	New Patient Packet	*4944 Sunrise Blvd* *Suite A* *Fair Oaks, CA 95628* *Tel: (916)534-7490* *Fax: (916)534-7498*

Ketamine Infusion

for Chronic Pain Management

This package prepared in 12 pages and your signature at the end means you acknowledge that you provided the most accurate information to your best knowledge.

Patient's Full Name: _____ **Today's Date: ----------**

Height: _____ Weight: _____DOB: _____ Age: _____

Occupation: _____

Your Best Address: _____ City:_____ State:__ Zip code_____

Your Best Phone Number:

Your EMAIL address:

Emergency contact name: _____

Relationship: _____ Phone:_____

Your Pharmacy Name and Location:

How did you hear about Ketamine Infusion? _____

Primary Care Physician Name: _____

Address: Phone:

Insurance Information

Primary carrier: _____Identification # _____

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Before you are able to receive Ketamine treatment, we need to make sure that it is safe for you to do so. To that end, we need information about the possible factors that could enhance your risk to experience unintentional adverse effects. Please fill out the questionnaire carefully and honestly. This form will subsequently be assessed by a physician.

Screening questionnaire: please select one

1. Do you have a history of problems with anesthesia? ☐ Yes ☐ No
2. Have you recently had a cold or the flu? ☐ Yes ☐ No
3. Are you allergic to latex (rubber) products? ☐ Yes ☐ No
4. Have you experienced chest pain? ☐ Yes ☐ No
5. Do you have a heart condition? ☐ Yes ☐ No
6. Do you have a history of hypertension or low blood pressure? ☐ Yes ☐ No
7. Have you ever had a stroke? ☐ Yes ☐ No
8. Have you ever undergone surgery to your head? ☐ Yes ☐ No
9. Have you ever had a severe head trauma? ☐ Yes ☐ No
10. Have you ever lost consciousness without any known reason? ☐ Yes ☐ No
11. Do you have asthma, bronchitis, or any other breathing problem? ☐ Yes ☐ No
12. Have you had hepatitis, liver disease, or jaundice? ☐ Yes ☐ No
13. Do you have, or have you ever had kidney disease? ☐ Yes ☐ No
14. Do you have any bleeding problems? ☐ Yes ☐ No
15. Have you ever (at present or in the past) suffered from a brain-related, neurological illness? ☐ Yes ☐ No
16. Do you suffer from frequent severe headaches? ☐ Yes ☐ No
17. Do you have another chronic illness/disorder not yet listed above? ☐ Yes ☐ No
18. Are you currently taking antibiotics? ☐ Yes ☐ No
19. Do you take any herbals or complementary or alternative medicines? ☐ Yes ☐ No

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20. Are you taking your medications as prescribed? ☐Yes ☐ No

21. (Women) are you pregnant, or is there a chance that you might be? ☐Yes ☐No

22. (Men) Do you take Viagra, Cialis, or other erectile dysfunction medicines? ☐Yes ☐ No

23. Does someone in your family have a psychiatric illness/disorder? ☐Yes ☐No

24. Does someone in your family have schizophrenia or a psychotic illness? ☐Yes ☐No

25. Do you have sleeping problems such as Obstructive Sleep Apnea? ☐ Yes ☐No

26. Do you experience panic/anxiety attacks? ☐Yes ☐No

27. Have you ever undergone TMS or Electroconvulsive therapy? ☐Yes ☐No

28. Do you averagely consume more than 3 alcoholic units a day? ☐Yes ☐No

29. Have you ever suffered from substance dependence or abuse? ☐Yes ☐ No

30. Are you using marijuana presently in the past 2 weeks? ☐Yes ☐ No

31. Have you used any recreational drugs during the past year? (Such as marijuana, ecstasy, cocaine, etc.) ☐Yes ☐No

32. Do you experience dissociation, which is a sudden feeling of being detached or disconnected from reality and your immediate surroundings, often occurring during a time of stress? ☐Yes ☐No

☐Please comment on positive (yes) responses to the previous questions: ☐

_____
_____
_____
_____
_____
_____
_____

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☐**Please do not forget list your** *Allergies:*

Current Medications and dosage:

Medication	**Dosage**	**Frequency (i.e. twice**	Remark

Health Information Questionnaire

1. **Please list and describe the symptoms that are bothering you in order of their importance:**

