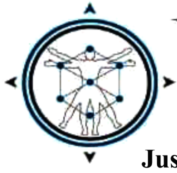
Appointment: ______________________



NORTHERN CALIFORNIA
PAIN SPECIALISTS

Justin Lo,Md J.Gabriel Tsang,Md Tanzina Khan,Md

2101 Forest Avenue - Suite #220A
San Jose, CA 95128
Phone: 408-295-8628
Fax: 408-295-8061

Please arrive 15minutes BEFORE scheduled time

Patient Registration Form

Personal Information

Today's Date [ ]

Patient's Name:

Date of Birth:

Sex M / F

Social Security Number:

Home Phone

Alternate Phone

Address:
(Street, City, State, Zip)

Email

Emergency Contact/ Name and Relationship

Emergency contact Phone Number

Employer

Employer Address

Name of Spouse

Workers Comp

Claim Number

Date of Injury

Insurance Carrier

Adjuster Name

Phone Number

FAX number

Primary Insurance

Insurance Carrier

Type of insurance PPO HMO EPO POS Private
(circle one)

Subscriber ID #

Address

Phone number

Secondary Insurance

Subscriber ID #

Pharmacy Name and Phone Number

Referring MD / Attorney

Address

Phone Number

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Intake Questionnaire

Name *(Last)* ______ *(First)* ______ *(M.I.)* ______

Date of Birth ______

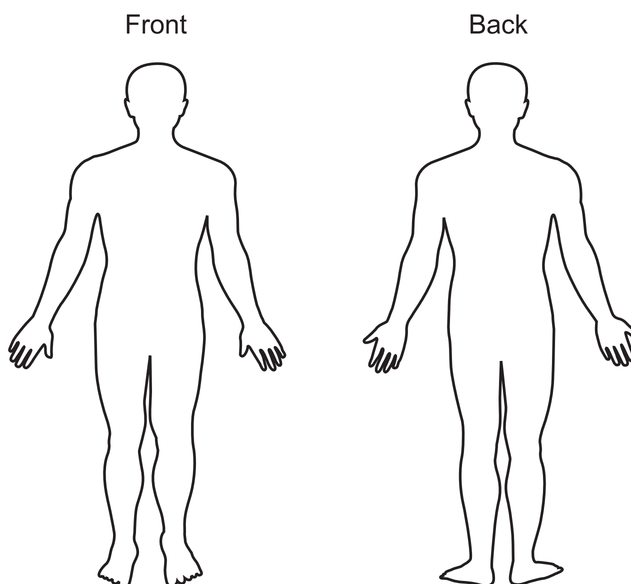
Referred By ______

Month/Year your pain began ______

1. Where is your pain?

- ☐ Lower back
- ☐ Chest
- ☐ Abdomen
- ☐ Thigh (R, L)
- ☐ Buttock (R, L)
- ☐ Calf (R, L)
- ☐ Hand (R, L)
- ☐ Mid Back (R, L)
- ☐ Ankle (R, L)
- ☐ Head
- ☐ Arm (R, L)
- ☐ Groin
- ☐ Face
- ☐ Neck
- ☐ Upper Back
- ☐ Shoulder (R, L)
- ☐ Other:____________________

2. Please mark the following drawing to highlight your areas of pain.



3. Please rate your pain level:

0=No Pain 10= worse possible pain

Maximum Pain: ☐

Least Pain: ☐

4. Is your pain related to one of the following:

Accident (Type of): __________________

Illness: ____________________________

Other: ____________________________

5.Would you describe your pain as:

- ☐ Sharp
- ☐ Burning
- ☐ Aching
- ☐ Throbbing
- ☐ Shooting

6. Does your pain travel?

Yes

Explain______________________

No

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Intake Questionnaire

7. What time of day is your pain worse?

7 AM 11 AM 3 PM 7 PM 11 PM 3 AM
(circle one)

8. Does the pain wake you up at night?

☐ **Yes** ☐ **No**

9. Describe (in your own words) your pain:

____
____
____
____
____

10. What makes your pain worse?

- ☐ Coughing
- ☐ Sneezing
- ☐ Standing
- ☐ Walking
- ☐ Sitting
- ☐ Bending
- ☐ Eating
- ☐ Sexual Intercourse

11. What makes your pain better?

- ☐ Sleeping/Resting
- ☐ Relaxation
- ☐ Away from work
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Exercise
- ☐ Alcohol
- ☐ Nothing
- ☐ Heat Application
- ☐ Cold Application
- ☐ Medicine (List):__________________________
  ____
- ☐ Other:__________________________________

12. Please list all current medications:

____
____
____
____
____

13. What treatments have helped your pain in the past?

☐ Medical Procedure or Surgery: (Explain)

____
____
____
____

☐ Medicine: (List)

