

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.

- | | | |
|---|---|--|
| <input type="checkbox"/> Andrew W. Hesseltine, MD | <input type="checkbox"/> John S. Cho, MD | <input type="checkbox"/> Suja Alexander, MN,FNP |
| <input type="checkbox"/> Abdul Kanu, MD | <input type="checkbox"/> Trisha Patel, MD | <input type="checkbox"/> Mareena Miller, FNP -BC |
| <input type="checkbox"/> Mark Macknet, MD | <input type="checkbox"/> 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 will 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 directly 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)

APPOINTMENT CANCELLATION AND NO-SHOW POLICY

As a patient receiving services from a physician at Inland Pain Medicine, I understand that I am responsible to cancel appointments within a 48-hour timeframe of my scheduled appointment. Failure to cancel an appointment within 48 hours is considered a No-Show. The following will apply:

- The patient will be expected to arrive on time for all scheduled appointments.
- The patient will be expected to cancel an appointment 48 hour in advance by telephoning the physician's office for notification during **normal business hours**.
- If the patient fails to telephone the office to cancel an appointment, it will be considered a "No-Show".
- If the patient fails to show for an appointment, the patient will be notified by telephone and will be given an opportunity to reschedule the appointment.
- Exclusions to this policy may be due to hospitalization, adverse weather conditions, or other unusual circumstances will **NOT** be considered as failure to cancel an appointment.
- The patient may be terminated from the doctor's services after four (4) documented no-show appointments within a 6-month period.
- Prior to terminating services, a letter will be sent from the doctor to the patient explaining the reason for termination.
- The termination letter will state that medications will be refilled, as medically necessary, for 30 days from the date of the termination of services letter.
- The patient's referring physician will be notified of the patient's failure to show for an appointment.

POLICY: Staff will attempt to remind the patient 24 hours before their scheduled appointment. This is a courtesy service that we provide, not required and does not relieve the patient from their responsibility to arrive for their scheduled appointment. Patients who consistently fail to present themselves for a scheduled appointment will be considered Chronic No-Shows. Four (4) no-show appointments in a 6-month period may result in the patient's dismissal from this practice.

Patient Name (Print)

Patient Signature

Date

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

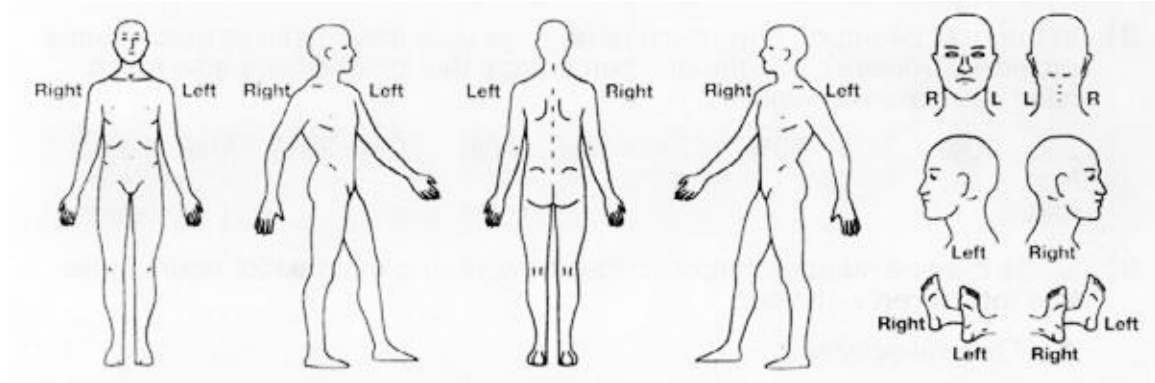
1	2	3	4	5	6	7	8	9	10
Mild				Moderate				Severe	

_____ 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



CURRENT PAIN DETAILS (CONTINUED)

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

- | | | |
|---|-------------------------------------|--|
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Chills | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Fevers | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Bowel incontinence | <input type="checkbox"/> Poor Sleep | <input type="checkbox"/> Current Infection |
| <input type="checkbox"/> Bladder Incontinence | <input type="checkbox"/> Fatigue | <input type="checkbox"/> 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.)

- | | | |
|-----------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Dull | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Pressure | <input type="checkbox"/> Burning | <input type="checkbox"/> Aching |
| <input type="checkbox"/> Numbing | <input type="checkbox"/> Electricity | <input type="checkbox"/> Pins and needle |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Burning | <input type="checkbox"/> Stabbing |
| <input type="checkbox"/> Heaving | <input type="checkbox"/> Tingling | <input type="checkbox"/> Tender |
| <input type="checkbox"/> Constant | <input type="checkbox"/> Radiating | <input type="checkbox"/> 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

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:				

MEDICATIONS TRIED

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

- | | | |
|--|---|---|
| <input type="checkbox"/> Opioids (Vicodin, Percocet, etc.) | <input type="checkbox"/> Constipation Medications | <input type="checkbox"/> Gout Medications |
| <input type="checkbox"/> Anticonvulsants | <input type="checkbox"/> Topical Creams | <input type="checkbox"/> Dopamine Stimulants |
| <input type="checkbox"/> Anti-inflammatory | <input type="checkbox"/> Sleep Aids | <input type="checkbox"/> Cymbalta / Savella |
| <input type="checkbox"/> Benzodiazepines | <input type="checkbox"/> Anti-Depressants | <input type="checkbox"/> Neurontin / Lyrica |
| <input type="checkbox"/> Muscle Relaxants | <input type="checkbox"/> Anti-Rheumatics | <input type="checkbox"/> NSAIDs (Motrin, Aleve, etc.) |
| <input type="checkbox"/> Oral Steroids | <input type="checkbox"/> Migraine Medications | <input type="checkbox"/> 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 CONTRAST allergies? Yes No

OTHER DOCTORS CONSULTED

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

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Acupuncturist | <input type="checkbox"/> Anesthesiologist | <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Dentist |
| <input type="checkbox"/> Endocrinologist | <input type="checkbox"/> ENT Physician | <input type="checkbox"/> General Physician | <input type="checkbox"/> Hypnotist |
| <input type="checkbox"/> Internist | <input type="checkbox"/> ENT Physician | <input type="checkbox"/> General Physician | <input type="checkbox"/> Orthopedic Surgeon |
| <input type="checkbox"/> Neurosurgeon | <input type="checkbox"/> Neurologist | <input type="checkbox"/> Ophthalmologist | <input type="checkbox"/> Plastic Surgeon |
| <input type="checkbox"/> Podiatrist | <input type="checkbox"/> Pain Physician | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Plastic Surgeon |
| <input type="checkbox"/> Other: _____ | | | |

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:
<input type="checkbox"/> MRI <input type="checkbox"/> Yes <input type="checkbox"/> No	Date: __/__/__	_____
<input type="checkbox"/> Discogram <input type="checkbox"/> Yes <input type="checkbox"/> No	Date: __/__/__	_____
<input type="checkbox"/> X-ray <input type="checkbox"/> Yes <input type="checkbox"/> No	Date: __/__/__	_____
<input type="checkbox"/> EMG/NCS <input type="checkbox"/> Yes <input type="checkbox"/> No	Date: __/__/__	_____
<input type="checkbox"/> Related Blood Work <input type="checkbox"/> Yes <input type="checkbox"/> No	Date: __/__/__	_____
<input type="checkbox"/> Other: _____	Date: __/__/__	_____

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

CURRENT MEDICATIONS

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

<u>Medication</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Purpose</u>

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

REVIEW OF SYSTEMS

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

- | | | |
|------------------------------------|---|---|
| Genitourinary: | <input type="checkbox"/> Urinating Frequently
<input type="checkbox"/> Urination
<input type="checkbox"/> Flank Pain
<input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Urinating Urgency
<input type="checkbox"/> Blood in Urine
<input type="checkbox"/> Painful
<input type="checkbox"/> Kidney Disease |
| Skin: | <input type="checkbox"/> Dryness
<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Itching | <input type="checkbox"/> Rash
<input type="checkbox"/> Ulcers
<input type="checkbox"/> Shingles
<input type="checkbox"/> Seasonal Allergies |
| Respiratory: | <input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Pulmonary Embolism | <input type="checkbox"/> Cough
<input type="checkbox"/> Wheezing |
| Endocrine: | <input type="checkbox"/> Cold Intolerance | <input type="checkbox"/> Hot Flashes
<input type="checkbox"/> Heat Intolerance |
| Gastrointestinal: | <input type="checkbox"/> Abdominal Pain
<input type="checkbox"/> Constipation
<input type="checkbox"/> Acid Reflux/Heart Burn
<input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Liver Disease
<input type="checkbox"/> Hernia
<input type="checkbox"/> Ulcer Disease
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Blood in Stool
<input type="checkbox"/> Nausea/ Vomiting |
| Musculoskeletal: | <input type="checkbox"/> Back Pain
<input type="checkbox"/> Neck Pain
<input type="checkbox"/> Skin Temp. Changes
<input type="checkbox"/> Edema
<input type="checkbox"/> Skin Color Changes | <input type="checkbox"/> Joint Pain
<input type="checkbox"/> Increase Sensitivity to Touch
<input type="checkbox"/> Muscle Spasms
<input type="checkbox"/> Joint Swelling |
| Neurological: | <input type="checkbox"/> Carpal Tunnel Syndrome
<input type="checkbox"/> Weakness
<input type="checkbox"/> Stork
<input type="checkbox"/> Numbness
<input type="checkbox"/> Loss of balance | <input type="checkbox"/> Headaches
<input type="checkbox"/> Tremors
<input type="checkbox"/> Migraines
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Seizures
<input type="checkbox"/> Dementia |
| Constitutional: | <input type="checkbox"/> Fevers
<input type="checkbox"/> Tremors
<input type="checkbox"/> Excessive Sweating
<input type="checkbox"/> Unexplained Weight Loss or Gain | <input type="checkbox"/> Chills
<input type="checkbox"/> Loss of Appetite
<input type="checkbox"/> Night Sweats
<input type="checkbox"/> Fatigue |
| Cardiovascular: | <input type="checkbox"/> Bleeding Disorder
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Blood Clots
<input type="checkbox"/> Angina
<input type="checkbox"/> Swelling in Feet
<input type="checkbox"/> Irregular Heartbeat
<input type="checkbox"/> Eye Pain | <input type="checkbox"/> Chest Pain
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Murmur
<input type="checkbox"/> Heart Failure
<input type="checkbox"/> Fainting
<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Facial Pain |
| Head/Eyes/Ears/Nose/Throat: | <input type="checkbox"/> Vertigo
<input type="checkbox"/> Nosebleeds
<input type="checkbox"/> Sore Throat
<input type="checkbox"/> Cataracts
<input type="checkbox"/> Hearing Loss
<input type="checkbox"/> Abnormal Smells
<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Excessive Tearing | <input type="checkbox"/> Blurred Vision
<input type="checkbox"/> Dry Mouth
<input type="checkbox"/> Dental Issues
<input type="checkbox"/> Difficulty Swallowing
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Ringing in Ears
<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Earaches
<input type="checkbox"/> Glasses |
| Psychiatric: | <input type="checkbox"/> Depression
<input type="checkbox"/> Anxiety | <input type="checkbox"/> Stress
<input type="checkbox"/> Difficulty Thinking
<input type="checkbox"/> Poor Sleep
<input type="checkbox"/> Claustrophobia |
| Reproductive: | <input type="checkbox"/> Decreased Sex Drive | <input type="checkbox"/> Inability to Sex Due to Pain |

Patient Signature

Date

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 headedness;
- 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

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) : _____

Inland Pain Medicine

Specialist in Pain Care & Management

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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 provide 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)