2. **When did you first note your present symptoms?**

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New Patient Packet

Ketamine Infusion

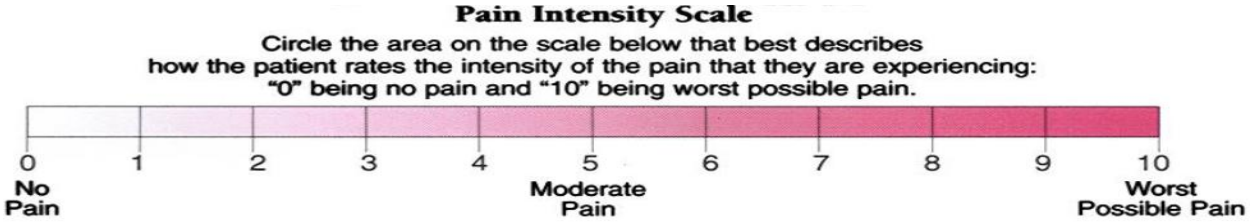
for Chronic Pain Management

3. **In your opinion what caused your present complaint:**

4. **Is your complaint related to a personal or work-related injury case? (ie. Motor Vehicle Accident)**
☐ Yes ☐ No *If yes, please give date and brief description*:

5. **Have you received Ketamine treatment for this problem before?**
☐ Yes ☐ No *If yes, please describe the type of treatment please include name of provider/facility and date:*

Please rate your **PRESENT pain level.** (0 = No pain 10= Worst pain)



How would you describe your pain? Please check the word/words that best describe your pain.

☐ Constant ☐ Aching ☐ Dull ☐ Numbing ☐ Coldness ☐ Burning
☐ Sharp ☐ Stinging ☐ Stabbing ☐ Tingling ☐ Cramping ☐ Radiating

When do you having the above sensations?

☐ all the time ☐ sometimes ☐ at nights ☐ during the day ☐ other: describe

Describe the effect of the following activities on your symptoms:

	Better	Worse		Better	Worse
Standing			**Twisting**		
Walking			**Sitting**		
Reaching			**Fatigue**		
Stretching			**Heat**		
Pulling			**Cold**		

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for Chronic Pain Management

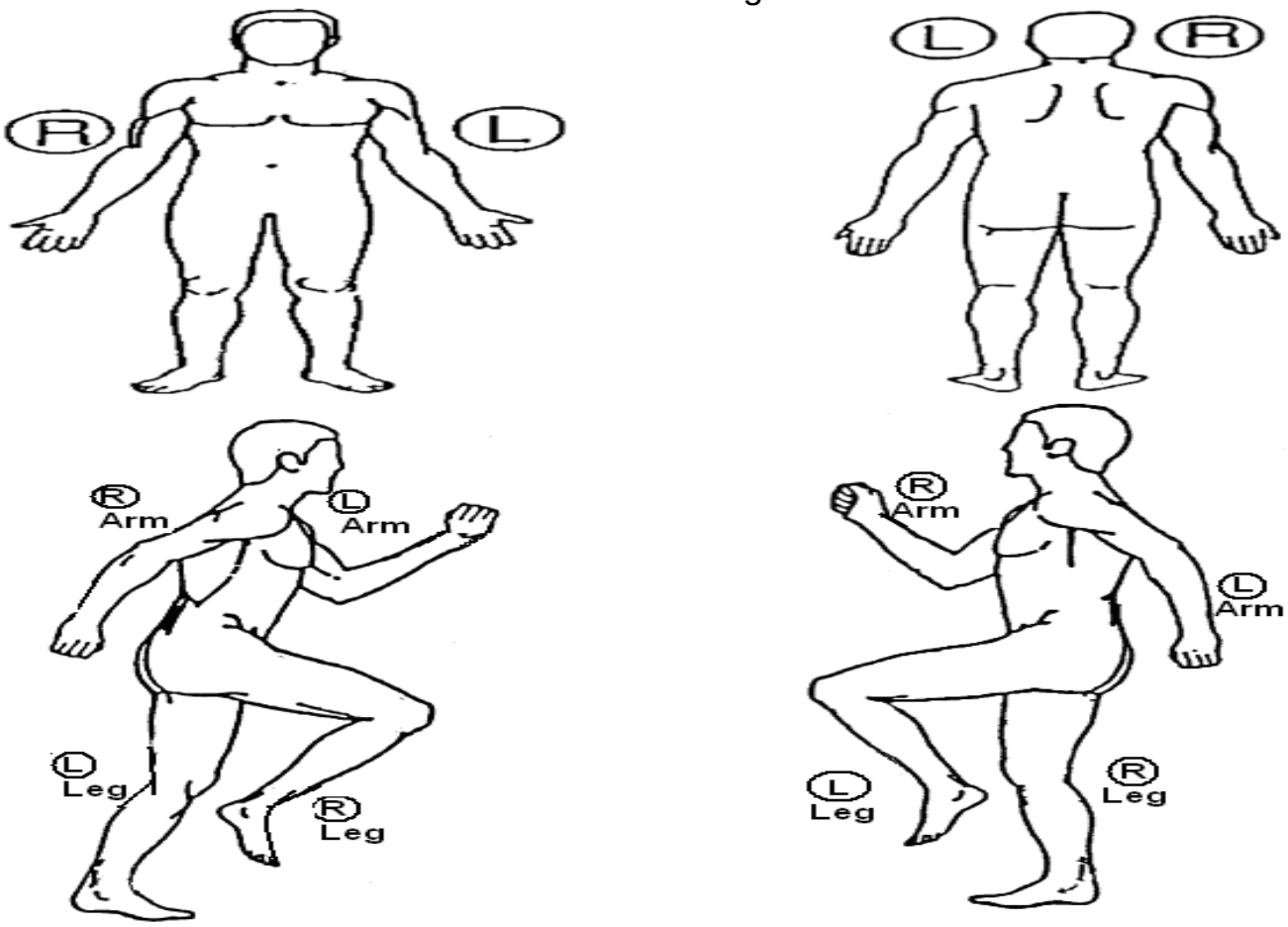
Grasping			**Resting**		
Limiting Activity			**Physical Therapy**		
Bending			**Massage**		
Twisting			**Urination**		
Sitting			**Bowel Move**		
Sneeze/ Cough			**Tension**		
Driving			**Twisting**		
Lifting			**Pushing**		
Hot Shower			**Change position**		

