Pacific Comprehensive Pain Management
REGISTRATION FORM

Today's Date: PCP:

PATIENT INFORMATION

Patient's last name: First: Middle: ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No If not, what is your legal name? (Former name): Birth date: Age: Sex: ☐ M ☐ F

Street address: Social Security no.: Home phone no.: ( )

P.O. box: City: State: ZIP Code:

Occupation: Employer: Employer phone no.: ( )

Chose clinic because/referred to clinic by (Please check one box): ☐ Dr. ☐ Insurance plan ☐ Hospital

☐ Family ☐ Friend ☐ Yellow Pages ☐ Other

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: Birth date: Address (if different): Home phone no.: ( )

Occupation: Employer: Employer address: Employer phone no.: ( )

Please indicate primary insurance: ☐ Medicare ☐ Aetna ☐ Blue Cross ☐ Blue Shield ☐ United HealthCare

☐ Cigna ☐ ILWU-PMA ☐ Worker's Compensation ☐ Tricare ☐ Other

Subscriber's name: Subscriber's S.S. no.: Birth date: Group no.: Policy no.: Co-payment: $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable): Subscriber's name: Group no.: Policy no.:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): Relationship to patient: Home phone no.: ( ) Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release an information required to process my claims.

Patient/Guardian Signature: **Date:**

MEDICATION LOG

Name Of Medication	Date Started	Dosage/ Dosage Times	Purpose	Prescribing Physician

HIPAA Policy/Consent

To our Valued Patients:

The Department of Health and Human Services has established a "Privacy Rule" to help insure that health care information is protected for privacy. The Privacy Rule was also created in order to provide a for health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payments or health care operations.

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

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to sign patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be 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 (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of you PHIE

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, to request restrictors and revoke consent in writing after you have reviewed our privacy notice.

We strive to achieve the very highest standards of ethics and integrity in performing services for our patients. Our policy is to listen to our patients and our employees. We welcome your input regarding any service problem so that we may the situation promptly.

Thank you for being one of our highly valued patients!

Signature: _____ Date: _____

Print Name: _____ Relationship to patient: _____

I am allowing the following persons to receive private health information about my health.

_____ _____

Signature: _____ Date: _____

3851 Katella Ave Suite 301 Los Alamitos CA 90720 PH (562) 799-3888, FAX (562) 799-3880

PACIFIC COMPREHENSIVE

PAIN MANAGEMENT

NO PAIN, MORE GAIN!

RECORDS RELEASE AUTHORITY

To:_____

_____

_____

I, _____ hereby request that you release to:

PACIFIC COMPREHENSIVE PAIN MANAGEMENT

STANLEY CHOU, M.D.
ROGER MOON, M.D.

3851 Katella Ave Suite 301
Los Alamitos CA 90720
PH (562) 799-3888
F (562) 799-3880

A report of my diagnosis, treatment, prognosis and recommendation, as well as other data pertinent to your treatment of me.

_____ _____

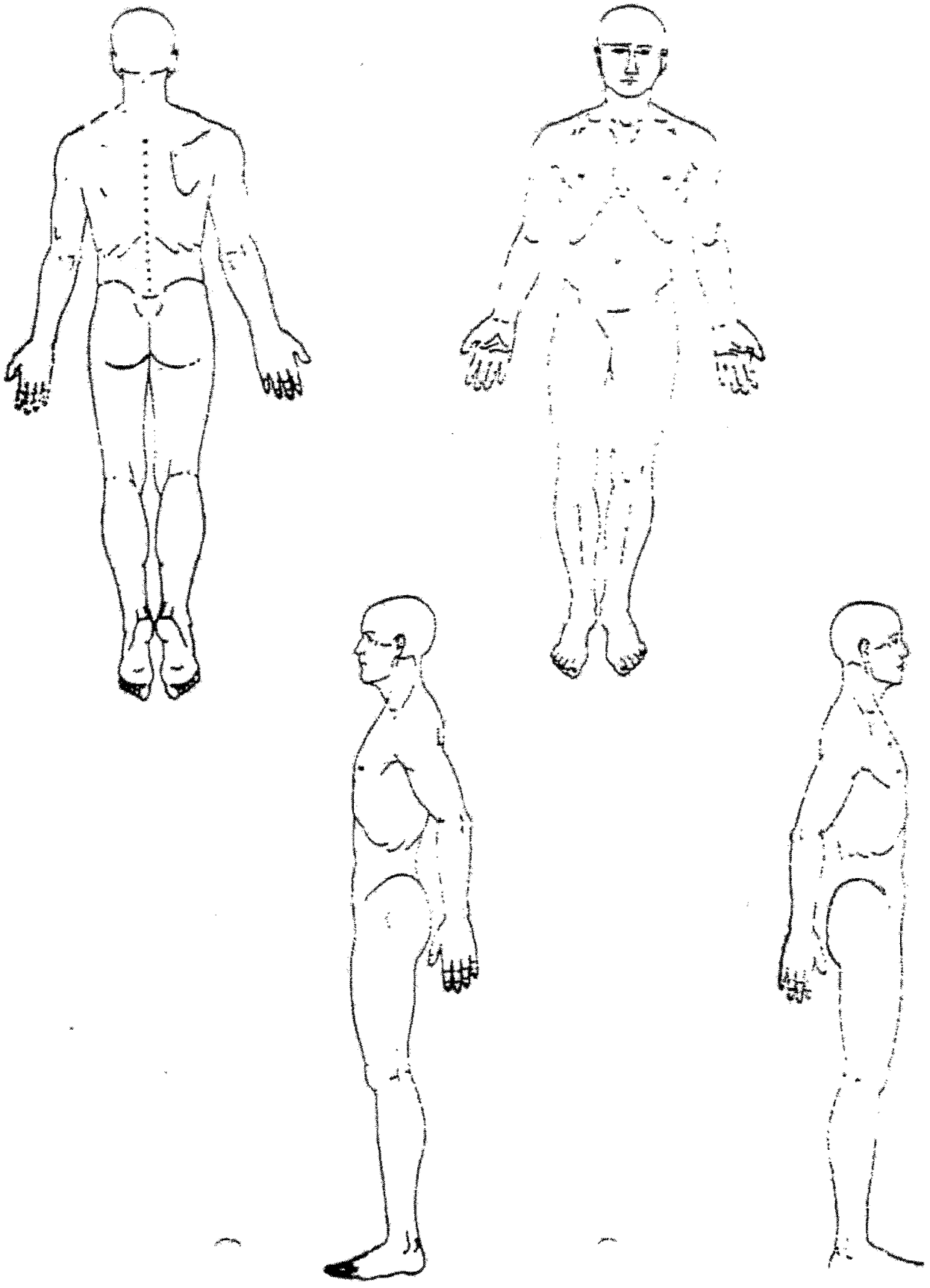
Patient Date of Birth | Signature of Patient, Guardian or personal Representative

_____ _____

Witness | Please PRINT name signed above

_____ _____

Date | Relationship to patient



AGREEMENT TO PAY

Thank you for choosing the Pacific Comprehensive Pain Management as your provider of services. The patient/responsible party does accept complete responsibility for payment.

- You are expected to pay all deductibles, co-pays, co-insurance amounts and non-covered services at time of service. We will bill your insurance for all covered services.
- You are responsible for payment in full if your insurance has not paid within 90 days of date of service. If your insurance makes a payment after that time, a refund will be sent to you. • You are responsible for payment in full if the claim is denied as a non-covered service, not medically necessary or if you did not obtain a referral or authorization as required by your insurance company.

☐ This is a self-pay (no insurance):

- You are expected to pay at the time of service, Any other financial arrangement must be set up with the billing specialist before services begin.

☐ Notice of Exclusion from Medicare Benefits (NEMB).

- Medicare does not pay for all health care costs, only for covered benefits.
- The following services are provided by Pacific Comprehensive Pain Management, but are excluded from Medicare benefits: Acupuncture
- This is only a general summary of exclusions from Medicare benefits. It is not a legal document and the official Medicare program provisions are contained in relevant laws, regulations and rulings.