____
____
____
____

- ☐ Physical Therapy
- ☐ Visual Imagery or Biofeedback
- ☐ Psychotherapy
- ☐ Other:__________________________________

14. What other symptoms accompany your pain?

- ☐ Numbness
- ☐ Tingling with pins & needles
- ☐ Skin Changes
- ☐ Weakness
- ☐ Coldness
- ☐ Bowel Problems
- ☐ Bladder Problems
- ☐ Increased Sweating
- ☐ Muscle Spasms or tightness
- ☐ Other:__________________________________

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Intake Questionnaire

15. How does your pain affect the following:

Sleep ______
Appetite ______
Concentration ______
Physical Activity ______
Emotions ______
Family ______
Social Relationships ______
Sexual Activity ______
Work Activity ______

16. What do *you* think is causing your pain now?

______
______
______

17. Since your pain began, has it:

- ☐ Decreased
- ☐ Increased
- ☐ Remained the same

18. What is your goal in regards to your pain?

______
______
______

19. Have you been hospitalized for your pain?

☐ Yes
Explain ______
______
______

☐ No

20. Have you had any of the following tests to evaluate your pain?

- ☐ X-ray
- ☐ MRI
- ☐ CT Scan
- ☐ EMG
- ☐ Myelogram

21. What specific treatments/procedures have you had for the treatment of your present pain?

Date ______
Procedure ______
Physician ______
How long did relief last? ______

Date ______
Procedure ______
Physician ______
How long did relief last? ______

Date ______
Procedure ______
Physician ______
How long did relief last? ______

22. Do you smoke?

What? ______
How much? ______
☐ N/A

23. Alcohol consumption

- ☐ None
- ☐ Social Only
- ☐ 1-2 Drinks per Day
- ☐ 3 or more

24. Does your medication intake concern you?

☐ **Yes** ☐ **No**

25. Do you have legal action pending related to you pain?

Attorneys Name: ______
Phone number: ______

26. Please list the name and phone number of your insurance adjuster:

______

Northern California Pain Specialists

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HIPAA Privacy Rule – Written Acknowledgement of Privacy Practices Receipt
New Patient Consent to the Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations

I, ___________________________, understand that as part of my heath care, the Center originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that information serves as:

- A basis for planning my care and treatment
- A means of communication among the may health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing the consent,
- Right to object to the use of my health information for a directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment call a payment, or health care operations.

Understand that the center is not required to agree to the restriction requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance is thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164. 506 of the Code of Federal Regulation.

I further understand that the Center reserves the right to change their notice and practices and prior tom implementation, in accordance with Section 164.52 of the Code of Federal Regulations. Should the Center change their notice, they will send a copy of any revised notice to the address I have provided (whether U.S mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

____

____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

_______________________________ Patient Signature

_______________________________ Date

FOR CENTER USE ONLY

{ } Consent received by: ____ on ___________________________

{ } Consent refused by patient, and treatment refused as permitted.

Contract for Controlled Substance Prescriptions:

This contract is an agreement between the patient and doctor to help better facilitate the legal distribution of controlled substances for the relief of pain. I understand the treatment goal while using controlled substances is to improve mu ability to function work and to alleviate the anguish of pain. I realize that my pain may not be totally alleviated by the use of potent controlled substances medication:

- I am responsible for my controlled substance medication (Pain Medication)
- If the prescription or medication is lost, misplaced, or stolen or if it used up sooner than the duration prescribed, I understand that the **medication will not be replaced.**
- I will keep all medication in a secure place, where no one can have access to it (especially children)
- Pain medication may cause drowsiness, especially if taken with others today sedating drugs. I will not drink alcohol while taking any medication. I will use caution when taking other sedating drugs cover including over the counter non-prescription medications (antihistamine)
- I will use caution before driving a car or using hazardous equipment
- I will take all my medication **exactly** as prescribed. I will not increase or abruptly stop medication without
- discussion with my doctor. All narcotic medication will be taken on a scheduled basis. If my pain is relieved, I may gradually take less medications.
- I must report stolen medication to the police
- I will not request nor accept controlled substance medication from any other position for the purpose of controlling pain. The only exceptions are if it is prescribed when I am admitted to a hospital or referred to another physician specifically for treatment of my pain.
- Only **one physician** is to prescribe **all** narcotic type medication at any given time. I will receive all controlled substance medication from one pharmacy if possible
- If I notice signs of any allergic reaction or withdrawal, I notify my doctor by phone and make an appointment as soon as possible.
- When my prescription for controlled substances have been written, I must review the total amounts to be dispensed and make sure I will have enough until my next follow up appointment.
- I will not stockpile medication and will dispose of any expired medication.

