Inland Pain Medicine
Specialist in Pain Care & Management
Colton, CA Upland, CA San Bernardino, CA Beaumont, CA Phone: 909-887-2991 Fax: 909-887-5694

Dear Patient:

Welcome and thank you for choosing to schedule your appointment with Inland Pain Medicine as your Specialist in Pain Management Care. You can visit us for information at www.inlandpainmedicine.com

Your scheduled appointment is on Date:_____ /_____ /_____ Time: _____ with the following provider.

[ ] Andrew W. Hesseltine, MD [ ] John S. Cho, MD [ ] Suja Alexander, MN,FNP

[ ] Abdul Kanu, MD [ ] Trisha Patel, MD [ ] Mareena Miller, FNP -BC

[ ] Mark Macknet, MD [ ] Yogesh Patel, MD

You are scheduled at the following location:

[ ] **Colton**: 1850 E. Washington St. Colton, CA 92324
[ ] **Upland**: 350 S. Euclid Ave. Unit C Upland, CA 91786
[ ] **San Bernardino** : 1823 Commercenter W. Ste. B San Bernardino, CA 92408
[ ] **Beaumont** : 851 E. 6th Ste. A Beaumont, CA 92223

Enclosed please find the information packet and forms necessary to complete your chart. In order to serve you in a timely manner, we ask that you complete the information PRIOR to your appointment and bring this information back with you at the time of your appointment. Please do not mail these forms back to our office. If your paperwork is incomplete or forgotten, please arrive 30-40 minutes early to fill out paperwork or we will likely need to reschedule your appointment.

Please bring with you your insurance card and driver's license. Deductibles and co-payments will be collected at the time of your visit. You will be responsible for payment at the time of service if you arrive without your insurance card. Your insurance is a contract between you and your carrier. Our staff will assist you to the best of their ability in dealing with your insurance company, but it is your responsibility to know your insurance policy and coverage of your plan before you arrive for your visit. If you are choosing to use your point of service or Out of Network Options, we recommend that you contact your insurance carrier prior to coming to our office to notify them that you are using this option for our doctors.

If you have any questions, please feel free to call our registration coordinator at 909.887.2991 option 6 or email us at patient.registration@inlandpainmed.com.

Thank you for choosing Inland Pain Medicine and we look forward to serving you.

Sincerely,

Melika Hesseltine

Chief Operating Officer

Inland Pain Medicine

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Patient's Legal Name: _____ DOB: ___/____/____ Age: _____ Gender: F M

Address: _____City: _____State: _____ Zip: _____

Email: _____@_____

Home Number: _____-_____-_____ Cell Number: ____-____-_____ Carrier: _____ Text for Appointment: [ ] Yes [ ] No

[ ] I authorization Inland Pain Medicine to contact me on any of the phone numbers that I have listed above.

Social Security: ____-_____- _____ Driver's License # _____Marital Status: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Current Employer: _____ Occupation: _____

Referring Doctor_____ Phone#: _____

Primary Care Physician: _____ Phone #: _____

Primary Insurance: _____ *If HMO* Group Name: _____ ID#: _____

Subscriber Name (if different than patient): _____ Subscriber DOB: __/___/___Subscriber Social: ___-___-____

Secondary Insurance: _____ ID #: _____

Emergency Contact: _____ Relationship: _____ Phone Number: ____-____-_____

If Workers Comp Or Personal Injury: Work Comp Carrier: _____

Employer At Time of Injury*:* _____ Phone Number: _____-_____-_____ DOI: ___/___/____

Address: _____City: _____ State: _____ Zip: _____

Authorized Body Part: (if applicable) _____ Claim Number: _____

Attorney Name: _____ Phone Number: _____-_____-_____ Fax: ____-_____-_____

Address: _____City: _____ State: _____ Zip: _____

Adjustor Name: _____ Phone Number: _____-_____-_____ Fax: _____-_____-_____

Address: _____City: _____ State: _____ Zip: _____

Claims Mailing Address: _____City: _____ State: _____ Zip: _____

I understand that patients who carry medication insurance should remember that professional services are rendered and charged to the patient, not the insurance company. In the event insurance payments are received directly.

