PACIFIC COMPREHENSIVE PAIN MANAGEMENT

REGISTRATION FORM

(Please Print)

Today's date: | PCP:

PATIENT INFORMATION

Patient's last name: | First: | Middle: | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | Marital status (circle one) 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 ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card and photo ID to the receptionist.)

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

Is this person a patient here? ❑ Yes ❑ No

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

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance]

❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ Welfare *(Please provide coupon)* ❑ 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.:

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

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 any information required to process my claims.

Patient/Guardian signature *Date*

Pacific Comprehensive Pain Management

FORMA DE REGISTRO DE PACIENTE NUEVO

Favor de usar letras de molde

Fecha:

PATIENT INFORMATION

Apellido:	Primer nombre:	Seg. Nom:	❑ Sr. ❑ Sra.	❑ Miss ❑ Ms.	Estado Civil Solo / Casa / Div / Sep / Wid

Es nombre legal? ❑ Si ❑ No	Si no, cual es to nombre legal?	(Nombre formal):	Fecha de Naciemnto: / /	Edad:	Sex: ❑ M ❑ F

Direccion:	No. de seguro social:	Telefono de casa: ( )

P.O. box:	Cuidad:	Estado:	Codigo Postal:

Ocupacion:	Empleado:	Telefono (Trabajo): ( )

Como escucho de nuestra oficina:	❑ Dr.	❑ Inseguranca	❑ Hospital

❑ Familia ❑ Amigo ❑ Cerca de trabajo/casa ❑ Yellow Pages ❑ Otra

INFORMACION DE SEGURO MEDICO

(POR FAVOR DEJA SU TARJECTA DE SEGURANZA CON LA RECEPCIONISTA)

Persona responable de bill: / /	Nacimento:	Direccion:	Telefono de casa.: ( )

Esta persona esta aqui? ❑ Si ❑ No

Ocupacion:	Empleado:	Direccion de empleado:	Telefono de empleado.: ( )

Paciente tiene seguranza? ❑ Si ❑ No

Indica su primer seguranza	❑ Medicare	❑ Aetna	❑ Blue Cross	❑ Blue Shield	❑ United Health Care

❑ Cigna ❑ ILWU-PMA ❑ Workers Comp ❑ Other

Nombre de suscriber:	Subscriber's seguro social.:	Nacimento: / /	No. Grupo:	Policy no.:	Co-Pago: $

Relacion de paciente a suscriber: ❑ Auto ❑ Esposo/a ❑ Nino(a) ❑ Otra

Segundo medico:	Nombre de suscriber:	No. Grupo:	No. Politica

Relacion de paciente a suscriber: ❑ Auto ❑ Esposo/a ❑ Nino(a) ❑ Otra

INFORMACION DE EMERGENCIA

Persona a quien llamar en caso de emergencia	Parentesco:	Telefono Casa ( )	Celular: ( )

Los pacientes que llevan seguro medico estandar deben recorder que los servicios profesionales esta rendidos y cargados al paciente y no a la compania de seguros. Se espera que todos los pacientes con seguro estandar hangan el pago cuando los servicios se rinden, sin importar el seguro pendiente, pleito, el etc. Los pacientes con planes de salud de contrato deben presenter su trajeta de identificacion de seguro a la recepcionista despues de llenar esta formulario. Algunos planes requieren una cuota a la hora de servicio. Algunos de los planes de contrato requieren que la demanda sea sometida por nuestra oficina

Firma de paciente o guardian *Fecha*

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.
10861 Cherry Street, Suite 308
Los Angeles, CA 90720
(562) 799-3888 ~(562) 799-3880 fax

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

_____ X_____
Patient Date of Birth — Signature of Patient, Guardian or personal Representative

_____ _____
Witness — Please PRINT name signed above

_____ _____
Date — Relationship to patient

HIPAA Policy/Consent

To our Valued Patients:

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care 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 strive to always take reasonable precautions to protect 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 care 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 obtain 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 PHI.

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 restrictions 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 remedy the situation promptly.

Thank you for being one of our highly valued patients!

Signature: _____ Date: _____

Printed name: _____ Relationship to patient: _____

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

_____ _____ _____

Signature: _____ Date: _____

10861 Cherry Street, Su 308 Los Alamitos, CA 90720 (562) . .9-3888 fax (562) 799-3880

PACIFIC COMPREHENSIVE
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Opiate Contract Pain Management Agreement

The purpose of this agreement is to prevent misunderstandings about certain medications you will be taking for pain management. This is to help you and your doctor to comply with the law regarding controlled pharmaceuticals.

_____ I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement.

_____ I understand that if I break this Agreement, my doctor will stop prescribing these pain control medicines.

_____ In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

_____ I would also be amenable to seek psychiatric treatment, psychotherapy, and/or psychological treatment if my doctor deems necessary.

_____ I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

_____ I will not use any illegal controlled substances, including marijuana, cocaine, etc., nor will I misuse or self-prescribe/medicate with legal controlled substances. Use of alcohol will be limited to time when I am not driving, operating machinery and will be infrequent.

_____ I will not share my medication with anyone.

_____ I will not attempt to obtain any controlled medications, including opiod pain medications, controlled stimulants, or anti-anxiety medications from any other doctor.

_____ I will safeguard my pain medication from loss or theft. Lost or stolen medications will **not** be replaced.

_____ I agree that refills of my prescriptions for pain medications will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends or over the phone.

I agree to use: _____ [Name of Pharmacy] Tel. number: _____

Located at: _____.

10861 Cherry Street, S. 308 Los Alamitos, CA 90720 (562) 799-3888 fax (562) 799-3880

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for filling my prescriptions for all of my pain medicine.

_____ I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize my doctor to provide a copy of this Agreement to my pharmacy, primary care physician and local emergency room. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

_____ I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medications.

_____ I agree that I will use my medicine at a rate no greater that the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

_____ I will bring unused pain medicine to every office visit.

_____ I agree to follow these guidelines that have been fully explained to me.

All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This Agreement is entered into on this _____ day of _____, 20____.

Patient signature: _____Print Name:_____

Physician signature:_____

Witnessed by: _____

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 non-payment of fees.

Medication Log

Name							Date		
Name of Medication	Date Started	Date Stopped	Dosage, Dosage Times	Special Instructions	Purpose	Prescribing Physician	Physician Phone Number	Side Effects?	Pharmacy Phone Number