San Diego Pain Consultants

Shafi Khalid, MD, FIPP

New Patient Information

Welcome To Our Office

Patient's Name (Please Print)	S.S.#	Marital Status	Sex	Birth Date	Age

Street Address	City and State	Zip Code	Home Phone #

Patient's Or Parent's Employer	Occupation (Indicate If Student)	How Long Employed

Employer's Street Address	City and State	Zip Code

Drug Allergies If Any

Nearest Friend or Relative Not Living With You

In Case of Emergency Notify: ______________________ Phone #: ______________

How Did You First Hear Of San Diego Pain Consultants?

- ☐ Seminar
- ☐ Direct Mail
- ☐ Doctor
- ☐ Phone Book
- ☐ Fiend/Family
- ☐ Radio
- ☐ Television
- ☐ Billboard
- ☐ Newspaper
- ☐ Website
- ☐ Other: ________

Person Responsible for payment	Street Address, City, State	Zip Code

Insurance Information	Effective Date	ID #	Group #
Other Insurance	Effective Date	ID #	Group #
Other Insurance	Effective Date	ID #	Group #

Referred By	Street Address, City, State	Zip Code	Phone #

The insurance information furnished here represents a full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose precertification/second opinion requirements for any and all plans to which I subscribe, may cause me to incur full liability for professional charges, as a result of non-payment by any carrier.

Patient Signature: ______________________ Date: ______________

San Diego Pain Consultants Shafi Khalid, MD, FIPP

CONSENT TO DISCLOSE ACCOUNT INFORMATION

According to State and Federal confidentiality laws, we cannot disclose any information about you to any other person without your consent. This includes other family members, unless you are less than 18 years old or under certain legal circumstances.

I understand that "information" includes activities involved in determining my eligibility for health plan coverage, billing and receiving payment from myself and from my health insurance plan, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.
I authorize this medical provider to disclose details of my account and my care to the following person(s) to ensure that payment is received for the services rendered to me.

[ ] *Please check here if you do not wish anyone else to have access to your financial information.*

Name	Date Of Birth	Relationship To Patient
Name	Date of Birth	Relationship To Patient

OTHER PHYSICIAN INFORMATION

(Only IF there is another physician with whom we should coordinate care)

Physician Name
Physician Address
May we contact your physician so that this provider may be fully informed and we may coordinate your treatment? ☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION

Emergency Contact Person		Relationship to Patient
Home Phone ( )	Work Phone ( )	Cell Phone ( )

POLICY STATEMENT

Thank you for choosing our office for your medical needs. We are committed to your treatment being successful. Please understand that payment of your services is considered part of your treatment. The following sets forth the terms and condition upon which our services are rendered.

CONSENT OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS: I hereby consent to the use or disclosure of my protected health information by San Diego Pain Consultants for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis and treatment of me is conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment payment or health care operations of this medical practice. San Diego Pain Consultants is not required to agree to the restrictions that I may request. However, if this office agrees to any restriction that I request, then this restriction is then binding. I have the right to revoke this consent, in writing, at any time, except to the extent that San Diego Pain Consultants has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected form me and created received by this provider, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical health, mental health or condition, and identifies me, or if there is a reasonable basis to believe the information may identify me.

I understand I have a right to review San Diego Pain Consultants, INC's Note of Privacy Practices prior to signing this document. This Notice of Privacy Practices is posted in the waiting room, or a copy is available upon my request. The Notice of Privacy Practices describes the types of uses and disclosure of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations. This Notice of Privacy Practices also describes my right and the duties with respect to my protected health information. I understand that this medical office reserves the right to change my privacy practices that are described in the notice of Privacy. I may obtain a revised notice of privacy practices by requesting it in writing, either by mail or at my next appointment, and a revised copy be sent in the mail or will be provided to me at the time of my next appointment.

CONFIDENTIALITY: Professional ethics and California state law specifies that communications to medical staff are confidential and privileged, and cannot be released or shared without the express written permission of the patient, except as noted above. However, there exist a few instances that are mandated by law to report certain information. These include, but are not limited to, abuse of minor, or if you express the intent of bringing harm to yourself or another person. In such circumstances, the provider is required to inform potential victim(s) and legal authorities.