☐ Senior Options/Aging Grant ' All co-payments any other non-covered charges are the responsibility of the patient.

Patients are responsible for notifying the Center immediately of any changes in their insurance policy and for obtaining insurance related referrals and/or authorizations.

I have read and understand the Pacific Comprehensive Pain Management policies as stated above. I understand that Pacific Comprehensive Pain Management cannot guarantee payment from insurance providers for services. Therefore, if my insurance provider denies payment, I agree to be fully responsible for payment.

Patient/Parent/Guardian Signature: Date:

Patient Name Printed: DOB:

We accept cash, personal check, VISA, MasterCard, and Discover & American Express. Pacific Comprehensive Pain Management reserves the right to discontinue services for nonpayment of fees

Medication Refill Policy

1. Request for medication refills of medication may take 48-72 hours for a response to the request

Plan Ahead

2. You should contact PCPM three (3) days before your medication is due to run out. IF you use mail order company, please contact PCPM fourteen (14) days before your medication is to run out. Message should be left for the staff.

3. If may take 2-3 business days to refill your prescription. We must review your medical records, check for expiration dates, verify the number of refills and ensure eligibility. Once the necessary information has been researched, it is presented to the doctor for final authorization. Certain medications require laboratory testing before they can be refilled and you might need to see the doctor before we can authorize a refill.

4. Refill request may also be made through your pharmacy. The pharmacy will forward the necessary information to our office to begin the research process.

5. We utilize strict control for medication containing opioids. Some opioids cannot be called into the pharmacy for refills. The patient must be seen in the office for those non-refillable pain medications to be refilled. Patient's taking opioids medication cannot have the medication refilled until the current prescription is fully expired.

6. Refills on medication can only be authorized on medications prescribed my physician on our office. We will not refill medications prescribed my other physicians.

7. If a patient has not been evaluated in one (1) or more months, a follow up visit will be needed to verify medication needs.

8. Refills will be handled **ONLY** during our regular clinic hours, Monday through Friday 8AM to 4PM. We cannot refill medication after hours or on weekends.

X _____ _____

Patient signature Date

Roger S. Moon, M.D.
Board Certified Anesthesiologist
Interventional Pain Management Specialist
Stanley Chou, M.D., F.A.C.P.M.
Diplomate, American Board of Anesthesiology
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Pain Treatment with Opioid Medications: Patient Agreement*

I, _____, understand and voluntarily agree that

(initial each statement after reviewing):

_____ I will keep (and be on time for) all my scheduled appointments with the doctor and other members of the treatment team.

_____ I will participate in all other types of treatment that I am asked to participate in.

_____ I will keep the medicine safe, secure, and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment and may not be replaced at all.

_____ I will take my medication as instructed and not change the way I take it without first talking to the doctor or other member of the treatment team.

_____ I will not call between appointments, at night or the weekends for refills. I understand that prescriptions will be filled only during scheduled office visits with the treatment team.

_____ I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.

_____ I will always treat the staff at the office respectfully. I understand that if I am disrespectful to the staff or disrupt the care of other patients, my treatment will be stopped.

_____ I will sign a release form to let the doctor speak to all other or providers that I see.

_____ I will use only one pharmacy to get all my medicine: _____

Pharmacy name/Phone #

_____ I will not get any opioid medicine or other medicine that can be addictive such as benzodiazepines klonopin, Xanax, valium) or stimulants (Ritalin, amphetamine) without telling a member of the treatment team before I fill prescription. I understand that the only exception to this is if I need pain medicine for an emergency of the evening during the weekends.

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_____I will not use illegal drugs such as heroin, cocaine, THC marijuana, or amphetamines. I understand that if I do, my treatment will be stopped.

_____I will come in for drug testing and counting of my pills within 24 hours of being called. I understand that I must make sure the office has my current contact information in order to reach me. Any missed test will be considered positive for my illegal drugs.

