Advanced Pain Associates

Charles R. Stevens, M.D.

Fellowship Trained in Anesthesia
Pain Management

Date:

Welcome to Advanced Pain Associates! Your Primary Treating Physician has referred you to Dr. Charles Stevens, who is a Pain Management Physician.

We are happy to have you join our clinic and look forward to managing your pain. We have made an appointment for_____on _____at_____.

Enclosed you will find a New Patient Packet; this must be filled out when you come to your first appointment. Please make sure each form that requires a signature is completed before the time of your appointment. If it is not filled out, your appointment may be cancelled and rescheduled.

We require that you bring all medications you are taking to each and every appointment; this is for your safety.

You will be asked to give a urine sample the first visit and periodically thereafter.

We will call your Primary Treating Physician and give them your appointment date and time.

We look forward to serving you.

Respectfully,

Dr. Charles R. Stevens and the APA Staff

1665 South Imperial Ave., Suite D
El Centro, CA 92243
(760) 482-0212 Phone
(760) 482-0166 Fax

CHARLES R. STEVENS, M.D.
PATIENT POLICY

Thank you for choosing our center for your pain management needs. We welcome you and would like to take this opportunity to provide you with some information about what you can expect during your visit.

In order for us to better serve you: please fill out the enclosed patient information packet and fill out completely. This will allow us to get an overview of your pain history. If you are receiving an injection, please allow at least 30-45 minutes for the visit. If you are taking any kind of blood thinners (Coumadin, plavix, aspirin) please let us know, so we can give you the appropriate instructions regarding to stopping them prior to the injection procedure.

Your first visit will consist of a consultation only. If your physician has specifically referred you for a particular injection procedure, please let us know so we may schedule you appropriately.

Please note that prior authorization is required for certain insurance carriers which may cause a delay in receiving an injection on your first visit but you will be taken care of in the most appropriate manner.

Co-payments are due at time of service and for your convenience; checks, cash and credit cards are accepted. Please bring your insurance card(s) with you.

We ask if you are unable to keep your appointment to please notify our office at least 24 hours in advance. We cannot serve you properly without keeping missed and / or cancelled appointments to a minimum. We thank you in advance.

Thank you for understanding and agreeing to our financial policy. Please let us know if you have any questions or

concerns. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our office.
1665 South Imperial Ave. Suite D, El Centro, CA 92243

I authorize Charles R. Stevens, M.D. to furnish information to the insurance carriers concerning my illness and treatments. I also authorize all medical payment for medical services rendered to my dependent or myself. I understand that I am responsible for any non allowed services or non-covered charges.

_____ **Date:**_____
Signature of Patient / Guarantor / Guardian

I authorize the release of any medical records to any insurance company, adjuster, examiner or attorney requesting information regarding my treatments. A photocopy of this release shall be considered effective and as valid as the original.

_____**Date:**_____
Signature of Patient / Guarantor / Guardian

Assignment of Benefits: I authorize payment of medical benefits directly to Dr. Charles Stevens and Advanced Pain Associates for services rendered.

_____**Date:**_____
Signature of Patient / Guarantor / Guardian

Sign here if you decline this consent: _____

Preamble of Sample Template Language

We are now in a new era of Health Care Reform - intended to help patients. Sadly, these reforms do not include any "Lawsuit Reforms" that would dramatically reduce costs for patients and also promote a better environment for patients and their physicians. In a recent nationwide poll[1] 83% of the nation's electorate wanted Congress to address the medical malpractice system as part of the Health Care Reform plan. We wish Congress had taken action implementing reforms that both doctors and patients could support. And the majority of patients agree. Congress missed the opportunity. Because of that we have taken action with the single goal of enhancing the relationship between patients and the physician.

We take great pride in our reputation for providing the highest levels of quality medical care to our patients. However, we realize there are times when some patients will not be satisfied with the outcomes of their treatments. We also recognize that in these instances, a patient has every right to pursue legal action if he/she feels we have been negligent in some way. We respect every patient's right to do so.

While some healthcare legal claims are justified, there are also frivolous legal claims filed in our country—claims that are driving up insurance rates and impacting court decisions for the patients who truly deserve compensation. We believe that an agreement early in the treatment process regarding the use of board-certified experts will help expedite resolution of concerns.

OUR COMMITMENT TO YOU
We commit to using only American Board of Medical Specialties (ABMS) board-certified expert medical witness(es) in any legal situation, who follow the code of ethics of our national specialty society. These steps ensure that expert medical witnesses we use have passed examinations, demonstrated expertise in their field and adhere to a solid code of ethics.

We demonstrate this commitment to you with our signature on this form.

WHAT WE ARE ASKING YOU TO DO
We are asking you or any representative to commit to this process also, by using only board-certified physician(s) as expert medical witness(es) if you are dissatisfied with your medical care and decide on legal action.

We hope, and believe, you will never have to consider this again. But if you do, we will honor this commitment to you.

Note[1] Poll conducted by ***Clarus Research Group*** (www.ClarusRG.com), a nonpartisan survey research firm based in Washington, DC.

Sample Language **(EXTENDED)**

PLEASE READ CAREFULLY
AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "Patient/Guardian" shall be understood to mean_____.

"Physician" shall be understood to mean ***Dr. Charles R. Stevens of Advanced Pain Associates***

I understand that I am entering into a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by the Physician, I, the Patient/Guardian, agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against the Physician.

Should I initiate or pursue a meritorious medical malpractice claim against Physician, I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Medical Specialties in the same specialty as the Physician. Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be members in good standing of the American Board of Anesthesiology.

I agree the expert(s) will be obligated to adhere to the guidelines or code of conduct defined by the American Board of Anesthesiology and that the expert(s) will be obligated to fully consent to formal review of conduct by such society and its members.

I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions.

In further consideration, Physician also agrees to exactly the same above-referenced stipulations.

Each party agrees that a conclusion by a specialty society affording due process to an expert will be treated as supporting or refuting evidence of a frivolous or meritless claim.

Patient/guardian and Physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other dependents.

Physician and Patient/guardian agree that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery or any other theory of recovery.

Patient/guardian and Physician acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physician's reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief.

Patient/guardian acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

Physician	Patient/Guardian
Effective from Date of Treatment:	Date of Signature

Version 5.0.1

Advanced Pain Associates
Charles R. Stevens, MD

1665 S. Imperial Ave., Suite D
El Centro, CA 92243
Phone: 760-482-0212 Fax: 760-482-0166

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Notes:

We do not create or maintain a hospital directory.
We do not create or maintain psychotherapy notes at this practice.

Access to your protected health information may also be obtained via our Patient Portal. Please contact our office for more information on how to register for the online resource.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: 07/09/2014

This Notice of Privacy Practices applies to the following organizations.

Advanced Pain Associates
1665 S. Imperial Ave., Suite D
El Centro, CA 92243

This notice also applies to ECRMC which operates the emergency services in the El Centro area:
El Centro Regional Medical Center
1415 Ross Ave.
El Centro, CA 92243

CHARLES R. STEVENS, M.D.
ADVANCED PAIN ASSOCIATES

Last Name:_____ First Name:_____ Middle:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Date of Birth:_____ Age:_____ SS#:_____ Gender: (F) (M) Marital Status:_____

Home Phone:_____ Other:_____ Work:_____

EMAIL ADDRESS: _____

Race:_____ Ethnicity: _____

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*Emergency Contact: Name:_____ Relationship:_____

Home Phone:_____ Other:_____ Work:_____

Primary Care Physician:_____ Referring Physician:_____
Phone #: _____ Phone #: _____

Fax #: _____ Fax #: _____

Pharmacies:

Primary Pharmacy: _____ Secondary Pharmacy: _____

INSURANCE INFORMATION REQUIRED:

Claim#: _____ Date of Injury: _____

Adjuster's Name:_____ Phone#:_____ Fax#:_____

Insurance Carrier: _____

Address:_____ City:_____ State: Zip:___ General Phone#:

_____ General Fax#:_____

UR Phone#:_____ UR Fax#:_____

Covered Body Parts: _____

Attorney: _____ Phone#:_____ Fax#:_____

Employer:_____ Occupation:_____ Phone#:_____

MISSEDAPPOINTMENT / CANCELLATION POLICY:
There is a $25 no show / cancellation fee. All appointments must be cancelled 24 hours in advance. An after hour message may be left with our answering service. Please note that your insurance will NOT cover any no show or cancellation fees.

Patient Signature:_____ Date:_____

Advanced Pain Associates
Charles Stevens, M.D.
1665 South Imperial Ave., Suite D
El Centro, CA 92243
Phone: 760-482-0212 Fax: 760-482-0166

Worker's Comp. Employer Information

(at the time of your injury)

Patient Name: _____

Employer/Company: _____

Supervisor: _____

Address: _____

Phone: _____ **Fax:** _____

Hire/Start date: _____

Date of Injury: _____

Occupation/Title: _____

Status: _____
(retired, currently working there, etc.)

PATIENT INTAKE FORM

Name_____Date_____Age_____

Referring Doctor_____Primary Care Doctor_____

1.Use the following rating scales to indicate how severe your pain is at its worst and as it usually is.

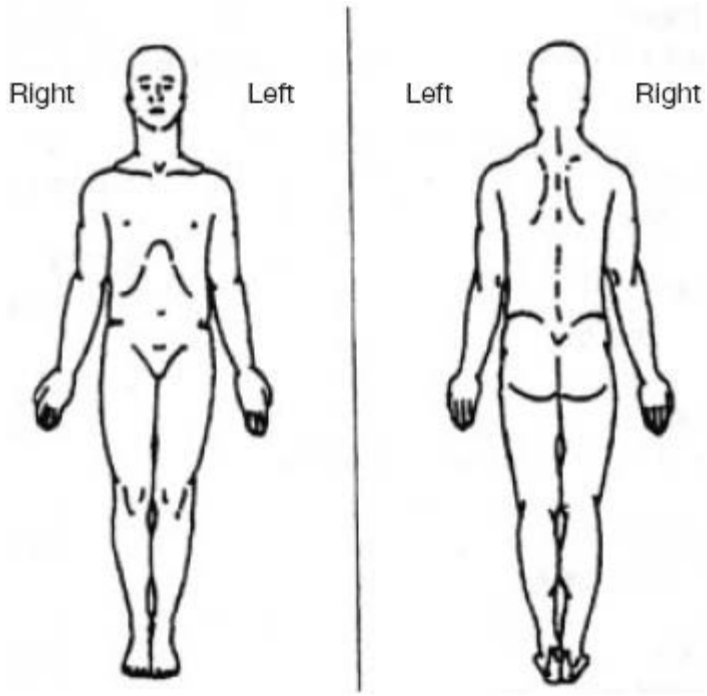
Your pain at its worst:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

Your Pain as it usually is:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

2. Please shade in the area(s) of your pain:



3. Please rate your current level of activity:

No Activity 0 1 2 3 4 5 6 7 8 9 10 Very Active

4. Does your pain travel anywhere ☐ No ☐Yes, where_____

The Oswestry Low Back Pain Disability Questionnaire

Instructions: Pleasecircle **ONE NUMBER** in each section which mos t closely describes your problem.

Section 1- Pain Intensity
0. I can tolerate the pain I have without having to use pain medication.
1. The pain is bad, but I can manage without having to take pain medication.
2. Pain medication provides me with complete relief from pain.
3. Pain medication provides me with moderate relief from pain.
4. Pain medication provides me with little relief from pain.
5. Pain medication has no effect on my pain.

Section 2- Personal Care (Washing, Dressing, etc.)
0. I can take care of myself normally without causing increased pain.
1. I can take care of myself normally, but it increases my pain.
2. It is painful to take care of myself and I amslow and careful.
3. I need help, but I am able to manage most of mypersonal care.
4. I need helpevery day in most aspects of my care.
5. I do not get dressed, I wash with difficulty, and I stay in bed.

Section 3- Lifting
0. I can lift heavy weights without increased pain.
1. I can lift heavy weights but it causes increased pain.
2. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table).
3. Pain prevents me lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
4. I can lift only very light weights.
5. I cannot lift or carry anything at all.

Section 4- Walking
0. Pain does not prevent me from walking any distance.
1. I cannot walk more than l mile without increasing pain.
2. I cannot walk more than 1/2 mile without increasing pain.
3. I cannot walk more than 1/4 mile without increasing pain.
4. I can walk only with crutches or a cane.
5. I cannot walk at all without increasing pain.

Section 5- Sitting
0. I can sit in any chair as long as I like.
1. I can only sit in my favorite chair as Jongas I like.
2. Pain prevents me from sitting more than **l** hour.
3. Pain prevents me from sitting more than 1/2 how·.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Section 6- Standing
0. I can stand as Jong as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than **l** hour without increasing pain.
3. I cannot stand for longer than 1/2 hour withoutincreasing pain.
4. I cannot stand for longer than 10 minutes withoutincreasing pain.
5. I avoid standing because itincreases pain immediately.

Section 7- Sleeping
0. Pain does not prevent me from sleeping well.
1. I can sleep well only by using painmedication.
2. Even when I take medication, I sleep Jessthan 6 hours.
3. Even when I take medication, I sleep Jess than 4 hours.
4. Even when I take medication, I sleep Jess than 2 hours.
5. Pain prevents me from sleeping at all.

Section 8- Social Life
0. My social life is normal and does not increase my pain.
1. My social life is normal but it increases the degree of pain.
2. Pain prevents me from pa11icipating in more energetic interests (i.e. sports, dancing, etc).
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of my pain.

Section 9- Traveling
0. I can travel anywhere without increased pain.
1. I can travel anywhere, but it increases my pain.
2. My pain restricts my travel over 2 hours.
3. My pain restricts my travel over l hour.
4. My pain restricts my travel to sh011 necessary journeys under ½ hour.
5. My pain prevents all travel except for visits to the physician/therapist or hospital.

Section 10- Employment/Homemaking
0. My normal homemaking/job activities do not cause pain.
1. My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
2. I can perform most of my normal homemaking/job duties, but pain prevents me from pe1forming most physically stressful activities (i.e. lifting, vacuuming, etc).
3. Pain prevents me from doing anything but light duties.
4. Pain prevents me from doing even light duties.
5. Pain prevents me from pe1forming any job or homemaking chores.

Total Score:____ c/50 % **Disability:**___ _

5. Complete the following:

	None	Mild	Moderate	Severe
Throbbing	☐	☐	☐	☐
Shooting	☐	☐	☐	☐
Stabbing	☐	☐	☐	☐
Sharp	☐	☐	☐	☐
Cramping	☐	☐	☐	☐
Gnawing	☐	☐	☐	☐
Burning	☐	☐	☐	☐

6. Which Statement best describes your pain?

☐ Always present, always same intensity
☐ Always present, intensity varies
☐ Usually present, but have short periods without pain
☐ Often present, but am pain free for most of the day
☐ Occasionally present, have pain once to several times per day, lasting a few minutes to an hour
☐ Occasionally present for brief periods every few days or week
☐ Rarely present, have pain every few days or week

7. What time of day is your pain worse?

☐Morning or arising
☐Later in the morning
☐Afternoon
☐Evening
☐Bedtime
☐Night during sleeping hours
☐Pain is always present at the same time
☐Pain varies, but is not worse at any particular time

8. Do any of the following make your pain feel worse?

☐Coughing, sneezing
☐Sitting
☐Standing
☐Laying Down
☐Walking
☐Physical Activity
☐Sexual Activity
☐Other_____

9. Do any of the following make your pain feel better?

☐Relaxation
☐Laying Down
☐Heat
☐Nothing makes it feel better
☐Sitting
☐Standing
☐Walking
☐Sexual Activity
☐Medicines
☐Alcoholic Drinks
☐Other

If you have or have had any of the following, please mark off accordingly:

Constitutional

☐ Anorexia ☐ Chills ☐ Cold intolerance ☐ Dizziness ☐ Facial swelling ☐ Fatigue ☐ Fever
☐ Headache ☐ Obesity ☐ Weight gain ☐ Weight loss ☐ Fainting ☐ Forgetfulness
☐ Headaches ☐ Loss of sleep ☐ Nervousness ☐ Numbness ☐ Sweats

Cardiovascular (CV)

☐ Angina ☐ Arrhythmia ☐ Cardiac murmur ☐ Chest congestion ☐ Chest pain
☐ Chest pressure ☐ Chest wall pain ☐ Claudication, interm ☐ Dyspnea ☐ Dyspnea on exertion
☐ Edema ☐ Palpitations ☐ Pedal edema ☐ Syncope ☐ Orthopnea
☐ Paroxysmal nocturnal

Ears Nose Throat (ENT)

☐ Ear pain ☐ Epistaxis ☐ Hard of hearing ☐ Hearing loss ☐ Hoarseness ☐ Nasal congestion
☐ Otorrhea ☐ Sinus congestion ☐ Sinusitis ☐ Snoring ☐ Tinnitus
☐ Voice change ☐ Nasal polyps ☐ Sore throat

Endocrine

☐ Bruit ☐ Cold intolerance ☐ Fatigue ☐ Goiter ☐ Gynecomastia ☐ Heat intolerance
☐ Hyperdefecation ☐ Increased Sweating ☐ Leg swelling ☐ Polydipsia
☐ Polyuria ☐ Rapid heart rate ☐ Tremor

Eyes

☐ Decreased hearing ☐ Diplopia ☐ Dry eyes ☐ Eye discharge ☐ Eye erythema
☐ Eye foreign body ☐ Eye pain ☐ Floaters ☐ Photophobia ☐ Scotoma
☐ Vision change ☐ Vision loss

Gastrointestinal (GI)

☐ Abdominal pain ☐ Change in bowel habits ☐ Constipation ☐ Diarrhea ☐ Dyspepsia
☐ Hemorrhoids ☐ Indigestion ☐ Nausea ☐ Rectal bleeding
☐ Gas and bloating ☐ Hematemesis ☐ Hematochezia ☐ Jaundice ☐ Melena
☐ Odynophagia ☐ Vomiting

Heme_Lymph

☐ Easy bruising ☐ Hemoptysis ☐ Lymphadenopathy ☐ Neck mass ☐ Night sweats
☐ Pale conjunctiva ☐ Spontaneous bleeding

Male Genitourinary (GU)

☐ Anuria/ oligura ☐ Dysuria ☐ Hematuria ☐ Urinary frequency ☐ Urinary incontinence
☐ Urinary retention / hesitancy ☐ Urinary urgency ☐ Flank pain ☐ Impotence ☐ Nocturia

Miscellaneous

☐ Aspiration ☐ Insomnia ☐ Lightheadedness ☐ Flushing ☐ Hay fever ☐ Hiccups ☐ Memory Loss
☐ Toothache

Musculoskeletal

☐ Arthralgia ☐ Back pain ☐ Lumbar strain ☐ Myalgia ☐ Neck sprain ☐ Joint pain
☐ Joint swelling ☐ limb pain

Neuro

☐ Aphasia ☐ Ataxia ☐ Migraine ☐ Vertigo ☐ Dysarthria ☐ Gait abnormality
☐ Mental status change ☐ Paresthesias ☐ Seizures ☐ Spasms / spasticity

Psych

☐ Anxiety ☐ Alcohol abuse ☐ Depersonalization ☐ Depression ☐ Derealization
☐ Dizziness ☐ Fear of dying ☐ Feeling of choking ☐ Hallucination ☐ Mental status change
☐ Panic ☐ Poor memory ☐ Psychotic thoughts ☐ stress ☐ Suicidal ideation
☐ Vocabulary deficits

Pulmonary

☐ Abnormal chest x-ray ☐ Asthma ☐ Blood in sputum ☐ Bronchitis ☐ Chronic cough
☐ Chronic phlegm ☐ Cough ☐ Pneumonia ☐ Shortness of breath
☐ Wheezing

Skin

☐ Crusting ☐ Easy bruising ☐ Edema ☐ Erosions ☐ Painless lesions ☐ Rash
☐ Sores – won't heal ☐ Tense blisters

Breast

☐ Breast mass ☐ Breast pain ☐ Cracked nipple ☐ Discharge ☐ Fissured nipple
☐ Nipple irritation ☐ Nipple retraction ☐ No lactation ☐ Skin dimpling ☐ Swelling
☐ Tenderness

OB-GYN

☐ Amenorrhea ☐ Anueria ☐ Dysmenorrhea ☐ Dysuria ☐ Flank pain
☐ Hematuria ☐ Menorrhagia ☐ Menstrual pain ☐ Nocturia ☐ Urinary frequency
☐ Urinary incontinence ☐ Urinary retention ☐ Urinary urgency ☐ Vaginal discharge

Employment

Current Employer: _____

Occupation: _____

Last day worked: _____ Retired: _____

Job Satisfaction: ☐ Good ☐ Fair ☐ Poor

Is return to work possible? ☐ Yes ☐ No

Does your work involve:

Standing: ☐ no ☐ yes If yes, how long at a time? _____

Driving: ☐ no ☐ yes If yes, how long at a time? _____

Walking: ☐ no ☐ yes If yes, how long at a time? _____

Lifting: ☐ no ☐ yes If yes, how many lbs. more than 6-8 times per hour? _____

If yes, how many lbs. less than 6 times per hour? _____

Sitting: ☐ no ☐ yes If yes, how many hours per day? _____

When did your pain begin? _____

How did your pain begin? _____

Location of your worst pain: _____

Other painful areas: _____

Who was your employer at the time of your injury? _____

How long have you been working for this employer at the time of your injury? What was your date of hire?

_____

What was your job title at the time of injury? What were your usual job duties? _____

_____

_____

As a result of this injury, what duties at work are you unable to perform now? _____

_____

_____

Did you work eight-hours per day, five-days a week? ☐ Yes ☐ No

If not, what were the usual work days and hours? _____

How did you get hurt and what were your initial complaints following the accident? _____

_____

_____

_____

_____

_____

_____

_____

When did you report the accident? _____ To whom did you report this to? _____

Where were you initially seen following the accident? _____

What type of treatment(s) have you received over the course of time? (Please be specific. Ex: Medications, surgery, injections, physical therapy. Did it help? For how long? Who are the physicians who performed or prescribed these treatments?)

Have you ever had pain or sustained an injury to these body parts before? ☐ Yes ☐ No

If yes, are you still being treated for this condition? With who? What type of treatment are you receiving?

Where were you employed PRIOR to this employer? What was your job title and duties? How long did you work there? Did you sustain any injuries during that employment? (Please refer back to five (5) years prior to the employer you worked for at the time of injury or three (3) employers, whichever is the most.)

Do you have any congenital or hereditary conditions?

Have you served in the military? If yes, what branch? What was your rate and rank? How long were you in the military? Did you sustain any injuries?

What are your hobbies / activities?

How have your hobbies / activities been affected by this injury?

Is there anything that we did not ask, that you feel is important to let us know?

Are you still being treated? If yes, what type of treatment are you being provided at this time? Are there any outstanding treatment recommendations that may be pending authorization or scheduling? _____

_____

_____

Following the injury, did you return to full work duty? Modified work duty? Have you been off of work? How long? Are you working now? _____

_____

_____

If you are currently working, what is your current work status? Are you working with any restrictions right now?

_____

_____

Describe your pain:

☐ Constant ☐ Intermittent ☐ Episodic (no pattern) ☐ Aching ☐Stabbing
☐ Throbbing ☐ Pressure ☐ Pins & Needles Numbness ☐ Traveling
☐ Burning ☐ Shooting ☐ Other _____

What makes your pain worse? _____

_____

What makes your pain better? _____

_____

Diagnostic Tests & Procedures completed

☐ MRI ☐ CT ☐ X-rays ☐ EMG ☐NCV ☐Lab Tests ☐Bone scan
☐ Other:_____

Allergies:_____

List reactions (ex: rash, shortness of breath) _____

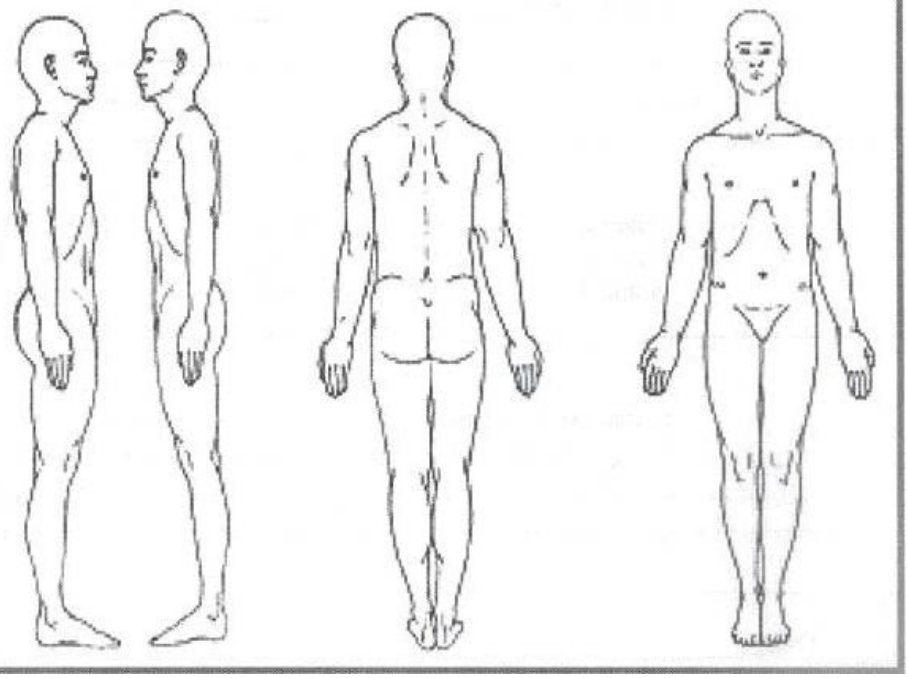
Medication and Dosage

Pain Meds:

Other Meds:

(Please, use the back for additional meds.)

DRAW YOUR PAIN



Are you experiencing any of the following?

☐ Unexplained sadness ☐ Inability to enjoy activities ☐ Flashbacks ☐ Physical violence
☐ Sexual abuse ☐ Phobias ☐ Loss of appetite ☐Panic attacks
☐ Sleep problems/difficulty: ☐ falling asleep ☐ during sleep; How many hours do you sleep? _____

Do you feel depressed (sad, empty)? ☐ No ☐ Mildly ☐ Moderately ☐ Significantly

Have you ever been arrested?_____ Have you ever been jailed? _____

Is there any legal action relating to your pain? _____

Health & Surgical History (patient)

☐ Heart Disease
☐ Stomach/ Bowel problems
☐ Bleeding Problems
☐ TB exposure/Positive Skin Test
☐ Head Injury/fainting/dizziness
☐ AIDS/HIV ☐ Sexually transmitted disease(s)
☐ Cancer (What type:_____)
☐ History of balance problems / Falls
☐ Lung Disease:
☐ Asthma ☐ COPD ☐ Emphysema
☐ Fever/Chills
☐ Urinary/Kidney Problems
☐ Eye problems (dryness, itching)
☐ Liver Disease ☐ Hepatitis; ☐ Cirrhosis
☐ Attention Deficit Disorder
☐ High Blood Pressure
☐ Reflux/Hiatal hernia
☐ Skin/Gum Problems, Dry Mouth
☐ Depression: ☐ Anxiety ☐ Suicide Ideation
☐ Weight Loss OR ☐ Weight Gain
How much_____; What length of time? _____
☐ Neurological: ☐ stroke ☐ seizure
☐ Fractures/Sprains/Skeletal
☐ Loss of bladder/bowel function
☐ Thyroid
☐ Muscle problems/weakness
☐ Fibromyalgia
☐ Diabetes
☐ Night Sweats
☐ Other medical problems? _____

Surgeries (List extras on back of this sheet): _____

Family History: **F** = father; **M =** mother**;** **S =** sibling

_____Chronic Pain _____Fibromyalgia _____Arthritis _____Bleeding disorder
_____Substance Abuse _____Alcohol Abuse _____Diabetes _____Hypertension
_____Heart Disease _____Migraine _____Depression _____Suicide
_____Cancer; type: _____

Social/Vocational History

☐ married/lives with spouse ☐ never married ☐divorced/separated
☐ widow/widower ☐ lives w/significant other ☐ lives alone
☐ List your hobbies: _____

Who do you seek for social support? _____

Habits

☐ Caffeine/amount per day:_____ ☐Smoking/ amount per day:_____ ☐ Alcohol/ amount per day: _____

☐ Have you ever used any illicit drugs? If checked, what kind? _____

Certification (To be signed by the patient)

I certify that I have answered truthfully all the questions, and I have not knowingly withheld any information concerning any of the above problems, either past or present.

_____ _____

Your signature Date

_____ _____

Witness Date

_____ _____

Signature of Reviewing Physician Date

STOP! (The following section will be used by the physician ONLY.)

Physician notes: _____

Medication Log

Patient:_____DOB:_____MRN: _____

Medication name, dosage, & frequency	Prescribing Physician	Start Date

Advanced Pain Associates
Charles R. Stevens, M.D.
Fellowship Trained in Anesthesia
Pain Management

C.U.R.E.S. Drug Monitoring Program: (Controlled Substance Utilization Review and Evaluation System)

The California Prescription Drug Monitoring Program's (PDMP) mission is to reduce pharmaceutical drug diversion while promoting legitimate medical practice and patient care. PDMP accumulates Schedule II through IV controlled substance prescription and dispensation information for facilitating diversion awareness and intervention. It is assumed prescribers and pharmacists dedicate their professional skills to identify and assist controlled substance abusers.

Prescribing practitioners and dispensers must treat this information in accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA), the California Confidentiality of Medical Information Act, and Health & Safety Code section 11165(c). Law enforcement users must obtain, use and share this information with criminal justice partners only in conjunction with criminal investigative matters. This data shall not be disclosed, sold, or transferred.

All of our patients will be monitored through this program on a monthly basis. We will be able to see your activity at different pharmacies as well as prescriptions given by other doctors. If you are in violation of your contract with **Advanced Pain Associates** you may be discharged from our clinic. If you have any questions please ask.

Advanced Pain Associates
Fellowship Trained Anesthesia
Pain Management

Rationale & Consent for Depression Screening

Rationale: The purpose of administering this psychological survey is to assess for characteristic depression related, but not limited to pain. Other indications include medications use (including opioids and other agents which could cause depression), response to medication prescribed for depression, establish a baseline for chronic or situational depression, determining if there is post-traumatic depression, assessing for any psychological side effects of medications prescribed for surgical interventions, and quantifying depression related to medical conditions such as cancer or chronic metabolic illness (see below).

Main Indications:

1. Chronic disease of any type
2. Pain conditions
3. Rheumatologic or Endocrine conditions
4. Cardiac conditions
5. Conditions of multiple traumas
6. Other related conditions
7. Depressions related to medications use
8. Suspected post-partum depression

Possible Outcomes: based on the responses

Negative: No evidence of treatable depression exists.

Borderline: You may be experiencing levels of tension, anxiety, depression, or other psychological problems outside of typical ranges. It may be warranted that additional or repeat testing, and professional evaluation may be suggested.

Positive: It is very likely a psychological condition is present which needs to be addressed. There may be cause for some type of potential interventions to determine possible causes of the distress, and to develop treatment strategy. Re-evaluation may be strongly encouraged to identify and possible shifts in possible depression over time.

Disclaimer: This inventory is a screening evaluation to identify those who may be at risk for inherent depression, or that relate to secondary factors. The results of this survey alone are not diagnostic, but suggest possible options for intervention and therapy. The patient (respondent) has been given opportunity for asking questions and for additional information. A list of local mental health professionals can also be provided upon request.

Patient Signature:_____ Date:_____

Advanced Pain Associates
Charles R. Stevens, M.D.
1665 S. Imperial Ave. Suite D
El Centro, CA 92243

DESIGNATED INDIVUALS AUTHORIZATION FORM

FORMA DE AUTORIZACION DE INDIVIDUOS DESIGNADOS

ENGLISH:
I hereby authorize one or all of the designated parties below to request and receive the release of any protected healthcare information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of the designated parties must be verified before the release of any information.

ESPANOL:
Por este medio autorizo a una o todas las personas desgnadas en la lista de abajo para solicitar y recibir la revelacion de alguna informacion de salud con repecto a mi tratamiento, pago o operaciones administrativas relacionadas con tratamiento y pago. Entiendo que la identidad de las personas designadas debe ser verificadas antes de la revelacion de alguna informacion.

Authorized designees / Designados autorizados:

Name / Nombre:_____ Relationship / Parentesco: _____

Name / Nombre:_____ Relationship / Parentesco: _____

Name / Nombre:_____ Relationship / Parentesco: _____

Name / Nombre:_____ Relationship / Parentesco: _____

_____
Patient Name – please print / Nombre Del Paciente

_____
Patient Signature / Firma Del Paciente

_____
Date / Fecha

ADVANCED PAIN ASSOCIATES PATIENT CONTRACT
Opioid and Controlled Substances Agreement and Informed Consent

Opioid medications are used judiciously in the treatment of benign or malignant pain conditions. The following is an agreement and explanation of issues related to treatment of painful disorders through the use of opioid medications and/or other controlled substances. These medications include but are not limited to morphine (e.g. MS Contin, Kadian,MS IR), oxycodone (e.g. Percocet, Oxycontin, Roxicodone), Hydromorphone (dilaudid), Hydrocodone (e.g.Vicodin,Lortab, Norco), propoxyphene (e.g. Darvocet), fentanyl (e.g. Duragesic patch, Actiq), methadone, codeine (e.g. Tylenol No. 3), benzodiazepines (e.g. Valium, Xanax), stimulants (e.g. Adderall, Ritalin), Barbiturates (e.g. Fioricet, Fiorinel),etc.

Side Effects & Risks:
Because these medications are potentially dangerous, as are all medications, the side effects and risks are discussed with you at the beginning of the treatment and periodically thereafter. Side effects/risks include but are not limited to allergic
reactions, sedation, somnolence, respiratory depression (i.e. slow breathing), dizziness, confusion , nausea, vomiting, urinary retention, suppression of menstrual cycle, hormonal imbalance, constipation, itching, physical dependence, tolerance, addiction, or death.

Caution:
Opioid medications may cause drowsiness. Alcoholic beverages should be avoided or be used with extreme caution and sparingly after approval of your pain physician while taking these medications. Driving a car or operating dangerous machinery may not be allowed initially until a stab le dose of these medications are obtained. Usually, most side effects of opioid use disappear over time and with continued use, except for constipation. Bowel maintenance should be addressed seriously and treated if necessary. If decision is made to terminate opioid therapy, a weaning manner rather than abrupt discontinuation of treatment should be exercise to prevent withdrawal symptoms (e.g. increased pain, agitation, nausea, diarrhea…) **The following conditions must be followed and agreed upon as long as the patient is receiving treatment at Advanced Pain Associates. Noncompliance with any one of these conditions may result in discharge from the practice.**
Advanced Pain Associates must be the only source for the medications that were reviewed above. The patient may not obtain these medicines from any other source or physician except when it is explicitly allowed and approved by Advanced Pain Associates. The patient understands that the treatment goal is to improve the quality of life and ability to function and/or work. These parameters will be assessed periodically to determine benefits of opioid therapy and adjust the dosage accordingly.
The patient understands that he/she must take the medications as instructed and prescribed. Any change in dosing must be approved by Advanced Pain Associates physician. The patient agrees to use only one pharmacy whose contact information and address the patient would provide to Advanced Pain Associates. If for any reason another pharmacy is to be used (e.g. unavailability of a certain medicine), the patient should notify Advanced Pain Associates.

Lost or stolen prescriptions or medications will NOT be replaced.
It is the patient's responsibility to ensure that prescriptions are filled correctly at the pharmacy. If the patient realizes a medication is lost, stolen, or misplaced, a police report must be filed, and the case number should be given to Advanced Pain Associates Center. To ensure efficacy of treatment and for monitoring purposes, the patient should keep all recommendedappointments.
Narcotic prescriptions will not be given over the phone, after hours, during the weekends, or holidays.
If there is a need to change any narcotic prescription a new appointment will be made.
Advanced Pain Associates has the right to directly communicate with other healthcare providers and pharmacies regarding the patient's use of controlled substances. Opioid therapy usually is only part of the overall treatment plan. The patient shall comply with all other treatments as outlined by their physician at Advanced Pain Associates.

The patient may be asked for urine and/or blood screening tests as well as random pill count. Failure to comply with this results in immediate discharge from the practice.

The patient understands that sharing of medications referred to above with anyone is absolutely forbidden and is against the law. Patient understands that the results of urine/blood testing can be given to the patient's other healthcare providers, insurance company, or other reimbursing agencies. The patient also authorizes any other healthcare provider, pharmacy, law enforcement, or judiciary body to release any pertinent information regarding the patient's prescription or urine/blood screen results. Patient agrees that any use of illicit substances (Marijuana, Cocaine, etc.) during treatment is strictly prohibited and if identified during a urine test it will result in discharge. The only exception is marijuana used for medicinal purposes and only when prescribed by a US licensed physician. I, the undersigned, attest that above was discussed with me, and I fully understand and agree to all of the above requirements and instructions. I also understand that failure to comply with above can result in my discharge from Advanced Pain Associates.

HIPPA NOTICE OF PRIVACY PRACTICES

HEALTH INFORMATION THAT WE MAINTAIN ABOUT YOU

We maintain records of:

1. Your name and (if different) the name and relationship of the person receiving treatment.
2. Your address
3. Your telephone number
4. Your (or the patient's, if different) condition
5. The date the doctor diagnosed the condition
6. Clinical findings related to the condition such as results of blood tests, procedures, examinations, and diagnostic modalities.
7. Your insurance and other coverage information such as billing records.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the right to:

- Request restrictions on certain uses and disclosures (we are not required to agree to the restriction)
- **Receive communications of protected health information by alternative means or at alternative locations such as home telephone numbers, cell phones, etc. We may leave messages at any or all telephone numbers listed by patient on the patient information form. We may contact any person left as an emergency contact listed on patient information form. We may contact the patient's spouse relaying any message regarding care, appointment or any necessary information deemed necessary for the patient's treatment or care.**
- Inspect, copy and amend your protected health information held at Advanced Pain Associates.
- Receive an accounting of certain disclosures (of your protected health information)
- Receive a paper copy of this notice even if you have received it electronically.

HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

We only use or disclose your health information as state and federal laws require or permit. In some cases, the law requires that you authorize the disclosure. In other cases, the law allows us to disclose your health information without your authorization.

Use and Disclosure Not Requiring Your Authorization

Treatment: We may use your health information for our treatment activities, such as disclosing it to other healthcare providers as helpful to treat you.

Payment: We may use and disclose your health information for our payment and collection activities, such as sending claims to insurance companies for the payment of metabolic treatment products.

Healthcare Operations: We may use and disclose your health information to manage our program operations, such as reviewing the quality of services you receive. Business Associates: We may disclose your health information to organizations that help us with our work, such as the billing service we use to process claims to your health

insurance company. We have a written agreement that requires these organizations to use your health information for only the reasons necessary to do the work, and protect it from other uses or disclosures, just like we do.
To Contact You: We may use the information in your health records to contact you if we have information about treatment or other health-related benefits and services that may be of interest to you.

Other Permitted Uses and Disclosures

HIPAA specifically permits us to use or disclose your health information for other purposes without your consent or authorization. In our experience such disclosures are rare, and the limited information we maintain is generally not applicable. However, when authorized by law, and to the extent we may have the information, HIPAA permits us to disclose it to:

- Comply with the requirements of federal, state, or local laws, court orders or other lawful process and for administrative or court proceedings
- report a public health authority for the purpose of preventing o r controlling disease, injury, or disability
- report to the FDA for the quality, safety or effectiveness of FDA-regulated products or activities
- notify a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition
- report abuse, neglect or domestic violence to a government authority
- provide necessary information to a health oversight agency for activities such as audits, investigations, inspections, licensure of the healthcare system, government benefit programs and regulated entities
- a law enforcement official for specified law enforcement purposes
- coroners or medical examiners for identification or determining cause of death
- funeral directors to carry out their duties with respect to the decedent
- organ procurement organizations for facilitating donation and transplantation researchers conducting studies approved by an Institutional Review Board
- prevent or lessen a serious and imminent threat to the health of safety of a person or the public
- authorized federal officials for specialized government functions such as military and veterans activities; national security and intelligence activities; protective services for the president; medical suitability determinations; correctional institutions; government entities providing public benefits and comply with workers' compensation laws

Phone Message/Call Authorization (means of communication via phone, fax, or email):
I, the undersigned, hereby authorize the staff of Advanced Pain Associates to leave messages on my answering machine or cell phone regarding my care or for appointment reminders or transmission of other information via fax and or e-mail.

Uses and Disclosures with Your Authorization
Other uses and disclosures or your personal information require your written authorization. You may revoke your authorization at any time by doing so in writing.
By signing this form I acknowledge that I have read and understood the contract agreement and will follow these instructions during my treatment. I have also received a copy of this agreement for my files.

Patient Name : _____

MRN #: _____

Patient Signature: _____

Date: _____