Refills of controlled substance medication:

- Refills will be made only during regular office hours 9:00 to 5:00 Monday through Friday, in person during a scheduled office visit.
- Refills will not be made on holidays, Friday afternoons, weekends or at night.
- Phone in refills for controlled substances will not be made.
- I will call at least 24 hours ahead if I need assistance with a medication.
- Refills will not be made in an "emergency", such as on Friday afternoon.

I understand that if I violate any of the above conditions, that my controlled substance prescriptions and/or treatment may be terminated immediately. If the violation involves obtaining controlled substances another individual, I may also be reported to my primary physician, local medical facilities and other authorities.

I have been fully informed by my doctor about psychological dependence (addiction) potential of controlled substances. All narcotic drugs are habituating and create tolerance, which is the need to increase the dose of the medication to achieve the same effect of pain control over a time. If I am taking potent medication for several weeks, I know I will develop a tolerance. If narcotic medication is stopped abruptly, Physical symptoms of withdrawal will develop including the possibility of tremors, sweats, nausea and diarrhea. I must taper narcotic medication gradually and only under medical supervision or I may have withdrawal symptoms. Occasionally a short hospitalization maybe necessary in order to discontinue narcotic medication I agree to comply if asked to detoxify my system of narcotic medication to help in the evaluation of my pain

I have read above agreement and have had all questions answered concerning days of controlled medications in my pain treatment program.

"The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov."

______________________________	______________________
Patient Signature	Date
______________________________	______________________
Witness Signature	Date

Medical Records Release Authorization

Signature needed only

To: ______________________________

Address: ______________________________

City: ____________ **State:** ______ **Zip:** ________

Phone Number: ____________ **Fax Number:** ____________

Patient Name: ______________________________

Date of Birth: ________ **Age:** ______ **SSN#:** ________

Records Requested:

- ☐ All Medical Records from: ____________________
- ☐ Recent MRI and X-ray reports
- ☐ Recent Progress notes
- ☐ Evaluation

Please provide medical records on/before: ____________________

I hereby authorize you, the above addressed physician, hospital or medical facility to release medical records or the information listed above to:

Justin Lo, MD
Jonelon Tsang, MD
Tanzina Khan, MD

Please send or fax records to:
Northern California Pain Specialists
2101 Forest Avenue Suite. #220A
San Jose, CA 95128
Phone: (408) 295-8628 Fax: (408)295-8061

______________________ ______________
Patient Signature/Guardian Date

Patient/Guardian Name: ______________________________

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San Jose, CA 95128

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Patient Insurance Responsibility

I hereby acknowledge that I am fully aware that it is my responsibility as the patient to find out whether my insurance is contracted with the provider. I am aware that if my doctor is not contracted and does not accept my insurance plan I will be fully responsible for all the cost incurred from office visits and treatments done by the doctor. I agree to check with my insurance as to what kind of insurance plan I have and understand that it is it is my responsibility alone to confirm my insurance plan type. If I do see the doctor despite having a non-contracted insurance then I know I am fully responsible for all cost incurred from office visits and treatments. It is also my responsibility to report any changes of insurance, address, and phone numbers to the office staff.

____________________________________ ________________________

Patient Name (Printed) Date

____

Patient Signature

____

Witness Signature

Patients Name:____

Date:____

"The open payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals it can be found at https://openpaymentsdata.cms.gov"

"For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open payments web page is provided here. The federal Physician Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drug, medical devices, and biologics to physicians and teaching hospitals be made available to the public."

Disclosure of the financial relationships between industry and healthcare providers is not intended to signify an inappropriate relationship, an Open Payments does nothing to prohibit such transactions. Collaborations among the medical product industry, physicians, and NPPs, and teaching hospitals contribute to the design and delivery of life saving drugs, devices, biologicals, and medical supplies. However these relationships may also influence research, education, and clinical decision-making in ways that compromise clinical integrity and patient care and may potentially lead to increased healthcare costs. While disclosure alone is not sufficient to differentiate between the beneficial financial relationships and those that may create conflicts of interest, transparency will shed light on the nature and extent of the relationships that exist and discourage the development of inappropriate relationships.

NO Show Office Policy & Acknowledgment Form

Dear [Patient Name],

We are so sorry that you couldn't make it to the scheduled appointment. Our records also reflect that we had confirmed your appointment without canceling or rescheduling the appointment.

Our account team has let us know that we need to charge $25.00 for the missed appointment according to our office policy.

Under the current circumstances, we are forced with no option other than to levy the charges for the missed appointment. You will receive the bill for the missed work via postal mail to the address on file. Our goal is to provide you with the best healthcare service possible as a healthcare provider. We hope you understand why we had to take this decision.

By signing below I acknowledge that I have fully read and understand the office policy. I understand that if I have any questions or concerns about this policy, it is my responsibility to discuss this with the office.

DATE: ____

PATIENT NAME (PRINT): ______________________________

PATIENT SIGNATURE:__________________________________