Conejo Pain Specialists Medical Group, Inc.
3366 E. Thousand Oaks Blvd. 2nd Floor Thousand Oaks, Ca. 91362
TEL: 805-497-8616 FAX: 805-497-7904

Patient Registration Form

ABOUT YOU

Last Name:_____

First Name:_____

M. Name: _____ Suffix: _____

Prev. Last Name:_____

Date of Birth: _____/ ____ / _____

SSN: _____--_____--_____

Address:_____

Address line 2:_____

City: _____

State: _____ Zip:_____

Home Phone: _____

Work Phone: _____

Mobile Phone:_____

Email address_____

Primary Language: _____

Race: _____ (Decline)

Ethnicity: _____ (Decline)

Marital Status: S M D W Separated

Deceased date: _____/ ____/ _____

How did you hear about us?

_____

_____

_____

INSURANCE INFORMATION

Primary Insurance

Name Last:_____

First_____ MI:_____

ID: _____

Group_____

Primary Subscriber's Name:

_____

Subscribers DOB _____

Relationship to Patient:_____

Secondary Insurance

Name Last:_____

First Name_____ MI:_____

ID: _____

Group_____

Secondary Subscriber's Name:

_____

Subscribers DOB _____

Relationship to Patient:_____

Please bring copy of insurance card (s)

Name:_____ DOB:_____ AGE:_____ Today's DATE:_____

YOUR AFFILIATES

Employment

☐Full Time ☐Part Time ☐Unemployed ☐Disabled as of date: _____ ☐Student

Employer Name: _____Occupation: _____
Address: _____Line 2: _____
City :_____State:_____Zip:_____ Phone:_____

Guardian
Last Name: _____
First Name: _____Mi:___
Phone:_____

Emergency Contact
Name: _____
Relation: _____
Phone: _____
Mobile Phone:_____

Next of Kin
Name: _____
Relation: _____
Phone: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any information necessary to process insurance claims and to obtain reimbursement. I hereby authorize payment of insurance benefits directly to Conejo Pain Specialists Medical Group, Inc. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all copays, deductible, coinsurance and noncovered charges not paid by my insurance.

Signature: _____Date: _____

PRIVACY STATEMENT ACKNOWLEDGEMENT

I acknowledge Conejo Pain Specialists Medical Group, Inc. has provided its notice of Privacy Practices, either posted or an individual copy, which provides a detailed description of the uses and disclosures allowed regarding my protected health information. If I desire a copy of the Notice of Privacy Practices, it is available for me to keep. If revisions are made, I understand that it is my responsibility to request a copy. (See date on posted copy.)

Signature: _____Date: _____

AUTHORIZATION TO LEAVE MESSAGES ON VOICEMAIL/ MACHINES

I acknowledge that it is my right to refuse to authorize reminder calls and other types of detailed messages to be left on my voice mail and /or answering machines. This authorization can only be revoked in writing.

- ☐ Yes, please leave me a message
- ☐ No, don't leave any specific messages

Signature: _____Date: _____

Name:_____ DOB:_____ AGE:_____ Today's DATE:_____

Current Pain Information

What pain problem brought you to see the doctor? Please describe the location of your primary pain.

_____

_____

_____

How did this problem arise? Please give details. Date of injury _____/ _____/ _____

_____

_____

_____

Have there been any prior injuries to this area? YES / NO . If yes, please give details.

_____

_____

_____

How long have you had this problem? _____

Have you had any of the following treatments for your pain problems? Please check all that apply.

- ☐ MRI's
- ☐ X-rays
- ☐ Physical Therapy
- ☐ Chiropractic
- ☐ Epidural Injections
- ☐ Trigger Point Injections
- ☐ Surgeries

Please list the names of other doctors and the treatment you received from them for your pain.

_____

_____

What makes your pain better? Please check all that apply.

- ☐ Walking
- ☐ Sitting
- ☐ Stretching
- ☐ Resting/ lying down
- ☐ Ice
- ☐ Heat
- ☐ Medication
- ☐ Other: _____

What makes your pain worse? Please check all that apply.

- ☐ Sitting
- ☐ Standing
- ☐ Getting Up and Down
- ☐ Lifting
- ☐ Twisting
- ☐ Reaching
- ☐ Other: _____

Name:_____ DOB:_____ AGE:_____ Today's DATE:_____

Do you have other areas of pain? Please describe._____

_____

_____

Which doctor do you see as your General Practitioner or Internist? _____

Please list all other doctors that you see and indicate their specialty.

_____

_____

_____

Please complete the following questions on your past medical history.

Past medical illness that required medical care: _____

_____

_____

MEDICATION ALLERGIES:

Medication	Reaction

FAMILY HISTORY: Does anyone in your family have a history of any conditions we should be aware of?

If so, please provide us with information to the following:

Relation	Medical Problem/ Condition	Onset Age	Died of Age	Additional info. (Notes)

Name:_____ DOB:_____ AGE:_____ Today's DATE:_____

SURGICAL HISTORY Have you had any surgeries performed we should be aware of?

If so, please provide us with information to the following:

Procedure Received	Date	Additional info. (Notes)

MEDICATION INFORMATION: Please list ALL medications that you are currently taking:

PAIN Medication / Dosage	NON-PAIN Medication/ Dosage

Are you on any of the following blood thinners (anti-coagulants)?

- ☐ Aspirin/ Dose _____
- ☐ Coumadin/ Dose_____
- ☐ Ticlid/ Dose_____
- ☐ COX2 Inhibitors (Celebrex, Bextra, Vioxx)/ Dose_____
- ☐ Ibuprofen/ Dose_____

☐ Other Anti-inflammatory medication_____ /Dose_____

☐ Other_____ / Dose_____

Name:_____ DOB:_____ AGE:_____ Today's DATE:_____

LIFESTYLE INFORMATION

Do you smoke? YES / NO (circle one) Amount per day? _____

Do you drink? YES/ NO (circle one) Amount _____

If female, is it possible you may be pregnant at this time? YES / NO (circle one)

I am RIGHT / LEFT (circle one) handed.

I weigh _____ pounds and I am _____ feet and _____ inches tall.

My marital status: S M D W Sep.(circle one) I have _____ boy and _____ girl children.

I live in: SINGLE STORY/ 2 STORY/ APARTMENT on floor _____ (circle one)

My occupation is: _____

Have you had a history of:	**Please circle yes or no**		**Additional information (Notes):**
Anxiety	YES	NO	
Asthma	YES	NO	
Bipolar Disorder	YES	NO	
Bronchitis	YES	NO	
Chronic fatigue syndrome	YES	NO	
COPD	YES	NO	
Coronary artery disease	YES	NO	
Depression	YES	NO	
Diabetes mellitus	YES	NO	
Diverticulitis	YES	NO	
Emphysema	YES	NO	
Fibromyalgia	YES	NO	
Headaches	YES	NO	
Hemorrhoids	YES	NO	
Hypertension	YES	NO	
Hyperthyroidism	YES	NO	
Hypothyroidism	YES	NO	
Irritable bowel syndrome	YES	NO	
Migraines	YES	NO	
Osteoarthritis	YES	NO	

Rheumatoid arthritis	YES	NO
Ulcerative coilitis	YES	NO

Other:

Name:_____ DOB:_____ AGE:_____ Today's DATE:_____

Please mark any symptoms you are experiencing:

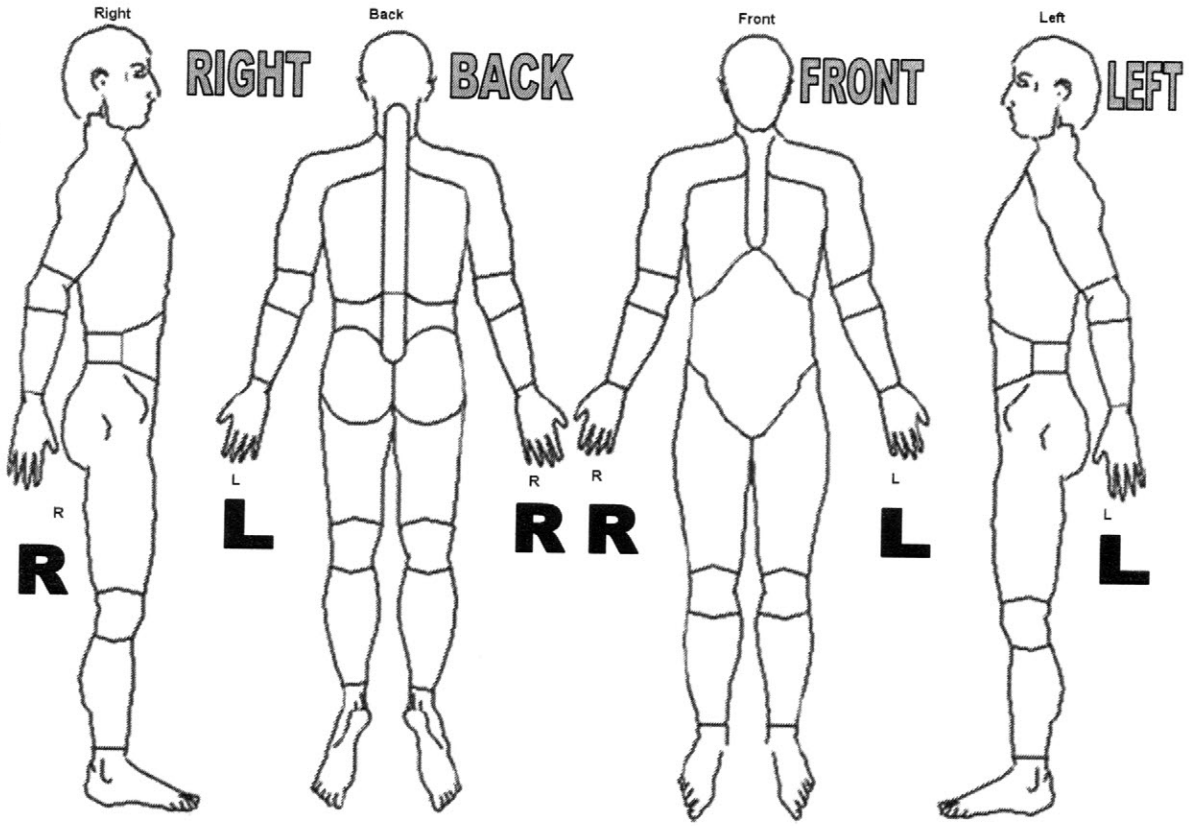
☐Difficulty breathing/ shortness of breathe ☐Chest pain/ angina ☐Recent cough ☐Recent diarrhea ☐Constipation

☐Recent infection ☐Urinary incontinence ☐Bowel incontinence ☐Burning with urination ☐Dizziness

☐Lightheadedness ☐Visual changes ☐Numbness in arms/legs ☐Weakness in arms/legs ☐Problems with balance

Using the figures below, mark the areas where you feel the described sensation on your body. Use the appropriate symbols include ALL the affected areas.

aaa	Aching
|||	Shooting
///	Stabbing
000	Numbness
ttt	Tingling
xxx	Burning
ccc	Cramping
sss	Sensitive



How would you rate your pain at its WORSE?

1	2	3	4	5	6	7	8	9	10

Mild — Uncomfortable/ Disruptive — Unbearable

How would you rate your pain at its LEAST?

1	2	3	4	5	6	7	8	9	10

Mild — Uncomfortable/ Disruptive — Unbearable

How would you rate your pain on AVERAGE?

1	2	3	4	5	6	7	8	9	10

Mild — Uncomfortable/ Disruptive — Unbearable

How has your pain interfered with your ABILITY TO TAKE CARE OF YOURSELF?

1	2	3	4	5	6	7	8	9	10

No Interference Disruptive Unable to care for myself

Name:_____ DOB:_____ AGE:_____ Today's DATE:_____

CONEJO PAIN SPECIALISTS MEDICAL GROUP, INC.

FREQUENTLY ASKED QUESTIONS

- **WHAT IS PAIN MANAGEMENT?**

Pain management, or pain medicine, is a medical specialty dedicated to treating acute, sub-acute, and chronic pain. The goal of pain medicine is to improve quality of life and help patients return to everyday activities.

- **WHO IS THE MEDICAL DIRECTOR?**

Kamyar Assil, MD has performed more than 15,000 fluoroscopy directed spinal injections. He is known as a *Doctors' Doctor* with a no-nonsense caring and gentle attitude. His philosophy is to treat all patients in an ethical, compassionate and competent manner. He is a volunteer instructor for ISIS (International Spine Intervention Society) and a visiting professor at USC Medical School pain center.

Assisting Dr. Assil is Rick Deleon, PA-C and Lana Galicia, M.D. Dr, Galicia was previously an attending professor at UC Davis.

- **IS PAIN MANAGEMENT RIGHT FOR ME?**

Pain can be a complex problem that may require treatment by a pain medicine specialist. Millions of people suffer pain every year at great personal cost. According to the American Academy of Pain Medicine, *pain affects more Americans than diabetes, heart disease and cancer combined*. If you find you cannot safely control your pain using over-the-counter medications, or have failed to find relief from other treatments and practitioners, you should consider pain management. For most patients, pain management is the way to regain function and improve quality of life.

- **WHAT ENTITIES ARE CONEJO PAIN SPECIALISTS MEDICAL GROUP, INC. AFFILIATED WITH?**

Conejo Pain Specialists Medical Group is affiliated with Saxon Surgical Center, Thousand Oaks Surgical Hospital, Los Robles Hospital and Medical Center, and Aspen Surgery Center in Simi Valley.

- **WHAT ABOUT MY PRIVACY?**

Conejo Pain Specialists is HIPPA compliant and works diligently to protect your privacy. We protect your privacy through the use of a secure electronic medical record system which eliminates paper waste and access from unauthorized personnel. We also shred all documents with patient information that are being disposed. Your right to privacy is important to us.

- **WHAT IS SAXON SURGICAL CENTER?**

Saxon Surgical Center is our private, single purpose ambulatory surgical center. It is fully licensed by the State of California and Medicare (CMS). This Center schedules a limited number of procedures each day to afford patients more personalized care. Although all surgical procedures present the risk of infection and complications, medical studies consistently report these risks are significantly reduced at ambulatory surgical centers like Saxon. A full staff of competent and caring nurses and technicians are attentive to every patient's needs.

- **I HAVE INSURANCE, DOES IT COVER THIS?**

Conejo Pain Specialists Medical Group, Inc., and Dr. Assil have been contracted by most of the Health Insurance Companies for Pain Management professional services.

Facility services at an ambulatory surgical center or at a hospital are different from professional medical services. These services are not part of the contract with doctors. Our staff will work with you to help you understand your benefits and options, if your diagnosis needs further treatment at our Saxon Surgical Center.

I have read the above information.

Patient's Name (please print): _____ Date:_____

Signature: _____

FINANCIAL POLICY

Conejo Pain Specialists Medical Group believes that communicating our financial policy is a good healthcare practice. Charges incurred for services rendered are the patient's responsibility regardless of insurance coverage. Your insurance coverage is a contract between you and your insurance company, not your insurance company and us. We will file your primary and secondary insurances only, as a courtesy. Please realize that having a secondary insurance does not necessarily mean that your services are covered at 100%. Secondary insurances typically pay according to a coordination of benefits with the primary insurance. It is your responsibility to provide us with accurate insurance information and to inform us of any changes in your coverage as they occur.

You are responsible for all copays, coinsurance, deductibles, and non-covered service/items. We are obligated to collect your copay at the time of service per your insurance company. We accept cash, check, MasterCard, Visa, or American Express. Statements are sent out monthly, and we ask that payment for balances due be paid when you receive your statement or at your next appointment, whichever is sooner. There is a $30.00 returned check fee charge. Payment will then need to be made by cash, money order or credit card for the balance due and service charge.

When you receive healthcare services from us and we bill your insurance, it is the same as us extending you credit. You receive the service and we await payment from you and/or your insurance. Due to the high cost of rendering care and the lowering reimbursement by many insurers, including Medicare, we cannot carry over large balances. Balances not paid within 90 days will be turned over to an outside collection agency unless prior arrangements have been made.

Because some patients may have incurred large balances for services provided, we will work with patients to set up a mutually feasible payment plan. If you miss a monthly payment while on the payment plan you run the risk of being sent to collections and being discharged from the practice. Please understand that we cannot waive deductibles, coinsurances or copays that are required by your insurance. This is a violation of our contracts with the insurance plans.

Completing DMV forms, disability forms, FMLA forms, and other requested supplemental forms requires time away from patient care and daily business operations. Prepayment of $25.00 per form is required. Please understand that in order to complete forms, your medical record must be reviewed, the forms completed, signed by the provider and scanned into your medical record. We request that you allow 5 business days for this process.

There will be a $75.00 charge for missing your scheduled appointment. We require 24 hour notice if you need to cancel an appointment.

I understand and agree to Conejo Pain Specialists' Financial Policy.

Print Name _____ Date _____

Signature _____

CONEJO PAIN SPECIALISTS MEDICAL GROUP, INC.

NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: AUGUST 11, 2011

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

If you have any question about this notice, please contact the **Facility Privacy Officer**.

Each time you visit a medical clinic, ambulatory surgical center, hospital, physician, or other healthcare provider, (each a "**Facility**") a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all the records of your care generated by the **Facility**, whether by **Facility** personnel, agents of the **Facility**, or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your health information created in the doctor's office or clinic.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy of your health information and provide you a description of our privacy practices. We will abide by the terms of this notice.

USE AND DISCLOSURES

How we may use and disclose Health Information about you.

The following categories describe examples of the way we use and disclose health information.

For Treatment: We may use health information about you to provide you treatment or services. We may disclose health information about you to doctors, nurses, technicians, or other **Facility** personnel who are involved in taking care of you. For example, a doctor treating you for back pain may need to know about your previous back surgery, as this information may help your treatment plan. Different **Facilities** also may share health information about you in order to coordinate the different things you may need, such as prescriptions, lab work, meals, and x-rays.

We may also provide your physician or subsequent healthcare provider with copies of various reports that should assist her or him in treating you once you're discharged from the **Facility**.

For Payment: We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information about your surgery procedure so they will pay us or reimburse you for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it.

For Health Care Operations: Members of the medical staff and/ or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve. For example, we may combine health information about many patients to evaluate the need for new services or treatment. We may disclose information to doctors, nurses, and other students for educational purposes. And we may combine health information we have with other **Facilities** to see

where we can make improvements. We may remove information that identifies you from this set of health information to protect your policy.

We may also use and disclose health information:

- **To business associates we have contracted to perform the agreed upon service and billing for it**
- **To remind you that you have an appointment for medical care**
- **To follow-up on how you are feeling after a surgery/ procedure**
- **To assess your satisfaction with our services**
- **To tell you about possible treatment alternatives**
- **For conduction training programs or reviewing competence of health care professionals**

When disclosing information, primarily appointment reminders and billing/ collections efforts, we may leave message on your answering machine/ voice mail.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do and bill you or your third-party payer for the services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Individuals Involved in Your Care or Payment for Your Care: We may release health information about you to a friend or family member who is involved in your medical care or who helps pay for your case. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research: We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research and granted a waiver of the authorization requirement.

Future Communications: We may communicate to you via newsletters, mail outs or other means regarding treatment options or health related information.

Organized Health Care Arrangement: This facility and its medical staff members have organized and are presenting you this document as a joint notice. Information will be shared as necessary to carry out treatment, payment and health care operations. Physicians and caregivers may have access to protected health information in their offices to assist in reviewing past treatment as it may affect treatment at the time.

As Required by Law: We may also use and disclose health information for the following types of entities, including but not limited to:

- **Food and Drug Administration**
- **Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability**
- **Correctional Institutions**
- **Workers' Compensations Agents**
- **Organ and Tissue Donation Organizations**
- **Military Command Authorities**
- **Health Oversight Agencies**
- **Medical Directors**
- **National Security and Intelligence Agencies**
- **Protective Services for the President and others**

Law Enforcement/ Legal Proceedings: We may disclose health information for law enforcement purposes as requires by law or in response to a valid subpoena.

State-Specific Requirements: Many states have requirements for reporting including population-based activities relating to improving health or reducing health care costs. Some states have separate privacy laws that may apply additional legal requirements. If the state privacy laws are more stringent than federal privacy laws, then state law preempts the federal law.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the **right to**:

Inspect and Copy: You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. We may deny your request to inspect and copy certain records in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the **Facility** 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.

Amend: If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the **Facility**. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

An Accounting of Disclosures: You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment or health care operations where an authorization was not required.

Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about an examination or procedure which you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Request for Confidential Communication: 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 may ask that we contact you at work instead of your home. The facility will grant reasonable requests for confidential communications at alternative locations and/ or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services. Please realize we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.

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. To exercise your rights, please obtain the required forms from the **Privacy Officer** and submit your request in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be effective for the information we already have about you as well as any information we receive in the future. The current notice will be posted by the **Facility** and include the effective date. Each time you visit a **Facility** for a treatment we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with: 1) the **Facility Privacy Official**, or 2) with Secretary of the Department of Human Services. To file a complaints with the **Facility**, contact the Facility Privacy Official. All complaints must be submitted in writing.

YOU WILL NOT BE PENALIZED FOR FILING A COMPLAINT.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to use will be made only with your written permission. If you provide us permission to use or disclose health 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 health 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 are required to retain our records of the care provided to you.

FACILITY PRIVACY OFFICIAL
Rosemary Gonzalez, *Practice Administrator*
Tel: 805-497-8616 Fax: 805-496-5585

To contact the Secretary of the Department of Health and Human Services, call 1-877-696-6775