_____I will keep up to date with any bills from the office and tell the doctor or member of the treatment team immediately if I lose my insurance or can't pay for treatment.

_____ I understand that I may lose my right to treatment. If I break any part of this agreement.

PAIN TREATMENT PROGRAM STATEMENT

We here at Pacific Comprehensive Pain Management 3851 Katella Ave # 301 Los Alamitos, CA 90720

We will help you schedule regular appointments for medicine refills. If we must cancel or charge your appointment for any reason, you have enough medication to last until your next appointment.

We will make sure that this treatment is as safe as possible. We will check regularly to make sure you are not having side effects.

We will keep track of your prescriptions and test for appropriate drug usage.

We will help connect you with other forms of treatment to help you with your condition. We will help set treatment goals and monitor your progress in achieving those goals.

We will work with any other doctors or providers so that they can treat you safely and effectively.

If you become addicted to these medications, we will help you get treatment to safely wean from the medication.

_____	_____	_____
PATIENT SIGNATURE	PATIENT NAME PRINT	DATE
_____	_____	_____
PROVIDER SIGNATURE	PROVIDER NAME PRINT	DATE

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PATIENT AGREMENT FORM

Patient Name:

Medical Records Number:

AGREEMENT FOR LONG TERM CONTROLLED SUBSTANCE PRESCRIPTIONS

The use of _____ (print names of medication(s)) may cause addiction and is only one part of the treatment for:_____ (print name of condition-e.g., pain. Anxiety etc.) as much as possible without causing dangerous side effects.

The goals of this medicines are:

- **To improve my ability to work and function at home.**
- **To help my_____(print name of condition--e.g., pain. Anxiety etc.) as much possible without causing dangerous side effects.**

I have been told that:

1. **If I drink alcohol or use street drugs, I may not be able to think Cleary and I could become injured.**
2. **I may get addicted to this medicine.**
3. **If I or anyone in my family has a history of drug of alcohol problems, there is a higher chance of addiction.**
4. **If I need to stop this medicine, I must do it slowly or I may get very sick.**

I agree to the following:

- **I am responsible for my medicine. I will not share, sell, or trade my medicine. I will not take anyone else's medicine.**
- **I will not increase my medicine until I speak with my doctor or nurse.**
- **My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.**
- **I will keep all appointments set up by my doctor e.g., primary care, physical therapy, mental health, substance abuse treatment, pain management)**
- **I will bring the pill bottles with any remaining pills of my medicine to my clinic visits.**
- **I agree to give a blood or urine sample, if asked, to test for proper drug utilization.**

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REFILLS

Refills will be made only during regular office hours- Monday- Friday, 8:00 Am-4:30 PM.

No refills on nights, holidays, or weekends. I must call at least three (3) working days ahead (M-F) to ask for a refill of my medicine. No exceptions will be made.

I must keep track of my medications. No early or emergency refills may be made.

PHARMACY

I will only one pharmacy to get my medicine. My doctor may talk to the pharmacist about my medicines.

The name of my pharmacy is _____.

PRESCRIPTIONS FROM OTHER DOCTORS

If I see another doctor who gives me a controlled substance medicine (for example a dentist, a doctor from the emergency room or another hospital, etc.) I must bring this medicine to primary care in the original bottle, even if there are no pills left.

PRIVACY

While I am taking this medicine, my doctor may need to contact other doctors or family members to get information about my care and/or use of this medicine. I will be asked to sign a release form at this time.

TERMINATION OF AGREEMENT

If I break any of the rules, or if my doctor decides that this medicine is hurting me more than helping me, this medicine may be stopped by my doctor in a safe way.

I have spoken about this agreement with my doctor and I understand the above rules.

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PROVIDERS RESPONSIBLITIES

As your doctor, I agree to perform regular checks to see how well the medicine is working.

_____ _____

Patient signature DATE

_____

Attending Physician's signature

- This document has been discussed with and signed by the physicians and patient. (A signed copy stamped with patient card should be sent to the medical records department and a copy given to the patient.)