Please mark the areas on your body where you feel pain

	New Patient Packet	4944 Sunrise Blvd Suite A Fair Oaks, CA 95628 Tel: (916)534-7490 Fax: (916)534-7498

Ketamine Infusion

for Chronic Pain Management



Past Medical History:

Have your ever been treated for any of the following medical problems? If yes, circle the appropriate one.

☐ Allergies	☐ Depression	☐ HIV
☐ Anemia	☐ Diabetes	☐ Hypertension
☐ Arthritis	☐ Epilepsy	☐ Kidney Disease
☐ Asthma	☐ Fibromyalgia	☐ Scoliosis
☐ Blood Disease	☐ Headaches	☐ Sickle Cell
☐ Bowel Disease	☐ Heart Disease	☐ Shingles
☐ Cancer	☐ Hepatitis	☐ Stroke

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New Patient Packet

Ketamine Infusion

for Chronic Pain Management

☐ Psychological problem, describe:

Do you drink alcoholic beverages? ☐ Never ☐ Rarely ☐ Daily Please describe_____

Have you ever smoked? ☐ Yes ☐ No If Yes: ____ pack(s) per day for ____ year(s)

Do you currently smoke? ☐ Yes ☐ No If Yes: ____ pack(s) per day

Have you abused drugs? ☐ Yes ☐ No (*Cocaine, Crack, LSD, Heroin, Prescription)*

Family History: **Are there any diseases that run in your family? Please list any family members (such as mother, father, brother, etc) that may have or are currently suffering from any medical or psychiatric conditions such as diabetes, hypertension, heart disease, cancer, stroke, chronic pain, depression, bipolar disorder, etc.)**

a. Condition:_____ Specific family member: ----------

b. Condition:_____ Specific family member:----------

c. Condition:_____ Specific family member:----------

Add more if needed:

Please check all medications/ therapy that you have tried in the past.

Treatment	If yes, last date	Treatment	If yes, last date
☐ Traction		☐ Physical Therapy	
☐ Spinal Injection		☐ Chiropractic Care	
☐ Joint Injection		☐ Psychotherapy	
☐ Muscle Injection		☐ Acupuncture	
☐ Ketamine		☐ TENS Unit	
☐ Nerve Block		☐ Others	