PAYMENT OF FEES: Payment for services is the patient's responsibility (or parent/guarding, if patient is a minor). I agree to pay my share of the charges, such as co-payment and deductible amounts at the time of each visit. The charge for each appointment depends upon the time I spend with the physician and the type of visit for which I am seen. I understand that San Diego Pain Consultants' fees are within the usual and customary rates for medical services in the San Diego area. For specific dollar amounts, please ask the office staff. Please note that this office charges a $25 services fee for all returned checks.

INSURANCE: This office will submit your insurance claims to your carrier, at no cost to you. However, we are not in a position to guarantee payment from your insurance company since the claim is based upon arrangements between you and the insurer. Please be aware that it is common for insurance companies to subcontract certain benefits to another company. In these instances, we may not bill your insurance company; we may be required to bill your medical group or a third party payer. I understand it is my responsibility to know if this is true.

PRIOR AUTHORIZATION: Prior authorization may be required before your first visit. Please be aware that it is your responsibility to know if this is true to your insurance coverage(s), and to get the necessary authorization(s).

APPOINTMENTS: Your appointment time has been reserved exclusively for you. I agree that If I fail to cancel my appointment with at least 24 hours advance notice I may be billed for the full fee at the discretion of San Diego Pain Consultants. I understand that insurance companies do not cover missed appointments.

MEDICAL RECORDS: I understand that San Diego Pain Consultants, INC will retain my medical records for seven years as per legal requirements. Copies of records can be transferred to other healthcare provides upon receipt of a valid written consent. I understand that this office requires at least 72 hours' notice prior to medical records being made available to the authorized party.

San Diego Pain Consultants Shafi Khalid, MD, FIPP

MEDICATIONS: I understand that medication refills will be considered during office hours only. This is so this office can conform with California Pharmacy statutes, and to prevent the possibility of other person from acting, or posing as patients of San Diego Pain Consultants, or obtaining medication illegally. I further understand that if I should need to have a prescription refilled that I should contact my pharmacy at least 1-2 days prior to needing the medication or the medication may not be available to me the same day. I understand refills for any medication will not be performed unless I have been seen within the last six (6) months.

AGREEMENTS: I have reviewed the preceding information and I certify that this information is accurate. I further understand that I am responsible for any financial loss due to incomplete or inaccurate information provided by me. I hereby authorize payment directly to my medical provider any insurance benefits that would otherwise be payable to me for services rendered. In instances where insurance does not pay any benefits, I agree to pay for those services. If payment is not received within 90-days form the date the claim was submitted, I agree that I will become responsible for the full amount of the balance on my account.

Should I break the financial arrangements as detailed above, I agree that my name may be released for collection purposes. I understand that no treatment related information will accompany this disclosure. I also agree that if any legal action is taken to enforce the provisions of the Policy Statement that the prevailing party shall be entitled to reasonable attorney's fees and costs.

☐ **I have read this Policy Statement and agree to the terms and stated:**

______________________ ______________________ ______________________

Patient's Name Signature Date

______________________ [ ]

Responsible Party (Sig) Initial here if you would like a copy of this policy statement

San Diego Pain Consultants Shafi Khalid, MD, FIPP

SF-36 Questionnaire

Name: ______________ Ref. Dr.: ______________ Date: ______________

Age: ______________ Gender: M / F

GENERAL HEALTH:

1. In general, would you say your health is:
   - ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. Compared to one year ago, how would you rate your health in general now?
   - ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

LIMITATIONS OF ACTIVITIES:

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

3. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports.
   - ☐ Yes, limited a lot ☐ Yes, limited a little ☐ No, not limited at all
   - ☐

4. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf
   - ☐ Yes, limited a lot ☐ Yes, limited a little ☐ No, not limited at all

5. Lifting or carrying groceries
   - ☐ Yes, limited a lot ☐ Yes, limited a little ☐ No, not limited at all

6. Climbing several flights of stairs
   - ☐ Yes, limited a lot ☐ Yes, limited a little ☐ No, not limited at all

7. Climbing one flight of stairs
   - ☐ Yes, limited a lot ☐ Yes, limited a little ☐ No, not limited at all

8. Bending, kneeling, or stooping
   - ☐ Yes, limited a lot ☐ Yes, limited a little ☐ No, not limited at all

9. Walking more than a mile
   - ☐ Yes, limited a lot ☐ Yes, limited a little ☐ No, not limited at all

10. Walking several blocks
    - ☐ Yes, limited a lot ☐ Yes, limited a little ☐ No, not limited at all

11. Walking one block
    - ☐ Yes, limited a lot ☐ Yes, limited a little ☐ No, not limited at all

12. Bating or dressing yourself
    - ☐ Yes, limited a lot ☐ Yes, limited a little ☐ No, not limited at all

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PHYSICAL HEALTH PROBLEMS:

During the past 4 weeks, you have had any of the following problems with your work or other regular daily activities as a result of your physical health?

13. Cut down the amount of time you spent on work or other activities
    - ☐ Yes ☐ No
14. Accomplished less than you would like
    - ☐ Yes ☐ No
15. Were limited in the kind of work or other activities
    - ☐ Yes ☐ No
16. Had difficulty performing the work or other activities (for example, it took extra effort)
    - ☐ Yes ☐ No

EMOTIONAL HEALTH PROBLEMS:

During the past 4 weeks, have you had any of the following problems with your work or other or other daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

17. Cut down the amount of time you spent on work or other activities
    - ☐ Yes ☐ No
18. Accomplished less than you would like
    - ☐ Yes ☐ No
19. Didn't do work or other activities as carefully as usual
    - ☐ Yes ☐ No

SOCIAL ACTIVITIES:

20. Emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?
    - ☐ None ☐ Slightly ☐ Moderately ☐ Severe ☐ Very Severe

PAIN:

21. How much bodily pain have you had during the past 4 weeks?
    - ☐ None ☐ Slightly ☐ Moderately ☐ Severe ☐ Very Severe
22. During the past 4 weeks, how much did pain interfere with your normal work?
    - ☐ None ☐ Slightly ☐ Moderately ☐ Severe ☐ Very Severe

ENERGY AND EMOTIONS:

These questions are about how you feel and how things have been with you during the last 4 weeks. For each question, please give the answer that comes closest to the way you have been feeling.

23. Did you feel full of pep?
- ☐ All the time
- ☐ Most of the time
- ☐ A good bit of the time
- ☐ Some of the time
- ☐ A little bit of the time
- ☐ None of the time

24. Have you been a very nervous person?
- ☐ All the time
- ☐ Most of the time
- ☐ A good bit of the time
- ☐ Some of the time
- ☐ A little bit of the time
- ☐ None of the time

25. Have you felt so down in the dumps that nothing could cheer you up?
- ☐ All the time
- ☐ Most of the time
- ☐ A good bit of the time
- ☐ Some of the time
- ☐ A little bit of the time
- ☐ None of the time

26. Have you felt calm and peaceful?
- ☐ All the time
- ☐ Most of the time
- ☐ A good bit of the time
- ☐ Some of the time
- ☐ A little bit of the time
- ☐ None of the time

27. Did you have a lot of energy?
- ☐ All the time
- ☐ Most of the time
- ☐ A good bit of the time
- ☐ Some of the time
- ☐ A little bit of the time
- ☐ None of the time

28. Have you felt downhearted and blue?

- ☐ All the time
- ☐ Most of the time
- ☐ A good bit of the time
- ☐ Some of the time
- ☐ A little bit of the time
- ☐ None of the time

29. Did you feel worn out?

- ☐ All the time
- ☐ Most of the time
- ☐ A good bit of the time
- ☐ Some of the time
- ☐ A little bit of the time
- ☐ None of the time

30. Have you been a happy person?

- ☐ All the time
- ☐ Most of the time
- ☐ A good bit of the time
- ☐ Some of the time
- ☐ A little bit of the time
- ☐ None of the time

31. Did you feel tired?

- ☐ All the time
- ☐ Most of the time
- ☐ A good bit of the time
- ☐ Some of the time
- ☐ A little bit of the time
- ☐ None of the time

SOCIAL ACTIVITIES:

32. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

- ☐ All the time
- ☐ Most of the time
- ☐ A good bit of the time
- ☐ Some of the time
- ☐ A little bit of the time
- ☐ None of the time

GENERAL HEALTH:

How true or false is each of the following statements for you?

33. I seem to get sick a little easier than other people

☐ Definitely True ☐ Mostly True ☐ Don't Know ☐ Mostly False ☐ Definitely False

34. I am as healthy as anybody I know

☐ Definitely True ☐ Mostly True ☐ Don't Know ☐ Mostly False ☐ Definitely False

35. I expect my health to get worse

☐ Definitely True ☐ Mostly True ☐ Don't Know ☐ Mostly False ☐ Definitely False

36. My health is excellent

☐ Definitely True ☐ Mostly True ☐ Don't Know ☐ Mostly False ☐ Definitely False

San Diego Pain Consultants

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PATIENT PAIN MEDICATION AGREEMENT AND CONSENT

This agreement is important for you:

- *You will have a safe and controlled pain treatment plan.*
- *Your medicines have a high potential for abuse. They can be dangerous if used in the wrong way. You need to understand the risks that come from use of pain medicines.*

Please read and make sure you understand each statement here. Here are rules about refills and health risks. Here are also reasons for stopping your pain control treatment.

I WILL:

- ☐ I will only get my pain medicine from this clinic during scheduled appointments.
- ☐ I will take my pain medicine the way that my healthcare provider has ordered.
- ☐ I will be honest with all my healthcare providers if I am using street drugs.
- ☐ I will be honest about all the medicine I use. This includes medicine from stores and herbal medicines.
- ☐ I will be honest about my full health history.
- ☐ I will tell my healthcare provider if I go to an emergency room for any reasons.
- ☐ If I get pain medicine from an emergency room, I will tell my healthcare provider.
- ☐ I will call this office if I am prescribed any new medicine.
- ☐ I will call this office if I have a reaction to any medicine.
- ☐ I will tell all other healthcare providers that I have a pain medication agreement.
- ☐ I will tell the emergency room people that I have a pain medication agreement.
- ☐ I will take drug tests and other tests when I am told to do so.
- ☐ I will go to office visits when I am told to do so.
- ☐ I will go to physical therapy when I am told to do so.
- ☐ I will go to counseling when I am told to do so.
- ☐ I will follow directions for all treatment.
- ☐ I will show up on time for all appointments.
- ☐ I will make an appointment for refills before I run out of medicine.
- ☐ I will tell my health provider if I will be out of town so that I can get my refills.
- ☐ I will get past health records from other offices when needed.
- ☐ I will deliver these records by hand if needed. I will do this within one month of being asked. I will pay for these records if needed.
- ☐ I will give permission to this clinic to talk about my treatment with pharmacies, doctors, nurses, and others who are helping me.
- ☐ I will give permission to any healthcare provider to get information from this clinic about my health and my pain treatment.
- ☐ I will take responsibility if I overdose myself accidentally or on purpose.
- ☐ I will tell my healthcare provider if I plan to become pregnant.
- ☐ I will tell my healthcare provider if I am pregnant while I am taking pain medicine.
- ☐ I will only take this medicine the way I was told to take it.

CONTINUED ON NEXT PAGE

I WILL NOT:

- ☐ I will not share or sell, or trade any of my medicine.
- ☐ I will not drink alcohol or take street drugs while I am taking pain medicine.
- ☐ I know that I cannot call the office to have my medicine refilled over the phone.
- ☐ I will not go to the emergency room or other doctors for more pain medicine or other drugs.
- ☐ I know that when I drive a car, I must be fully alert. I know that when I use machines, I must also be fully alert. Pain medicines can make me less alert. When I am taking pain medicines, I need to be sure that I am alert. I need to be sure that it is safe for me to drive a car or use a machine.
- ☐ I will not stand in high places or do anything to hurt others after I have taken pain medicine.
- ☐ I will not leave my medicine where it can be stolen or where others can take it.
- ☐ I will not leave my medicine where children can find it.
- ☐ I will not suddenly stop taking my medicine. I know that if I do this, I can have withdrawals.

WHEN USING A PHARMACY, I WILL:

- ☐ I will use the same pharmacy for all my medicines. This is the pharmacy that I have picked: ______________________________
- ☐ I will not ask for early refills or more pain medicine, even if I lose my medicine.

I KNOW THAT

- ☐ Pain management may include other treatment. Some treatment may not include medicine.
- ☐ Pain medicine will probably not get rid of all of my pain. Pain medicine can reduce my pain so that I can do more and have a better life.
- ☐ Part of my treatment is to reduce my need for pain medicine.
- ☐ If the pain medicines work, I will continue to use them. If the pain medicine does not help me, it will be stopped.
- ☐ My medicines will not be replaced if any of these things happen: Medicine is lost. Medicine gets wet. Medicine is destroyed
- ☐ If my medicine is stolen, I might be able to get more medicine if I get a report from the police about the medicine being stolen.
- ☐ Any of my healthcare providers can find out from the California Prescription Drug Monitoring Program about any other medicines I get from any other pharmacy in California. This is called a CURES report.
- ☐ My healthcare provider may contact the drug enforcement agency, if I try to get other doctors to give me pain medicine.
- ☐ Healthcare providers may contact the drug enforcement agency if I am not honest about how I take pain medicine.
- ☐ My doctor and my clinic will help with any investigation if I am suspected of prescription drug abuse.
- ☐ I may be sent somewhere else for drug abuse or addiction help if I need it.
- ☐ Pain medicine can be addictive. This means that my body may need more and more pain medicine or that it can be hard for me to stop taking this medicine.
- ☐ If I suddenly stop using the medicine, I can get withdrawals.
- ☐ If I use too much pain medicine, I can end up with health problems. I could die.
- ☐ If I mix medicines, I could also end up with health problems. I could die.
- ☐ Here are some things that could go wrong if I use too much medicine or mix medicines:

Overdose	Addiction	Constipation	Vomiting	Sleepiness
Slower reflexes	Nausea	Difficulty with urination	Confusion	Itching
Problems with sex	Dry mouth	Depression	Trouble breathing	Death

CAUSE FOR DISMISSAL FROM THIS CLINIC

- ☐ I know that the pain medicines may be stopped if I break any part of this contract.

My signature below means that I have read this contract. I am signing this to say that I understand all of this contract.

Patient Name ______________________ Doctor Name ______________________

Patient Signature ______________________ Doctor Signature ______________________

Date: ______________________

San Diego Pain Consultants Shafi Khalid, MD, FIPP

Medicare and other insurance carriers ask us to help identify patients that may be at risk for falls.

Please circle all that apply.

Balance/fall assessment self-test

1. Have you fallen in the past year?

Yes No

2. Do you feel dizzy or off balance if you make a sudden change in movement, such as bending over, standing up or quickly turning? (Bed, toilet, stairs)

Yes No

3. Do you have any migraines, hearing loss or ringing in your ears?

Yes No

4. Do you avoid certain activities for fear of falling?

Yes No

5. Do you have balance problems when you are walking or climbing stairs?

Yes No

Name: ____________________

Signature: ____________________

Date: ____________________

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Patient Name: ___________________

Date: ____________________

DRUG ABUSE SCREENING TEST (DAST)

1. Have you used drugs other than those required for medical reasons? ( )Yes ( )No
2. Have you misused prescription drugs? ( )Yes ( )No
3. Do you misuse more than one drug at a time? ( )Yes ( )No
4. Can you get through the week without using drugs (other than those required for medical reasons)? ( )Yes ( )No
5. Are you always able to stop using drugs when you want to? ( )Yes ( )No
6. Do you misuse drugs on a continuous basis? ( )Yes ( )No
7. Do you try to limit your drug use to certain situations? ( )Yes ( )No
8. Have you had "blackouts" or "flashbacks" as a result of drug use? ( )Yes ( )No
9. Do you ever feel bad about your drug misuse? ( )Yes ( )No
10. Does your family ever complain about your involvement with drugs? ( )Yes ( )No
11. Do your friends or relatives know or suspect you misuse drugs? ( )Yes ( )No
12. Has Drug misuse ever created problems between you and your spouse? ( )Yes ( )No
13. Has any family member ever sought help for problem related to your drug use? ( )Yes ( )No

Have you ever?

14. Lost friends because of your use of drugs? ( )Yes ( )No
15. Neglected your family or missed work because of your use of drugs? ( )Yes ( )No
16. Been in trouble at work because of drug misuse? ( )Yes ( )No
17. Lost a job because of drug misuse? ( )Yes ( )No
18. Gotten into fights when under the influence of drugs? ( )Yes ( )No
19. Been arrested because of unusual behavior while under the influence of drugs? ( )Yes ( )No
20. Been arrested for driving while under the influence of drugs? ( )Yes ( )No
21. Engaged in illegal activities to obtain drugs? ( )Yes ( )No
22. Been arrested for possession of illegal drugs? ( )Yes ( )No
23. Experienced withdrawal symptoms as a result of heavy drug intake? ( )Yes ( )No
24. Had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, or bleeding)? ( )Yes ( )No
25. Gone to anyone for help for a drug problem ( )Yes ( )No
26. Been in hospital for medical problem related to your drug use? ( )Yes ( )No
27. Been involved in a treatment program specifically related to drug use? ( )Yes ( )No
28. Been treated as an outpatient for problems related to drug dependence or misuse? ( )Yes ( )No

Scoring: Each positive response yields 1 point, except for questions 4, 5, and 7 which yield 1 point for a negative response or false direction.

San Diego Pain Consultants Shafi Khalid, MD, FIPP

San Diego Pain Consultants, INC.

SOAPP Version 1.0

Name: ______________________________ Date: __________

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you feel that your pain is "out of control?" 0 1 2 3 4
2. How often do you have mood swings? 0 1 2 3 4
3. How often do you do things that you later regret? 0 1 2 3 4
4. How often has your family been supportive and encouraging? 0 1 2 3 4
5. How often have others told you that you have a bad temper? 0 1 2 3 4
6. Compared with other people, how often have you been in a car accident? 0 1 2 3 4
7. How often do you smoke a cigarette within an hour after you wake up? 0 1 2 3 4
8. How often have you felt a need for higher doses of medication to treat your pain? 0 1 2 3 4
9. How often do you take more medication that you are supposed to? 0 1 2 3 4
10. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs? 0 1 2 3 4
11. How often have any of your close friends had a problem with alcohol or drugs? 0 1 2 3 4
12. How often have others suggested that you have a drug or alcohol problem? 0 1 2 3 4
13. How often have you attended an AA or NA meeting? 0 1 2 3 4
14. How often have you had a problem getting along with the doctors who prescribed your medicines? 0 1 2 3 4
15. How often have you taken medication other than the way that it was prescribed? 0 1 2 3 4
16. How often have you been seen by a psychiatrist or mental health counselor? 0 1 2 3 4
17. How often have you been treated for an alcohol or drug problem? 0 1 2 3 4
18. How often have your medication been lost or stolen? 0 1 2 3 4
19. How often have others expressed concern over your use of medication? 0 1 2 3 4
20. How often have you felt a craving for medication? 0 1 2 3 4
21. How often has more than one doctor prescribed pain medication for you at the same time? 0 1 2 3 4
22. How often have you been asked to give a urine screen for substance abuse? 0 1 2 3 4
23. How often have you used illegal drugs in the past five years? 0 1 2 3 4
24. How often, in your lifetime, have you had legal problems or been arrested? 0 1 2 3 4

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice explains the ways in which we may use and disclose medical information about you. It describes your rights and certain obligations we have regarding the use and disclosure of your medical information. The law requires us to (1) Ensure your medical information is protected; (2) Provide you with this Notice describing our legal duties and privacy practices with respect to medical information about you; (3) Follow the current terms of the Notice in effect.

WAYS WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

The following sections describe different ways that we may use and disclose your medical information. For each category of uses or disclosures, we will explain what we mean to try to give some examples. Not every use or disclosure will be listed. All of the ways we permitted to use and disclose information, however, will fall within one of the following categories.

Some information such as certain drug and alcohol information, HIV information and mental health information is entitled to special restrictions related to its use and disclosure. Our office shall abide by all applicable state and federal laws related to the protection of this information.

1. **Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, or other personnel who are involved in your care. For example, a doctor treating you may need to know if you have diabetes because diabetes may slow the healing process. We may also share medical information about you with our office personnel or other providers, agencies or facilities in order to provide or coordinate such things as prescriptions, lab work, and x-rays. We also may disclose medical information about you to people outside our office who may be involved in your continuing medical care after you leave our office such as other healthcare providers, transport companies, community agencies, and family members.
2. **Payment.** We may use and disclose medical information about the treatment and services you receive at our office so that payment may be collected from you, an insurance company or a third party. For example, we may need to give information to your health plan about treatment you received at our office so your health plan will pay us or reimburse you. We may also tell your health plan about a proposed treatment in order to obtain prior approval or to determine whether your plan will cover the treatment.
3. **Healthcare Operations.** We may use and disclose medical information about you to support our office operations. These uses and disclosures are made to improve our quality of care. Your medical information may also be used to disclosed to comply with laws and regulations, for contractual obligations, patients, claims, grievances, or lawsuits, healthcare contracting, legal
4. **Appointment reminders and notification of normal laboratory results.** We may contact you to remind you that you have an appointment at our office or to notify a normal laboratory result and leave a message in your answering machine.
5. **Treatment alternatives.** We may tell you about or recommend possible treatment options or alternative that may be interest to you
6. **Health-Related benefits and services.** We may contact you to tell you about benefits or services that we provide
7. **Others involved in your care.** We may release medical information to anyone involved in your medical care. For example, a friend, family member, personal representative, or an individual you identify. We may give information to someone who helps pay for your care or we may tell your family or friends about your general conditions
8. **Research.** Your medical information may be important to further research efforts. We may use and disclose your medical information for research purposes, subject to the confidentiality provisions of state and federal law.
9. **As required by law.** We will disclose medical information about you when required to do so by federal or state law; if asked to do so by law enforcement in response to a court or administrative order, subpoena, discovery request, warrant, summons or other lawful process; or for intelligence, counterintelligence, and other national security activities authorized or required by law.
10. **To avert a serious threat to health or safety.** We may use and disclose medical information about you for public health purposes or when necessary to prevent or lessen a serious and imminent threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to someone able to help stop or reduce the threat.
11. **Workers' compensation.** We may use or disclose medical information about you for Workers' Compensation or similar programs as authorized or required by law. These programs provide benefits for work-related injuries.
12. **Inmates.** If you are an inmate of a correctional institution or under the custody of law enforcement officials, we may release medical information about you to the correctional institution as authorized or required by law.

YOUR RIGHTS REGUARDING MEDICAL INFORMATION ABOUT YOU

Although the medical information we obtain about you is the property of our office, you do have the following rights:

1. **Inspect and Copy.** With certain exceptions, you have the right to inspect and/or receive a copy of your medical and billing information. To inspect and/or to receive a copy of your information, you must submit your request in writing to our **Office Manager [Medical Practice Address].** If you request a copy of the information, we may charge a fee for these services. We may deny your request to inspect and/or to receive a copy in certain limited circumstances. If you are denied access to medical information, in most cases, you may have the denial reviewed. Another licensed health care professional chosen by our office will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
2. **Request and Amendment or Addendum.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information or add an addendum (addition to the record). You have the right to request an amendment or addendum for as long as the information is kept by or our office. To request an amendment, your request must be made in writing and submitted to our **Office Manager.** In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: Was not created by our office; Is not party of the medical information kept by or for our office; is not part of the information which you would be permitted to inspect and copy; or is accurate and complete in the record. An addendum must not be longer than 250 words per alleged incomplete or incorrect item in your record.
3. **Accounting of Disclosures.** You have the right to receive a list of the disclosers we have made of medical information about you that were for purposes other than treatment, payment, healthcare operations, and certain other purposes. To request this accounting of disclosures, you must submit your request in writing to our **Office Manager.** Your request must state a time period that may not be longer than the six previous years and may not include dates before April 14, 2003. You are entitled to one accounting within any 12-month period at no cost. If you request a second accounting within that 12-month period, we may charge you for the cost of compiling and accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.
4. **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use to disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information to a family member about a surgery you had. ***We are not required to agree to your request.*** If we do agree, our agreement must be in writing, and we will comply with your request unless the information is needed to provide emergency treatment. To request a restriction, you must make your request in writing to our **Office Manager.** In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.
5. **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to our **Office Manager.** We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
6. **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

CHANGES TO OUR PRIVACY PRACTICES AND THIS NOTICE

We reserve the right to change our office's privacy practices and this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice at our office. The Notice will contain the effective date on the first page in the top right-hand corner. N addition, at any time you may request a copy of the current Notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our **Office Manager, SDPC, 15725 Pomerado Road, Suite 105, Poway, CA 92064.** All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we will retain our records of the care provided to you as required by law.

PF-2000 Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices for the medical practice of San Diego Pain Consultants, INC.

Our practice reserves the right to modify the privacy practices outlined in this notice.

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Name of Patient (Please print)

______________________________ ____________

Signature of Patient Date

______________________________ ____________

Signature of Patient Representative Date

(Required if patient is a minor or an adult who is unable to sign this form)

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Relationship of Patient Representative to Patient