I hereby give my consent for medical consultation, treatment and billing changes to my insurance. I hereby authorize payment directly to Inland Pain Medicine of insurance benefits otherwise payable to me. I understand that I will be responsible for any charges that insurance company will not cover.

Signature: _____Date: _____

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Medical Information Release Form

(HIPAA Release Form)

Name: **Date of Birth: _____/____/_____**

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

If the patient is a minor or unable to sign, check one of the following

[ ] The patient is a minor: I/we sign consent to the foregoing.

[ ] The patient is unable to sign because _____ and I/we sign the foregoing consent on his/her behalf.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

_____ _____
Authorized Signature / Parent or Legal Guardian Date

_____ _____
Witness Date

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Financial Policy

PLEASE READ CAREFULLY

You and your insurance carrier are responsible for your bill. Knowing your insurance benefits plan is your responsibility.

If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy.

(WE ACCEPT CASH, CHECKS, VISA AND MASTERCARD)

Insurance information must be presented/updated at the time of making your appointment not at the time of service. Most insurance companies have requirements for authorization of services and/or referrals from the Primary Care Provider prior to the services. If you present for your appointment and you have not provided your correct insurance to ensure verification, authorization of services and all required referrals you will not be seen and your appointment will be rescheduled.

Payment in Full for non-insurance services is expected at the time of service. Co-payments for services are required at the time of registration. Please be advised that we are contractually obligated by your insurance carrier to collect your co-payment at the time of service. If you arrive without the ability to pay for your services or your co-pay you will not be seen and your visit will be rescheduled.

If you have insurance, as a courtesy to you, we will file your primary and secondary insurance claim for services at no cost to you. However, we will not wait more than 45 days for the insurance to pay. After 45 days, it is your responsibility to contact your insurance company and follow up on why your claim has not been paid. You must take the necessary action required to get your claim paid and communicate your actions to our office. Failure to assist our office in timely payment of your insurance claim will result in the total charges being transferred to patient liability. Any patient liability assigned to you by your insurance carrier will be billed to you. Once insurance has paid, payment in full of the patient assigned liability will be expected with the receipt of your statement. You will receive two billing statements regarding your balance. If we do not hear from you after these two statements, your account will be subject to our collection process unless prior arrangements are made with our financial office.

Inland Pain Medicine is committed to providing the highest quality care for our patients and we charge what is usual and customary for our area. You are ultimately responsible for all clinic and surgery fees relating to your care. **You are responsible for payment regardless of your insurance company's arbitrary determination of usual and customary rates.** Your insurance policy is a contract between you and your insurance company. Any disagreement you have concerning the amount your insurance pays should be directed to your insurance company.

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover or which they may consider medically unnecessary, and, in some instances, you will be responsible for these amounts. Your policy may also contain plan specific limitations that apply to referrals, referral dates and number of visits. We will make every effort to ascertain your coverage for our services before treatment and will make you aware of our findings. However, this does not guarantee payment from your insurance carrier. The contract of coverage is between you and your insurance carrier and it is your responsibility to understand your coverage, coverage requirements and limitations due to the variations between policies. You will be expected to pay for the patient liability assigned to you by your insurance carrier.

For services that are not covered by insurance, the practice requires payment of 100% of the total **estimated charges** unless prior payment arrangements have been set up with our office.

Insured individuals electing to be self-pay. The patient has the right to elect not to file their health insurance and elect to be a self-pay patient for services provided. The patient will be financially responsible for charges incurred and payment will be due at the time of service. After services have been rendered, the patient will not be able to file their health insurance for the services due to insurance claim submission requirements. Inland Pain Medicine will not file insurance for any services where the patient elected to be self-pay. The patient's election to not file the services to their insurance company does not affect or reduce any out of pocket financial responsibility for future services as determined by their insurance plan.

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If you do not have insurance coverage for the service, are self-pay, **or have insurance that Inland Pain Medicine does not participate in or accept**, payment is expected at the time of service. Inland Pain Medicine has established a discounted self-pay rate for our services. Prior financial arrangements must be made and approved before your visit if you cannot pay 100% at the time of service.

No discount of assigned insurance patient liability (co-pay, deductibles, co-insurance) will be made to comply with federal insurance regulations and law.

If financial arrangements have not been made and you arrive without the ability to pay for the services you will not be seen and your visit will be rescheduled.

All patient-responsible balances that remain delinquent after 120 days, with no response from our requests for payment, may be referred to a collection agency. Once an account is turned over to the collection agency, the patient or responsible party will need to settle the debt with the agency prior to scheduling any further treatment.

I understand that I am financially responsible for all charges weather or not paid by insurance. Payment is due and payable at the time services are rendered unless prior arrangements have been made with a billing coordinator. All returned checks are subject to a **$30** return check fee. Check writing privileges with be revoked and all future payments will be accepted as cash, credit card or money order.

I authorize and request my insurance company to pay all claims direc6tly to Inland Pain Medicine and will relinquish any payments assigned to me to Inland Pain Medicine. I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Out of Network Insurance – Some insurance plans require you to pay different out-of- pocket amounts based on the provider and/or location where the service is performed. Deductibles, co-insurance and co- payments may also apply according to your insurance plan. By law, you are responsible for these amounts, as well as any non-covered services outlined in your health plan. It is your responsibility to inquire about any plan specific coverage limitations with your insurance company. You can choose to have the services performed as “Out of Network” or as self-pay. You may also apply for financial hardship review if the “Out of Network” patient liability exceeds your ability to pay.

Insurance information provided after the services have been provided will be billed or not billed at the discretion of Inland Pain Medicine. Due to the Insurance contractual requirements for referrals, authorization of services and timely filing limitations insurance must be presented prior to services being provided. If Inland Pain Medicine agrees to bill your insurance you will be held liable for the charges if the insurance denies your claim as untimely because of late presentation of coverage or for lack of timely authorizations or referrals.

Patients who request payment arrangements and/or financial hardship adjustments are required to supply financial documentation to support their request. Financial documentation will include income and expenses as outlined on our financial assistance application. Failure to supply the required documentation will result in normal collection activity being adhered to.

In the event your account/s must be turned over for outside collections, you will be billed and are responsible for all fees involved in the collection process. Returned checks are subject to a handling fee of **$30.00**

Please note that our office charges **$50.00** for missed appointments. Please contact our office 48 hours in advance to reschedule your appointment in order to avoid this fee.

In the event you have an account with a credit balance, we reserve the right to transfer credits to any other outstanding account balances prior to issuing a refund.

Patients with a history of presenting for their appointment without the ability to pay their co-pay, short notice (less than 48 hours) cancelling of appointment or not showing up for their appointments will be subject to reviewed for dismissal from our practice.

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There is a minimum charge of **$50.00** complete FMLA paperwork, forms for disability claims, accident or injury claims, attorney verification of medical condition or any other non-medical services reimbursement paperwork. Payment must be made at the time the forms are complete. Some third-party forms requests must be paid for prior to the forms being completed.

We realize that temporary financial problems do occur. If such problems do arise, we encourage you to contact us promptly for assistance. If you have any questions about the above information, or any uncertainty regarding your insurance coverage, PLEASE do not hesitate to ask us.

Authorization: I hereby authorize Inland Pain Medicine to administer treatment, diagnostic testing and perform procedures as may be deemed necessary or advisable in my diagnosis. I further authorize the release of any medical information necessary to process my insurance claim and request payment of medical services to be assigned directly to Inland Pain Medicine. In the event my insurance makes payment directly to me for services I will immediately endorse and assign the payment to Inland Pain Medicine. If my insurance does not cover services rendered, I agree to be personally and fully responsible for payment. I give Inland Pain Medicine permission to appeal any denials by my insurance for services rendered on my behalf. I will assist Inland Pain Medicine with follow up of timely payment, requests for information and appeals to my insurance as necessary to ensure full and timely payment for services received.

I have read the Inland Pain Medicine's Financial Policy and understand and agree to its terms. This authorization is to remain in full force unless I revoke the same in writing.

_____ _____
(Patient/Responsible Party) Signature (Patient/Responsible Party) Printed Name

_____ _____
(Date) (Date)

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New Patient Questionnaire

PATIENT INFORMATION

Dear Patient:

Welcome to Inland Pain Medicine! By answering the following questions, you will help us serve you more efficiently and safely. Thank you!

Today's Date: ___/____/_____

Patient Name: _____ DOB: ____/____/_____Age: _____

Email Address: _____@_____.com Primary Care Physician: _____

What is your preferred language? [ ] English [ ]Spanish [ ]Other:_____

What is your ethnicity? [ ] Not Hispanic / Latino [] Hispanic/ Latino [ ] Decline to Answer

What is your race? [ ] American Indian or Alaskan Native [ ]African American or Black [ ]Asian

[ ] Native Hawaiian or Other Pacific Islander [ ] White [ ] Decline to Answer [ ] Other: _____

Reason for visit: _____

Intensity:

_____ Without medication

1 2 3 4 5 6 7 8 9 10
Mild **Moderate** **Severe**

_____ With medication

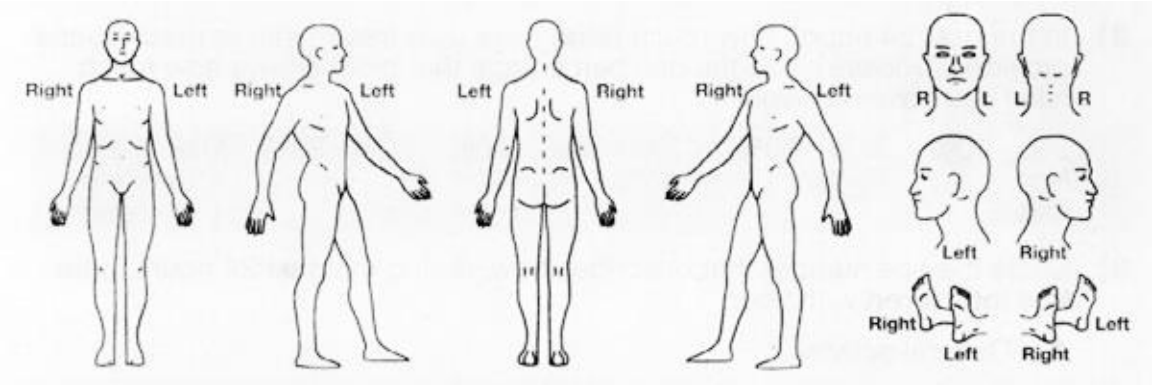
1 2 3 4 5 6 7 8 9 10
Mild **Moderate** **Severe**

_____ Average over last 30 days

1 2 3 4 5 6 7 8 9 10
Mild **Moderate** **Severe**

CURRENT PAIN DETAILS

Circle Pain Location on Diagram



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CURRENT PAIN DETAILS (CONTINUED)

Have you developed any of the following? (Please check all that apply.)

[ ] Numbness	[ ] Chills	[ ] Vomiting
[ ] Weakness	[ ] Fevers	[ ] Nausea
[ ] Bowel incontinence	[ ] Poor Sleep	[ ] Current Infection
[ ] Bladder Incontinence	[ ] Fatigue	[ ] Paresthesia

[ ] I have not recently developed any of the above problems.

Please indicate the type of pain / discomfort you are having. (Check all that apply.)

[ ] Sharp	[ ] Dull	[ ] Throbbing
[ ] Pressure	[ ] Burning	[ ] Aching
[ ] Numbing	[ ] Electricity	[ ] Pins and needle
[ ] Itching	[ ] Burning	[ ] Stabbing
[ ] Heaving	[ ] Tingling	[ ] Tender
[ ] Constant	[ ] Radiating	[ ] Intermittent

[ ] Morning Stiffness : [ ] 15 minutes [ ] 15-30 minutes [ ] 30 min- 1 hours [ ] >1 hour

Duration of Pain: _____ [ ] Days [ ] Weeks [ ] Months [ ] Years

PAIN SYMPTOM CHARACTERISTICS

What makes your pain better or worse? (Please circle one for each activity)

Bending Backward	Better	Worse	No Change
Bending Forward	Better	Worse	No Change
Twisting	Better	Worse	No Change
Prolonged Standing	Better	Worse	No Change
Prolonged Sitting	Better	Worse	No Change
Walking	Better	Worse	No Change
Lying Flat on Your Back	Better	Worse	No Change
Lying on Your Stomach	Better	Worse	No Change
Weather Changes	Better	Worse	No Change
Climbing Stairs	Better	Worse	No Change
Coughing / Sneezing	Better	Worse	No Change
Lifting Objects	Better	Worse	No Change
Rising from Sitting	Better	Worse	No Change

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EXERCISE / WORK

How often do you exercise? [ ] Daily [ ] 2-3 days a week [ ] Weekly [ ] Monthly

Are you currently on disability? [ ] Yes [ ] No Are you seeking disability? [ ] Yes [ ] No

Are you currently working? [ ] Yes [ ] No If no, reason: _____

Are you able to perform your daily activities? [ ] Yes [ ] No

Do you exercise? [ ] Yes [ ] No If yes, what do you do? _____

INTERVENTIONS TRIED

Which of the following interventional pain treatments have you tried for your pain? (Please check all that apply)

[ ] Facet Injections [ ] Never Blocks [ ] Intrathecal Therapy (Pump)
[ ] Epidural Steroids Injections [ ] Radiofrequency Ablation [ ] Trigger Point Injections
[ ] Medial Branch Block [ ] Spinal Cord Stimulator [ ] Vertebroplasty or Kyphoplasty
[ ] Other: _____
[ ] I have not tried any interventional procedures performed for my current pain condition.

Which of the following therapies have you tried and did it make your pain better, worse or was there no change? (Please circle one for each therapy)

Physical Therapy	Never Tried	Better	Worse	No Change
TENS	Never Tried	Better	Worse	No Change
Acupuncture	Never Tried	Better	Worse	No Change
Biofeedback	Never Tried	Better	Worse	No Change
Brace Support	Never Tried	Better	Worse	No Change
Traction	Never Tried	Better	Worse	No Change
Psychological Therapy	Never Tried	Better	Worse	No Change
Injections	Never Tried	Better	Worse	No Change
Surgery	Never Tried	Better	Worse	No Change
Massage Therapy	Never Tried	Better	Worse	No Change
Chiropractic Care	Never Tried	Better	Worse	No Change
Ice	Never Tried	Better	Worse	No Change
Heat	Never Tried	Better	Worse	No Change
Daily Exercise	Never Tried	Better	Worse	No Change
Other:				

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MEDICATIONS TRIED

Which of the following medications have you tried for your pain? (Please check all that apply)

[ ] Opioids (Vicodin, Percocet, etc.)
[ ] Anticonvulsants
[ ] Anti-inflammatory
[ ] Benzodiazepines
[ ] Muscle Relaxants
[ ] Oral Steroids
[ ] Constipation Medications
[ ] Topical Creams
[ ] Sleep Aids
[ ] Anti-Depressants
[ ] Anti-Rheumatics
[ ] Migraine Medications
[ ] Gout Medications
[ ] Dopamine Stimulants
[ ] Cymbalta / Savella
[ ] Neurontin / Lyrica
[ ] NSAIDs (Motrin, Aleve, etc.)
[ ] Other: _____

ALLERGIES

Do you have Allergies to any Medications? [ ] Yes [ ] No If yes, please list:

Medication	Reaction

Do you have any LATEX allergies? [ ] Yes [ ] No

Do you have any CONTAST allergies? [ ] Yes [ ] No

OTHER DOCTORS CONSULTED

Which of the following doctors have you consulted for pain relief?

[ ] Acupuncturist [ ] Anesthesiologist [ ] Chiropractor [ ] Dentist

[ ] Endocrinologist [ ] ENT Physician [ ] General Physician [ ] Hypnotist

[ ] Internist [ ] ENT Physician [ ] General Physician [ ] Orthopedic Surgeon

[ ] Neurosurgeon [ ] Neurologist [ ] Ophthalmologist [ ] Plastic Surgeon

[ ] Podiatrist [ ] Pain Physician [ ] Physical Therapist [ ] Plastic Surgeon

[ ] Other: _____

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LITIGATION

Is your pain due to an injury or accident? [ ] Yes [ ] No If Yes Date Of Injury: _____

Is there any pending litigation? [ ] Yes [ ] No

Is your pain related to a worker's compensation case? [ ] Yes [ ] No

Are you involved in a personal injury case? [ ] Yes [ ] No

Please give a brief summary of incident:

_____

_____

_____

BLOOD THINNERS

Are you on any blood thinners? [ ] Yes [ ] No

If so, please check all that apply:

		[ ] NSAIDS	[ ] Aspirin
[ ] Aggrenox	[ ] Ticlopidine	[ ] Coumadin/Warfarin	[ ] Heparin
[ ] Lovenox	[ ] Plavix	[ ] Other: _____	

DIAGNOSTIC TEST AND IMAGING

Which of the following have you had done?		When?	Location:
[ ] MRI	[ ] Yes [ ] No	Date: __/____ /____	_____
[ ] Discogram	[ ] Yes [ ] No	Date: __/____ /____	_____
[ ] X-ray	[ ] Yes [ ] No	Date: __/____ /____	_____
[ ] EMG/NCS	[ ] Yes [ ] No	Date: __/____ /____	_____
[ ] Related Blood Work	[ ] Yes [ ] No	Date: __/____ /____	_____
[ ] Other: _____		Date: __/____ /____	_____

[ ] I have not had any diagnostic test performed for my current pain condition.

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CURRENT MEDICATIONS

Please list your CURRENT MEDICATIONS, Dosage, Frequency and Purpose: (Please print clearly.)

Medication	Dosage	Frequency	Purpose

[ ] No current medications

PAST MEDICAL HISTORY

Have you had any of the following disease or conditions? (Please check all that apply.)

General: [ ] Cancer [ ] Diabetes [ ] Headaches [ ] High Cholesterol
[ ] Hypertension [ ] Kidney Dysfunction [ ] Liver Dysfunction [ ] Migraines

Head/Eyes/Ears/Nose/Throat: [ ] Cataracts [ ] Hypothyroidism [ ] Head Injury
[ ] Stroke [ ] Hyperthyroidism

Gastrourinary: [ ] Dialysis [ ] Kidney Stones
[ ] Urinary Incontinence [ ] UTIs/Bladder Infections

Cardiovascular: [ ] Anemia [ ] Heart Murmur [ ] Angina
[ ] Peripheral Vascular Disease [ ] Phlebitis [ ] Heart Attack
[ ] Coronary Artery Disease [ ] Vascular Disease

Gastrointestinal: [ ] Bowel Incontinence [ ] GERD/Heartburn [ ] Constipation
[ ] GI Bleeding [ ] Crohn's/Ulcerative [ ] Irritable Bowel [ ] Colitis
[ ] Colitis [ ] Diarrhea

Respiratory: [ ] Asthma [ ] COPD [ ] Bronchitis [ ] Emphysema

Musculoskeletal: [ ] Amputation [ ] Joint Injury [ ] Bursitis Tendonitis
[ ] Lateral Epicondylitis [ ] Carpal Tunnel [ ] Medical Epicondylitis [ ] Osteoarthritis
[ ] Central Pain [ ] Chronic Joint Pain [ ] Osteopenia [ ] Chronic Pain
[ ] Elbow Pain [ ] Rheumatoid Arthritis [ ] Phantom Limb Pain [ ] Osteoporosis
[ ] Fibromyalgia [ ] Reflex Sympathetic Dystrophy /CRPS

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Infectious Diseases:

[ ] Hepatitis [ ] Pneumonia [ ] HIV/AIDS [ ] Tuberculosis
[ ] MRSA History [ ] Current Infection

Any Psychiatric care? [ ] Yes [ ] No
Are you currently pregnant? (Females Only) [ ] Yes [ ] No
If yes, date of last menstrual periods? _____

FAMILY HISTORY

Has anyone in your immediate family had any of the following conditions? (Please check all that apply.)

[ ] Chronic Pain [ ] Diabetes [ ] Kidney Problems [ ] Seizure History
[ ] Arthritis [ ] Hypertension [ ] Liver Problems [ ] Alcohol Abuse
[ ] Rheumatoid Arthritis [ ] Heart Disease [ ] Headaches [ ] Drug Abuse
[ ] Cancer [ ] Lung Disease [ ] Stroke [ ] Depression

SURGICAL HISTORY

Please List any Surgeries you have had: [ ] No past surgical history

Surgery	**Approximate Date**
_____	_____
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY

Marital Status: [ ] Single [ ] Married [ ] Civil Union [ ] Domestic Partner
[ ] Separated [ ] Divorced [ ] Widow
Children: _____
Do you drink alcohol? [ ] Often [ ] Socially [ ] Never Drank Alcohol
Do you smoke? [ ] Everyday [ ] Somedays [ ] Never Smoked
Do you use illegal drugs? [ ] In the Past [ ] Still Using [ ] Never Used Drugs
If Yes, for marijuana do you have a license? [ ] Yes [ ] No Exp Date: _____
Have you ever abused / misused medication? [ ] Yes [ ] No
Have you ever been seen for Alcohol or Drug Abuse? [ ] **YES** [ ] **NO**
Have you ever been in a Detox Program? [ ] **YES** **[ ]NO**
Have you ever been arrested related to Drugs/Alcohol? [ ] **YES** [ ] **NO**

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REVIEW OF SYSTEMS

Do you have or have you ever had any of the following diseases or conditions? (Please check all that apply.)

Genitourinary: [ ] Urinating Frequently [ ] Urinating Urgency [ ] Painful
[ ]Urination [ ] Flank Pain [ ] Kidney Stones [ ] Blood in Urine [ ] Kidney Disease

Skin: [ ] Dryness [ ] Rash [ ] Shingles
[ ] Hay Fever [ ] Itching [ ] Ulcers [ ] Seasonal Allergies

Respiratory: [ ] Shortness of Breath [ ] Cough [ ] Wheezing
[ ] Pulmonary Embolism

Endocrine: [ ] Cold Intolerance [ ] Hot Flashes [ ] Heat Intolerance

Gastrointestinal: [ ] Abdominal Pain [ ] Liver Disease [ ] Diarrhea
[ ] Constipation [ ] Acid Reflux/Heart Burn [ ] Hernia [ ] Blood in Stool
[ ] Irritable Bowel Syndrome [ ] Ulcer Disuse [ ] Nausea/ Vomiting

Musculoskeletal: [ ] Back Pain [ ] Joint Pain [ ] Muscle Spasms
[ ] Neck Pain [ ] Skin Temp. Changes [ ] Increase Sensitivity to Touch [ ] Joint Swelling
[ ] Edema [ ] Skin Color Changes

Neurological: [ ] Carpal Tunnel Syndrome [ ] Headaches [ ] Dizziness
[ ] Weakness [ ] Numbness [ ] Tremors [ ] Seizures
[ ] Stork [ ] Loss of balance [ ] Migraines [ ] Dementia

Constitutional: [ ] Fevers [ ] Chills [ ] Night Sweats
[ ] Tremors [ ] Excessive Sweating [ ] Loss of Appetite [ ] Fatigue
[ ] Unexplained Weight Loss or Gain

Cardiovascular: [ ] Bleeding Disorder [ ] Chest Pain [ ] Fainting
[ ] Dizziness [ ] Swelling in Feet [ ] High Blood Pressure [ ] Shortness of Breath
[ ] Blood Clots [ ] Irregular Heartbeat [ ] Murmur [ ] Pacemaker
[ ] Angina [ ] Eye Pain [ ] Heart Failure [ ] Facial Pain

Head/Eyes/Ears/Nose/Throat: [ ] Blurred Vision [ ] Ringing in Ears
[ ] Vertigo [ ] Hearing Loss [ ] Dry Mouth [ ] Sinusitis
[ ] Nosebleeds [ ] Abnormal Smells [ ] Dental Issues [ ] Earaches
[ ] Sore Throat [ ] Sinus Problems [ ] Difficulty Swallowing [ ] Glasses
[ ] Cataracts [ ] Excessive Tearing [ ] Glaucoma

Psychiatric: [ ] Depression [ ] Stress [ ] Poor Sleep
[ ] Anxiety [ ] Difficulty Thinking [ ] Claustrophobia

Reproductive: [ ] Decreased Sex Drive [ ] Inability to Sex Due to Pain

_____ _____

Patient Signature **Date**

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Treatment Agreement & Refill Policy

As part of your treatment, our medical staff may prescribe medication for you. As you know, medication can have serious side effects if they are not managed properly. Your health and safety are very important to us, and we need your help to make sure your treatment follows the prescribed guidelines. No prescriptions will be written for you unless you accept the following agreement.

I, _____, understand that the possible complications of chronic opioid therapy may
(Print name)

Include:

- Constipation, dry mouth, nausea, vomiting, or decreased appetite;
- Dizziness, tiredness or light headiness;
- Respiratory depression;
- Muscle twitches, sweating, itching;
- Decreased urination
- Decreased sex drive;
- Physical dependence;
- Addiction;
- Over dosage and death;
- (Females only) Chronic substance abuse may pose serious risk to fetus, therefore contact your provider immediately if you are or suspect you may become pregnant.

If you experience any of the following serious side effects, stop taking the narcotic and seek immediate emergency medical attention:

- An allergic reaction (difficulty breathing; closing of your throat; swelling of your lips, tongue, or face; hives);
- Seizures;
- Cold, clammy skin;
- Severe weakness or dizziness;
- Unconsciousness

Narcotics can be habit forming. Do not stop taking them suddenly.

Side effects other than those listed here may also occur. Consult our doctor about any side effects that seem unusual or that is especially bothersome.

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ONLINE PORTAL

Inland Pain Medicine is proud to offer an Online Patient Portal!

Complete the bottom of this page today and gain access to your Visit Summaries Online at any time.

A Visit Summary may include:

- Your clinical diagnosis
- Newly prescribed medications
- Medications you are already taking
- Instructions for taking you medications

We are committed to keeping the Patient Portal secure, so that only you and your provider may access your information. In the future, we will integrate new features into the Patient Portal, allowing patients the most convenient access to personal medical information and services.

Future features of the Patient Portal may include:

- The ability to schedule appointments online
- Electronic access to lab results
- Online correspondence with your provider
- Capability to update your personal information and medical history online

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Patient Portal Access

Print Name: _____ Date of Birth: _____

Email address: (please print legibly):

_____@_____.com

I am requesting access to information in my medical records via the Online Patient Portal.

Patient Signature: _____ Today's Date: _____

Please return completed sheets to the front desk. You will receive an email with your username and password.

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Authorization for Use and Disclosure of Medical Information

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. *Note: Information and records regarding treatment of minors, HIV, psychiatric/ mental health conditions or alcohol substance abuse have special rules that require specific authorization.*

Provider's Name and Address for Release of Records:

Name: _____

Address: _____

_____

Fax: _____

Phone: _____

Recipient and Address for Delivery of Records:

Name: Inland Pain Medicine

Address: 1850 E Washington St.
Colton, CA 92009
Phone: 909-887-2991
Fax: 909-887-5694

Purpose: I understand that the specific purpose of this authorization is:

_____

Information to be disclosed: This authorization permits the above-named healthcare provider to disclose the following medical records:

[ ] All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy and notes other mental health information, drug, alcohol or other controlled substance information, billing information, correspondence, and records from my other health care providers that the above-named health care provider may hold.

[ ] All of my health information described above except the following: _____

[ ] Only the following records of types of health information (Insert dates of treatment, types of treatment of other designation) : _____

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Term: This authorization will remain in effect for one (1) year from the date this authorization is signed.

Refusal to sign/ Right to revoke: I understand that I may refuse to sign or may revoke (at anytime) this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

Revocation: I understand that the authorization will remain in effect until the term of this authorization expires or I provider a written notice of revocation to my health care provider at my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this authorization before it received my written notice of revocation.

Questions: I may contact my provider's office for answers to my questions about the privacy of my health information. I understand that I have the right to receive a copy of this authorization from my health care provider.

Photocopy: A photocopy, fax or electronic copy of this authorization shall be considered as effective and as valid as the original.

_____ _____
Signature Date

_____ _____
Signature of Witness Date

Name: _____
(Please Print)

If individual is unable to sign this authorization, please complete the information below:

_____ _____ _____
Signature of Personal Representative Legal Relationship Date

_____ _____
Signature of Witness Date

Name: _____
(Please Print)