☐ Fentanyl (Actiq, Fentora, Duragesic)	☐ Diclofencac (Arthrotec, Voltaren, Voltaren Gel)
☐ Demerol	☐ Oxaprozin (Daypro)
☐ Hydrocodone (Lortab, Norco, Vicodin, Vicoprofen)	☐ Meloxicam (Mobic)
☐ Tramadol (Ultram ER Ultram)	☐ Nabumetone (Relafen)
☐ Morphine (Avinza, kadian, Embeda, MS Contin)	☐ Aspirin
☐ Oxymorphone (Opana, Opana ER)	☐ Indomethacin (Indocin)
☐ Methadone	☐ Ibuprofen (Motrin, Advil)
☐ Oxycodone (Oxycontin, Percocet)	☐ Acetaminophen (Tylenol)
☐ Hydromorphone (Dilaudid, Exalgo)	☐ Celecoxib (Celebrex)
☐ Tapentadol (Nucynta)	☐ Etodolac (Lodine)
☐ Propoxyphene (Darvocet, Darvon)	☐ Naproxen (Naprosyn)
☐ Buprenorphine (Suboxone, Subutex, Butrans)	☐ Flector patch
☐ Codeine	

New Patient Packet

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Ketamine Infusion

for Chronic Pain Management

- ☐ Baclofen
- ☐ Methocarbamol (Robaxin)
- ☐ Carisoprodol (Soma)
- ☐ Cyclobenzaprine (Flexeril, Amrix)
- ☐ Metaxalone (Skelaxin)
- ☐ Tizanidine (Zanaflex)

Sleep Aids

- ☐ Zolpidem (Ambien, Ambien CR)
- ☐ Lunesta
- ☐ Rozerem
- ☐ Xyrem
- ☐ Restoril
- ☐ Sonata

- ☐ Cymbalta
- ☐ Nortriptyline (Pamelor)
- ☐ Remeron
- ☐ Wellbutrin
- ☐ Effexor
- ☐ Paxil
- ☐ Serzone
- ☐ Zoloft
- ☐ Amitriptyline (Elavil)
- ☐ Pristiq
- ☐ Imipramine (Tofranil)
- ☐ Lexapro
- ☐ Fluoxetine (Prozac)
- ☐ Trazodone

- ☐ Axert
- ☐ Hydroxyzine
- ☐ Lyrica
- ☐ Tegretol
- ☐ Zonegran
- ☐ Relpax

- ☐ Buspar
- ☐ Imitrex
- ☐ Maxalt
- ☐ Topamax
- ☐ Frova
- ☐ Lidoderm Patch

- ☐ Keppra
- ☐ Gabapentin (Neurontin)
- ☐ Vistaril
- ☐ Gabitril
- ☐ Zomig

18. Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

19. What is your current work status? ☐ Employed ☐ Retired ☐ Disabled ☐ Unemployed

20. What is the highest level of your education? ☐ High School ☐ College ☐ Degree:

21. What effects have your present medical problem(s) had on your social life?

Review of Systems: Please indicate if you have any of the following by checking the box.

Constitutional	☐ None ☐ Drowsiness ☐ Fever ☐ Sweat ☐ Weight loss / gain ☐ Fatigue
Eyes	☐ None ☐ Cataract ☐ Eye Problem ☐ Double vision ☐ Wear Contacts/ Glasses
Ear, Nose, Throat	☐ None ☐ Loss of sense of smell ☐ Sinus Infection ☐ Hearing Loss ☐ Ear Pain ☐ Jaw Pain
Respiration	☐ None ☐ Cough ☐ Asthma ☐ Wheezing ☐ Shortness of Breath
Cardiovascular	☐ None ☐ High blood pressure ☐ Varicose Veins ☐ Palpitation ☐ Claudication
Gastrointestinal	☐ None ☐ Abdominal Pain ☐ Black stool ☐ Heartburn ☐ Hemorrhoid ☐ Ulcers

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Ketamine Infusion

for Chronic Pain Management

Female	☐ None I am ☐ currently Pregnant I am ☐ currently NOT Pregnant
Male	☐ None ☐ Burning urination ☐ Prostate problem ☐ Erectile dysfunction
Endocrine	☐ None ☐ Cold/ Heat intolerance ☐ Goiter ☐ Hair Loss ☐ Diabetes ☐ Excessive Hunger
Skin	☐ None ☐ history of skin disease ☐ Rash ☐ Itching ☐ Varicose Vein
Nervous system	☐ None ☐ Weakness ☐ Numbness ☐ Stroke ☐ Loss of Memory ☐ Sleep Problem ☐ Slurred Speech ☐ Gait Problem ☐ Balance Problem ☐ Stress
Psychological	☐ None ☐ Bi-polar ☐ Depression ☐ Insomnia ☐ Behavioral Changes
Hematologic	☐ None ☐ Bleeding ☐ Fatigue ☐ Bruising Easily ☐ Anemia

SLEEP BEHAVIOR:

Have you been evaluated for sleep apnea with a sleep study? ☐ Yes ☐ No

If yes, were you diagnosed with sleep apnea? ☐ Yes ☐ No

TREATMENT GOALS; My Goals are:

☐ **1)**

☐ **2)**

☐ **3)**

I acknowledge that I have provided you with the most accurate and complete information about my medical history to the best of my ability.

FINANCIAL AGREEMENT "SIGNATURE ON FILE" CLAIM AUTHORIZATION CANCELATION POLICY

We want to welcome you to our office. We are committed to providing you with the best possible care and we will be pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please feel free to ask any questions that you may have about our fees, financial policy of your responsibilities. We cannot bill your insurance unless you bring your complete insurance information with you. Our office will bill your insurance as a courtesy, but ultimately the balance is your

Ketamine Infusion

for Chronic Pain Management

responsibility. Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. If you have a co-payment with your insurance, it is due at the time of service or we will charge you $15 billing fee per missed co-payment. You may choose to pay by cash, Visa or Mastercard. It is necessary for you to verify your benefits through your insurance, as some services may be considered "non-covered" or may have a benefit limitation. Auto Accidents- We will bill your auto insurance if you have "Med Pay" on your policy. If you are represented and you lose your case, you are fully responsible for all charges. Medicare Clients- Medicare will pay 80% of the acceptable charges. If you have a secondary insurance, we will bill them for the remaining 20%. If you do not have a secondary insurance, the balance will be due and payable by you. You will receive a statement for your portion after Medicare has completed their payments. I have read the above and fully understand and agree to the terms of this policy. I hereby assign all medical benefits to Foad Elahi MD California Center of Pain Medicine and Rehabilitation. I understand I am personally responsible for all legitimate charges incurred, regardless of insurance coverage. I request that payment of all medical benefits be made directly Foad Elahi MD California Center of Pain medicine and Rehabilitation, A Medical Corporation. If the payment from my insurance comes directly to me, I understand that I am fully responsible for the balance. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits, of the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. Coinsurance and deductible are based upon the charge determination of the insurance carrier. Foad Elahi MD California Center of Pain medicine and Rehabilitation, A Medical Corporation, will bill your insurance company for services provided by your doctor. If you wish us to do so, we will need your consent. I acknowledge and agree that I am personally financially responsible for payment of services that are performed by California Center of Pain medicine and Rehabilitation, A Medical Corporation. I understand that my insurance company may not pay for services in full. I understand that I am responsible for any deductible or co-payments which are required by my insurance company and are payable at the time of my visit. **ASSIGNMENT OF BENEFITS:** I hereby assign to California Center of Pain Medicine and Rehabilitation, A Medical Corporation, my right, title, and interest in and to any and all health care and/or pain procedures benefits, otherwise payable to me for medical treatment. The "assignment of benefits" does not ensure the physician will receive payment from the third-party payer. If a payer refuses to make a partial or total payment to physician, they may seek full payment directly from the patient or the financially responsible person. By merely assigning benefits to the physician the patient cannot escape the burden of the obligation to pay physician for services rendered if the payer fails to pay. Patients still remain liable to physicians (unless they formally release the patient of such obligation). Therefore, when the payer is not paying the physician for any apparent reason, despite the physician's repeated attempts to obtain payment, the physician may bill the patient. **Patient Reschedule and Cancellation Policy:** In order for us to continue to provide the highest quality service, it is requested that you give 24 hour notice, should you need to reschedule or cancel an appointment. I understand that I may be charged a $40.00 fee for each cancelled/ no show appointment where a 24 hour notice has not been provided.

HIPPA- Notice of Privacy Practice: The Health Insurance Portability and Accountability act of 1996 ("HIPAA") requires that, effective April 14, 2003, we provide you a printed copy of our Notice of Privacy Practices. For your convenience, we are providing this brief summary*. We are required to ask you to sign a one-time acknowledgement that you have reviewed this summary. A copy of the full Notice is available upon request.* Your Rights as a Patient You have rights with respect to your protected health information. These are summarized below and described in detail in our full Notice of Privacy Practices. Use of Protected Health Information We are permitted to use your protected health

information for treatment purposes, payment, and to conduct our business and evaluate the quality and efficiency of our processes. Also, we are permitted to disclose protected health information under specific circumstances to other entities. We have put into place safeguards to protect the privacy of your health information. However, there may be incidental disclosures of limited information, such as overhearing a conversation, that occur in the course of authorized communications, routine treatment, payment, or the operations of our practice. HIPAA recognizes that such disclosures may be very difficult to avoid entirely, and considers them permissible. Disclosures of Protected Health Information Requiring your Authorization For disclosures that are not related to treatment, payment or operations, we will obtain your specific written consent, except as described below. Disclosures of Protected Health Information Not Requiring your Authorization We are required by state and federal law to make disclosures of certain protected health information without obtaining your authorization. Examples include mandated reporting of conditions affecting public health, subpoenas, and other legal requests. Restrictions to Use and Disclosure You may request restrictions to the use or disclosure of your protected health information, but we are not required by HIPAA to agree to such requests. However, if we do agree, only the minimum amount of such information will be used to accomplish the intended goal. Access to Protected Health Information You may request access to or a copy of your medical records in writing. If we deny the request, we will tell you why. You may appeal this decision, which, under specified circumstances, will be reviewed by a third party not involved in the denial. Amendments to Medical Records You may request in writing that corrections be made to your medical records. We will either accept the amendments, and notify appropriate parties, or deny your request with an explanation. You have rights to dispute such denials and have your objections noted in your medical record. Accounting of Disclosures of Protected Health Information You may request in writing an accounting of disclosures of your protected health information. This accounting excludes disclosures make in the course of treatment, payment, or operations. Complaints Related to Perceived Violations of your Privacy Rights You may register a complaint about any of our privacy practices with our Privacy Officer or with the Secretary of Health and Human Services. Faxed Medical Records Your medical records will be provided to primary care physicians, referring doctors, and adjusters, etc., via fax. Therefore, you by signing this page acknowledge that Foad Elahi MD California Center of Pain Medicine and Rehabilitation has provided a written copy of their summary Notice of Privacy Practices. I hereby give my consent to Foad Elahi MD California Center of Pain Medicine and Rehabilitation to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Foad Elahi MD California Center of Pain Medicine and Rehabilitation Notice of Privacy Practices provides a more complete description of such uses and disclosures. With this consent, Foad Elahi, M.D. California Center of Pain Medicine and Rehabilitation may call my home or other alternative locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others. With this consent, Foad Elahi, M.D. California Center of Pain Medicine and Rehabilitation may mail to my home or other alternative location any items to assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

SERVICE ARBITRATION AGREEMENT: The Foad Elahi MD California Center of Pain Medicine and Rehabilitation (CCPMR) doctor agrees to provide to the undersigned patient medications, procedural, surgical and related health care, those are services in consideration for the payment on a fee for service basis. **ARTICLE I:** It is understood that any dispute as to CCPMR/doctor malpractice, that is as to whether

Ketamine Infusion

for Chronic Pain Management

any procedures/ services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. **ARTICLE II:** Said agreement for arbitration as provided in Article I above shall apply to the doctor, agents, representatives and employees, successors in interest and staff of the CCPMR/doctor and the patient "whether or not a minor" his heir sat- law, personal representatives and any claim in tort, contract or otherwise the other of demand for arbitration of any controversy, the parties to the controversy shall each appoint an arbitrator and give notice has been given, the two arbitrators so selected shall select a neutral arbitrator and give notice of the selection of the neutral arbitrator. All notices or other papers required to be served shall be served by U.S. MAIL. **ARTICLE III** The CCPMR doctor named below agrees only to provide such services as in his opinions are reasonable, necessary and appropriate. Should patient for reasons personal to him/herself refuse to accept the procedures, medicines or course of treatment recommend by the CCPMR/doctor, and if the CCPMR/ doctor believes that no professionally acceptable alternative exists, and after being so advised that patient refuses to follow the recommended treatment or procedure, then the patient shall be given no further treatment and the CCPMR/doctor shall have no further responsibility to provide services specified herein for the condition under treatment. **ARTICLE IV:** This agreement may be terminated only if written notice is given by the patient within thirty (30) days from the date patient executes this agreement and is no such notice is given, the agreements herein concerning arbitration shall be binding and compulsory. NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE AN ISSUE OF CCPMR/ DOCTOR MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

Remember: It is not always possible to relieve pain completely. We will work with you, your referring healthcare provider, and any other health care provider(s) you would like us to give you the best care possible. We do not routinely perform disability evaluation or ratings as part of our practice currently. We look forward to working in partnership with you to produce a successful treatment plan.

Today's Date: **Your** Signature: