement for those services) and **health care operations activities** (accreditation, certification, licensure, professional education, peer review, auditing services, business planning, provider contracting, etc).

BILLING AND PAYMENT POLICIES

I FAILURE TO KEEP APPOINTMENT

A. In order to have an efficient and orderly office, we request your consideration of the physician's time by asking that you provide us with Twenty-Four (24) hour notice if you cannot attend a scheduled appointment. This will allow other patients who are waiting for a cancellation to be notified. We understand situations may arise that are out of our control, and Twenty-Four (24) hour advance notice may not be feasible. However, in these situations, we ask that you notify our office as soon as possible.

Patients who fail to inform the office of the above or fail to show for a scheduled appointment will be charged a fee up to Fifty ($50) dollars and/or the specialty office visit copay. This charge will be collected at the time of your next scheduled appointment and/or will be billed to you directly. We will not bill your insurance company for missed appointments.

When a patient repeatedly misses scheduled appointments, it becomes an inconvenience to the office. Therefore, if a patient misses three consecutive appointments without proper notification, he/she may be subjected to dismissal from our office, at the discretion from the treating physician. A letter will be sent to the patient informing him/her of the decision.

II MANAGED CARE (AND MEDICARE MANAGED CARE)

A. All managed care patients are expected to know their policy requirements and participate actively with our staff to ensure that policy guidelines are met.
B. Patients are required to obtain the necessary referral forms and present them at the time of their scheduled visit(s).
C. All co-payments are due and collected at the time of the visit.
D. **Patients presenting for consults or treatment visits who are unable to meet their co-payment requirement at the time of service or who have neglected to bring a required referral form will be required to re-schedule their visit.**

Note: Our contractual agreements with the various managed care plans obligate us to adhere to the rules of these plans. We make every effort to do so, but often these rules are confusing to our staff as well as the patient(s). Please work with us so that your care plan is properly approved and we can all have confidence that reimbursement will be expedited by your plan, and no unexpected payments required by you, the patient.

III STANDARD INDEMNITY INSURANCE

A. Any co-payments and applicable deductibles will be due and collected at the time of visit.
B. Pre-authorization will be obtained for all surgery.
C. Unpaid deductibles and co-payment requirements relative to surgery will be due and payable prior to the scheduled date for surgery.

IV MEDICARE (STANDARD)

A. We are participating providers with Medicare, and will bill all claims for Medicare patients.
B. Medicare patients are expected to pay their full co-payment amount, unless you have a Medi-gap policy. Our office will then also bill your Medi-gap policy.
C. Medicare patients are expected to pay their annual deductible, in the event it is not covered by the Medi-gap policy.
D. For Medicare patients who participate in a managed care or HMO Medicare plan, please note that the policies applicable are those listed in Category II, above.

V SELF PAY

A. **For those patients without insurance, payment in full is required at the time of service. The estimated fees for your visit will be provided in advance (by phone or at the front desk upon check in). Full payment will be expected before the visit. Any balance due after the visit will be calculated at the conclusion of the visit.**
B. In the event a patient anticipates difficulty with this obligation, arrangements for a payment plan must be made in advance of the first visit. We will be happy to provide an estimate for your initial visit charge, by telephone, before your first visit. If you would like to arrange this pre-visit estimate so that you can be prepared, please call our office at 714 556-7246 and ask to be connected to our office manager.
C. **In the event that no payment arrangements have been made and no payment ability is available at the time of the visit, it will be necessary to re-schedule the visit.**

VI PERSONAL INJURY

We do not accept personal injury or lien cases.

VII RETURNED CHECK CHARGES

A. We fully anticipate that all of our patients are careful in the management of their finances and checkbooks. However, in the event that a patient does present us with a check which is returned by their bank the patient will be charged a $25.00 returned check handling fee and no checks will be accepted in the future – only cash or credit card payments.

For payments to be made by patients, we accept personal checks, cash and credit cards.

❑ My signature indicates that I understand and agree to the above billing policies.

Patient Signature: _____

Patient Name: DOB: Date: