.

Patient Information

Title: Mr. Mrs. Miss Dr. Email:

Name: Birthday: Gender: M / F

Street Address: Suite/Apt #

City: State: Zip Code:

Home Phone: Mobile: Work:

Driver's License #: State Issued: SS Number:

Parent/ Spouse/ Guardian Details

Name: Date of Birth: Relation:

Address:

Phone: SS Number:

Emergency Contact

Primary Contact: Phone:

Secondary Contact: Phone:

Employer Details

Employer Name: Occupation: Employment Status:

Address: Phone:

Background Information

Marital Status: Married Single Divorced Widowed Separated Live-in

Preferred language: Race:

Ethnic background: Religion:

Pharmacy Details

Preferred Pharmacy: Phone Number:

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COMPREHENSIVE PAIN MANAGEMENT CENTER

Physician and Referral Details

Primary Physician: Phone:

Referring Physician/ Source:

Insurance Details

Primary Insurance: Subscriber ID:

Secondary Insurance: Subscriber ID:

Subscriber Name: Date of Birth: Relation:

SSN: Cell Phone: Work Phone:

Notice of Privacy Practice

I hereby acknowledge that I received a copy of this medical practice's **Notice of Privacy Practices.** I further acknowledge that a copy of the current notice will be posted in the recreation area, and that a copy of any amended **Notice of Privacy Practices** will be available at each appointment.

- ❏ I would like to receive a copy of any amended Notice of Practices by email at:

Patient Signature: Date:

Print Name: Phone:

If not signed by the patient, please indicate relationship:

- ❏ Parent/ Guardian of minor patient
- ❏ Guardian or conservator of an incompetent patient

Name and address of patient:

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COMPREHENSIVE PAIN MANAGEMENT CENTER

Pain Management Treatment Agreement

This document is an agreement between _____, the patient, and James T. Lin, M.D., physician. Patient agrees to the policies as listed below to manage chronic pain. Patient acknowledges the fact of habituation on the opioid medication as a direct consequence of its use. Because of the controlled nature of these medications, strict accountability is required. The following policies are necessary for continued treatment:

- Regularly monthly visits for patient with scheduled II medication must be made to assess response and observe complications.
- ALL pain medications will be prescribed by ONE physician, which in this case, Dr. James Lin.
- ALL pain medication prescriptions will be filed at one pharmacy. Patient chooses:

Pharmacy Name: _____

Address: _____

Phone: _____

- Physician has complete liberty to discuss treatment details with the pharmacist at the dispensing pharmacy, and may ask the pharmacy for information about other medications, which have been prescribed for the patient.
- Random urine drug screens will be requested at any time. Urine must be given in before given medication prescription.

NOTE: YOU ARE RESPONSIBLE FOR ANY LAB FEES THAT ARE BILLED TO YOU. IF YOU HAVE INSURANCE WITH A HIGH DEDUCTIBLE, EXPECT A LAB BILL. YOU CAN ALSO PAY LAB CASH FEE (ASK LAB TECH FOR FEES) TO AVOID BILLS. IF YOU DO NOT HAVE INSURANCE YOU ARE RESPONSIBLE FOR EACH URINE DRUG TEST GIVEN. MEDICARE PATIENTS, YOU ARE RESPONSIBLE FOR 20%, IF YOU HAVE SECONDARY INSURANCE, PLEASE MAKE SURE WE HAVE YOUR SECONDARY INSURANCE TO AVOID A BILL.

Sign: _____ Date: _____

- Prescribed medication will be closely guarded. Please note these medications could be hazardous or lethal to another person, who is not tolerant to their effect. Patient will take as much care with medications, and written prescription, as they would their driver license or credit cards.
- Medications WILL NOT be replaced (if they are lost, fall into the toilet, are eaten by pets, left on airplane or car, or for any other reason. If your medications are lost or stolen an INCIDENT REPORT must be filed at the local police station or by a police officer. Once a hard copy of the police report is obtained, ONE exception may be made. Be sure to ask officer for turn around time.
- Early refills will not be given. If patient uses a month supply of medications within three weeks, the last week will be without medications.
- All confidentiality of prescription and medication records is waived if there is any request from legal authorities for the information concerning inappropriate or unlawful use of controlled substances. Failure to adhere to these policies will result in permanent cessation of pain medication prescribed by Dr. James Lin. Patient understanding that he/she will not take medications or substances (prescription or recreational), which have been disclosed to physician.

Patient Signature:	Date:
Print Name:	Witness:
Physician Signature:	Date:

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COMPREHENSIVE PAIN MANAGEMENT CENTER

Financial Agreement

1. **PAYMENT** is expected at the time of you visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, copayment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. We do ask for a copy of an ID card and of license due to the many cases of identity theft in the news lately. (Please do not be offended!)

2. **INSURANCE** We are out-of-network providers. We will file all of these insurance claims. A list of these insurance plans is available upon request. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment from your insurer, we will refund any overpayment to you.

   If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejects for the lack of one.

   Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

   Patients who insist on "day of" urgent/emergent scheduling or care after hours or on days the office is closed will be assessed an additional urgent care or after hours fee. These fees will be billed to your insurance carrier or collected as part of the office charges or self-pay patients.

3. **LATE CHARGES** of 12% annually will be applied to all patient balances 90 days old or greater.

4. **RETURNED CHECKS** Will incur a $35.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $35 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $35 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted in Ventura County.

5. **ACCOUNTING PRINCIPALS** Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

6. **FORMS FEE** Completing insurance forms, copying medical records, etc... Requires office staff time and time away from patient care for out doctors. We require pre-payment for completing forms, copying medical records, notarizing, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. Base form charges are $35.00 per occurrence plus an applicable postage or notary fees. Postage is for our office fee schedule. Comprehensive Pain Management Center will have 15 business days in which to copy records before making them available for patient to pick up, and these 15 days will commence after payment for copying has been received and after patient has signed this form authorizing records' release.

7. **BILLING OFFICE** If you have any questions in regards to any of your billing statements our billing department is available to assist you. Please CALL 805-557-7050 ext 119.

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8. **CANCELLATIONS OR MISSED APPOINTMENTS** If you do not cancel your appointment at least 24 hours before, or if you no-show, we will assess you a $50.00 missed appointment fee.

9. **RESPONSIBILITY FOR PAYMENT** I understand that I, personally, am financially responsible to James Lin, MD/ Comprehensive Pain Management Center for charges not covered by the assignment of insurance benefits.

10. **ASSIGNMENT OF INSURANCE BENEFITS** I hereby assign, transfer, and set over directly to James Lin, MD/Comprehensive Pain Management Center sufficient monies and /or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my department in said clinic. I authorize James Lin, MD/ Comprehensive Pain Management Center to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to James Lin, MD/Comprehensive Pain Management Center. I authorize James Lin, MD/Comprehensive Pain Management Center to release all medical information (including but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers, any other third-party payers.

11. **CHANGING INSURANCE,** I am responsible to notify James Lin, MD/ Comprehensive Pain Management Center immediately if I change my insurance carrier, policy or status of coverage. I understand that failure to notify James Lin, MD/Comprehensive Pain Management Center will result in incorrect billing in eligibility. This means that I am responsible for all balance of the services that incurred during this time.

12. **RELEASE OF INFORMATION** I hereby authorized James Lin, MD/Comprehensive Pain Management to release to governmental agencies, Insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

13. **COLLECTION FEES** I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pain in full.

14. **DIVORCED PARENTS OR PATIENTS** by signing below, the adult who signs a minor child into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

I have read and understand the practice's financial policy and I agree to be bound by its terms.

I also understand and agree that such terms may be amended by the practice from time to time.

Patient Signature:	Date:
Patient Print Name:	

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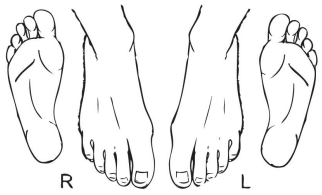
COMPREHENSIVE PAIN MANAGEMENT CENTER

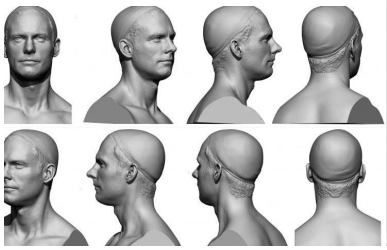
Name: **Date:**

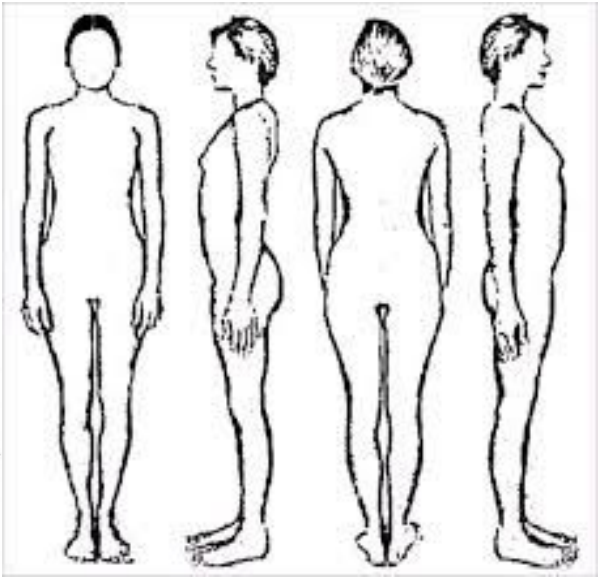
New Patient Evaluation

What is the major reason you are coming to see the doctor (chief complaint)?:

Mark an "X" on the figures below where your pain start and show where it goes with an arrow.







When did pain start?

What were you doing when the pain first started?

Does the pain occur at certain times?

- ❑ No
- ❑ Yes, please explain

Describe your pain:

❑ Throbbing	❑ Heavy	❑ Gnawing
❑ Shooting	❑ Sickening	❑ Burning
❑ Stabbing	❑ Fearful	❑ Aching
❑ Sharp	❑ Punishing Cruel	❑ Tender
❑ Cramping	❑ Splinting	❑ Exhausting

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COMPREHENSIVE PAIN MANAGEMENT CENTER

Describe your pain at its worst (0 to 10, 10 being the worst):

Describe your pain at its best (0 to 10, 0 being the best):

Describe your average pain (0 to 10):

What makes your pain worse:

❑ Bending	❑ Sexual Intercourse	❑ Coughing
❑ Lifting	❑ Standing a long time	❑ Sneezing
❑ Defecation	❑ Sitting a long time	❑ Other:

What makes your pain better:

❑ Ice	❑ Activity	❑ Bending Backwards
❑ Heat	❑ Bending Forward	❑ Medications
❑ Sitting	❑ Fetal Position	❑ Other:

Are there any other symptoms/ problems associated with your pain?

❑ Difficulty Sleeping	❑ Depression
❑ Difficulty with Intercourse	❑ Other:

Treatment History

Which of the following types of caregivers have you visited?

❑ Sports Medicine	❑ Neurology
❑ Orthopedics	❑ Spine Surgeon
❑ Rehabilitation Medicine	❑ Chiropractor

Which of the following have you taken prior to your visit here today?

❑ Tylenol (acetaminophen)	❑ Opioids	❑ Lyrica
❑ Anti-inflammatory agents	❑ Steroids	❑ Amitriptyline (Elavil)
❑ Muscle relaxers	❑ Neurontin	❑ Other:

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COMPREHENSIVE PAIN MANAGEMENT CENTER

Have you had any of the following interventions done for your pain?

❑ TENS Unit	❑ Nerve Blocks	❑ Radiofrequency
❑ Cryotherapy	❑ Trigger Point Injections	❑ Sacroiliac Joint Injection
❑ Ultrasound	❑ Facet Injection	❑ Other:
❑ Diskography	❑ Epidural Steroid Injections	❑

Have you had any of the following surgical interventions done for your pain?

❑ Discectomy	❑ Fusion	❑ Spinal Cord Stimulator	❑ Laminectomy
❑ Pain Pump	❑ Kyphoplasty	❑ Other:	

Have you undergone any of the following for your pain?

❑ Bed Rest	❑ Physical Therapy	❑ Medications
❑ Lumbar Traction	❑ Biofeedback	❑ Prolotherapy
❑ Exercises	❑ Acupuncture	❑ Counseling
❑ Manipulations	❑ Loss of Work	❑ Other:

Drug allergies and reaction:

- ❑ NKDA (No Known Drug Allergies
- ❑ Allergies or reactions to:

Medication List (continue on back side if needed)

Medications & Directions		
1.	6.	11.
2.	7.	12.
3.	8.	13.
4.	9.	14.
5.	10.	15.

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COMPREHENSIVE PAIN MANAGEMENT CENTER

Past Medical History

List all medical problems	Treating Physician
1.	
2.	
3.	
4.	
5.	

Past Surgical History

List all surgeries	Surgeon	Surgery Date
1.		
2.		
3.		
4.		
5.		

Social History

Any use of tobacco? What type and for how long?

Any use of alcohol? What kind and for how long?

Any use of recreational drugs? What kind and for how long? If yes, please include if you've joined any recovery programs. If in recovery, please include how long.

Family History

List all family medical problems

Relation	Medical Problem

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Patient Name: Date:

How much does your chronic pain limit your abilities to perform these activities?

PHYSICAL ACTIVITIES- Lower body

Walking

❑ Not at all	❑ Mildly	❑ Moderately	❑ Severely

Climbing stairs

❑ Not at all	❑ Mildly	❑ Moderately	❑ Severely

Bending

❑ Not at all	❑ Mildly	❑ Moderately	❑ Severely

PHYSICAL ACTIVITIES-Upper body

Carrying groceries

❑ Not at all	❑ Mildly	❑ Moderately	❑ Severely

Reaching above

❑ Not at all	❑ Mildly	❑ Moderately	❑ Severely

Turning your head

❑ Not at all	❑ Mildly	❑ Moderately	❑ Severely

PERSONAL & HOUSEHOLD CARE

Bathing or dressing

❑ Not at all	❑ Mildly	❑ Moderately	❑ Severely

Getting in and out of bed

❑ Not at all	❑ Mildly	❑ Moderately	❑ Severely

Performing housework

❑ Not at all	❑ Mildly	❑ Moderately	❑ Severely

WORK

Concentrating at work

❑ Not at all	❑ Mildly	❑ Moderately	❑ Severely

Working with hands

❑ Not at all	❑ Mildly	❑ Moderately	❑ Severely

Performing tasks at work

❑ Not at all	❑ Mildly	❑ Moderately	❑ Severely

SOCIAL ACTIVITIES

Visiting family & friends

❑ Not at all	❑ Mildly	❑ Moderately	❑ Severely

Getting out of house

❑ Not at all	❑ Mildly	❑ Moderately	❑ Severely

Pursuing hobbies & friends

❑ Not at all	❑ Mildly	❑ Moderately	❑ Severely

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COMPREHENSIVE PAIN MANAGEMENT CENTER

Review of Systems

CONSTITUTIONAL

❑ Fever	❑ Weight	❑ Fatigue

EYE PROBLEMS

❑ Blurred vision	❑ Loss of vision	❑ Eye pain	❑ Eye dryness	❑ Other:

EAR-NOSE-THROAT

❑ Loss of balance	❑ Ringing in ears	❑ Dizziness
❑ Trouble hearing	❑ Other:	

CARDIAC

❑ Chest pain	❑ Irregular heart beat	❑ High blood pressure
❑ Limb swelling	❑ Other:	

RESPIRATORY

❑ Trouble breathing	❑ Chronic cough
❑ Coughing blood	❑ Other:

GASTRO-INTESTINAL

❑ Nausea	❑ Heartburn	❑ Abdominal pain	❑ Vomiting
❑ Constipation	❑ Diarrhea		

MUSCULO

❑ Muscle pain	❑ Joint pain	❑ Back pain	❑ Neck pain
❑ Muscle cramp	❑ Joint swelling	❑ Loss of muscle bulk	

NEUROLOGIC

❑ Headache	❑ Tremors	❑ Seizures
❑ Weakness	❑ Trouble concentrating	❑ Others:

ENDOCRINE

❑ Heat-cold intolerance	❑ Excessive urination
❑ Excessive thirst	❑ Other: