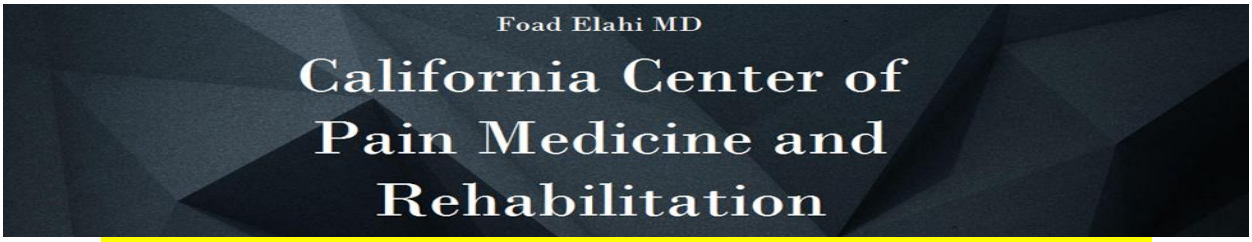


Please bring this packet with you to your appointment fully completed. If not completed, your appointment may be rescheduled.

Patient Information

Patient's name: _____ Date of birth:_____

Home address: _____

City:_____ State:_____ Zip code:_____

Home phone: _____

Work phone:_____

Cell phone: _____

Social Security number: _____

Driver License number: _____

Occupation: _____ Employer: _____

How long employed: _____

Work address: _____

City:_____ State:_____ Zip code:_____

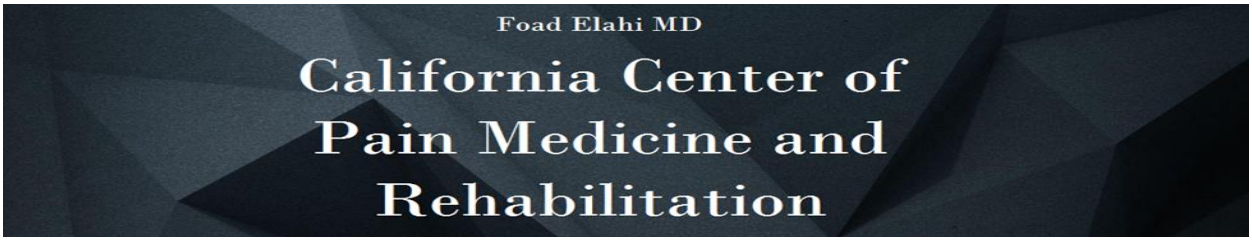
Social Security number: _____

Emergency contact: _____ Relationship:_____

Phone:_____

Address: _____

City:_____ State: _____ Zip code:_____



Referring Physician _____
Phone: _____

Address: _____

City: _____ State: _____ ZIP code: ___

Primary Care Physician _____
Phone: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Insurance Information

Primary carrier: _____

Identification # _____

Secondary carrier: _____

Identification # _____

If work related, date of injury: _____

Claim#:_____

Workman's Compensation and/or Attorney's Information

Adjuster's Name: _____

Phone: _____

R.N. Case Mgr: _____

Phone: _____

Attorney's Name: _____

Phone: _____

Foad Elahi MD

California Center of Pain Medicine and Rehabilitation

Health Information Questionnaire

Patient's Name: _____ Date: _____

DOB: _____ Age: _____ Handedness: (L / R / Both)

Gender: (M / F)

History of Present Illness:

1. What is the main purpose of your visit?

_____

1a. Are you referred for injection/ procedure? ☐ Yes ☐ No ☐ I don't know

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

1._____

2._____

3._____

4._____

3. When did you first note your present symptoms:

_____

4. In your opinion what caused your present complaint:

_____

4a. Is your complaint related to a personal injury case? (i.e. Motor Vehicle Accident)

1. Yes 2. No *If yes, please give date and description*:

_____

4b. Is your complaint due to a work related injury? (i.e. Worker's Compensation Case)

1. Yes 2. No *If yes, please give date and description*:

_____

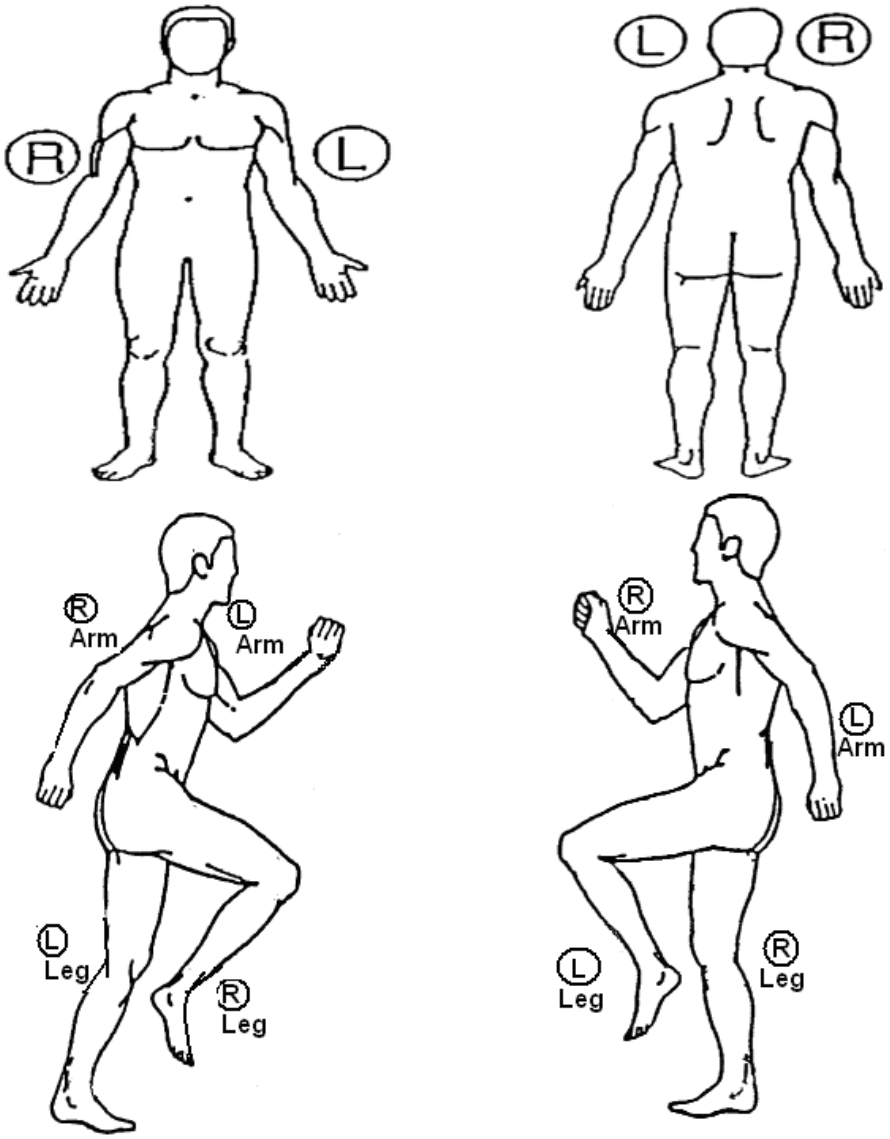
5. Have you received treatment for this problem before?

1. Yes 2. No *If yes, please describe the type of treatment please include name of provider/facility and date:*

Foad Elahi MD

California Center of Pain Medicine and Rehabilitation

Please mark the areas on your body where you feel pain



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

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

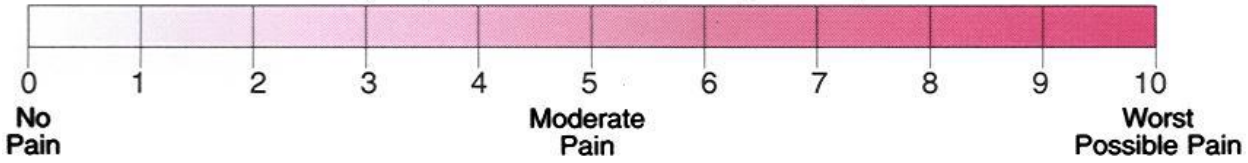
Please rate your **average pain level**. (0 = No pain 10= Worst pain)

Foad Elahi MD

California Center of Pain Medicine and Rehabilitation

Pain Intensity Scale

Circle the area on the scale below that best describes
how the patient rates the intensity of the pain that they are experiencing:
"0" being no pain and "10" being worst possible pain.



How would you describe your pain?

Please check the word/words that best describe your pain.

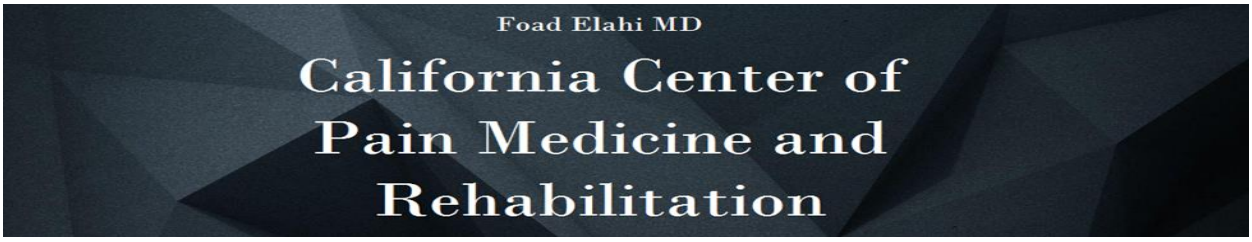
☐ Aching	☐ Dull	☐ Constant	☐ Numbing	☐ Coldness	☐ Burning
☐ Sharp	☐ Stinging	☐ Stabbing	☐ Tingling	☐ Cramping	☐ Radiating

6. How often have you had pain (over the past month)?

_____ **Intermittent -** less than one fourth of the time when you are awake *(up to 25%)*
_____ **Occasional -** between one fourth and half of the time when you are awake *(25-50%)*
_____ **Frequent -** between one half and three fourths of the time when you are awake *(50-75%)*
_____ **Constant -** between three fourths and all of the time when you are awake *(75-100%)*

7. When you are experiencing pain, is it generally (check one):

_____ **Annoying -** does not interfere with daily activities or sleep
_____ **Tolerable -** may interfere with some daily activities and sleep. Aspirin/Motrin may be taken regularly.
_____ **Limiting -** severely interferes with daily activities and sleep. Prescription/Narcotic medication taken.
_____ **Disruptive -** Inhibits daily actives, social/recreational activities and disrupts sleep. Narcotic medications may not relieve pain



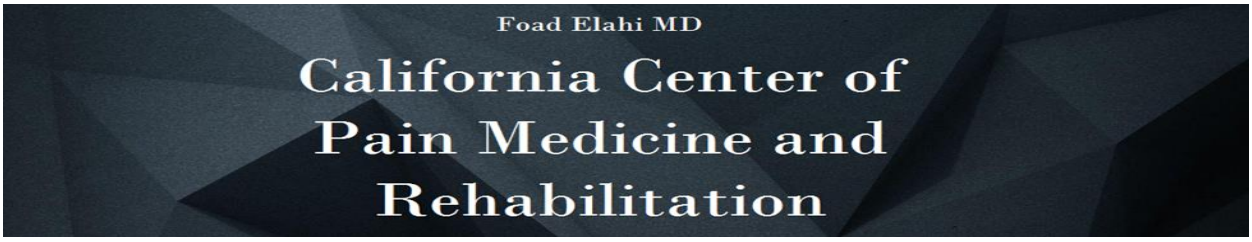
8. Describe the effect of the following activities on your symptoms:

	Better	Worse	No Effect
Standing			
Walking			
Reaching			
Stretching			
Pulling			
Grasping			
Limiting Activity			
Bending			
Twisting			
Sitting			
Sneezing /coughing			
Driving			
Lifting			
Pushing			
Hot Shower			
Changing position			
Twisting			
Sitting			
Fatigue			
Heat			
Cold			
Resting			
Physical Therapy			
Massage Therapy			
Urination			
Bowel Movement			
Tension			

9. If you had to continue the rest of your life with your condition as it is right now, how would you feel about it?

☐ Extremely dissatisfied ☐ Very dissatisfied ☐ somewhat dissatisfied
☐ Somewhat satisfied ☐ Very satisfied ☐ Extremely satisfied

Please rate your ability to cope with pain. (0 = Not able 10 = Very able)



Past Medical History:

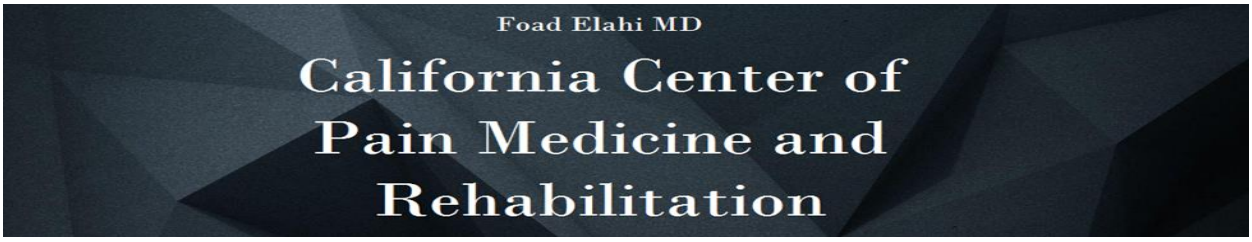
10. Have your ever been treated for any of the following medical problems? If yes, circle the appropriate one.

1. Diabetes 2. Arthritis 3. Cancer 4. Epilepsy 5. Hypertension
6. Stroke 7. Migraine 8. Heart Disease 9. Kidney Disease
10. Bowel Disease 11. Bladder Disease 12. Lung Disease 13. Pneumonia
14. Asthma 15. Emphysema 16. Headaches 17. Liver Disease
18. Hepatitis 19. Blood Disorders 20. Anemia
21. Excessive Bleeding 22. AIDS 23. Psychological difficulties
24. Others
Please describe:

11. Please list any/all major illnesses:

12. Have you had any operations/ surgery?
1. Yes 2. No *If yes, please list below and indicate the year.*

13. Have you had any serious trauma?
1. Yes 2. No I*f yes please explain*



14. Have you had any of the following treatments for your pain?

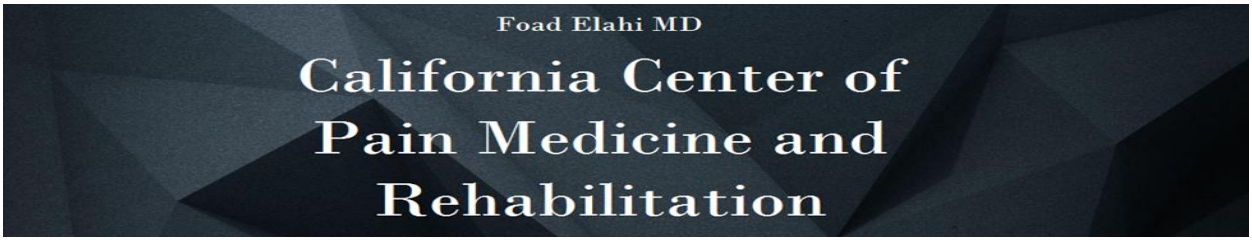
Treatment	**If yes, last date**
☐ Traction	
☐ Spinal Injection	
☐ Joint Injection	
☐ Muscle Injection	
☐ Ketamine Infusion	
☐ Nerve Block	
☐ Physical Therapy	
☐ Chiropractic Care	
☐ Psychotherapy	
☐ Acupuncture	
☐ TENS Unit	
☐ Others	

15. Are you allergic to any medication, anesthetic, or x-ray dye?

1. Yes 2. No I*f yes please list:*

Current Medications and dosage:

Medication	**Dosage**	**Frequency (i.e. twice a day, etc.)**	Remark



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

Opioid medications
☐ Fentanyl (Actiq, Fentora, Duragesic)
☐ Demerol
☐ Hydrocodone (Lortab, Norco, Vicodin, Vicoprofen)
☐ Tramadol (Ultram ER Ultram)
☐ Morphine (Avinza, kadian, Embeda, MS Contin)
☐ Oxymorphone (Opana, Opana ER)
☐ Methadone
☐ Oxycodone (Oxycontin, Percocet)
☐ Hydromorphone (Dilaudid, Exalgo)
☐ Tapentadol (Nucynta)
☐ Propoxyphene (Darvocet, Darvon)
☐ Buprenorphine (Suboxone, Subutex, Butrans Patch)
☐ Codeine

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

NSAIDs
☐ Diclofencac (Arthrotec, Voltaren, Voltaren Gel)
☐ Oxaprozin (Daypro)
☐ Meloxicam (Mobic)
☐ Nabumetone (Relafen)
☐ Aspirin
☐ Indomethacin (Indocin)
☐ Ibuprofen (Motrin, Advil)
☐ Acetaminophen (Tylenol)
☐ Celecoxib (Celebrex)
☐ Etodolac (Lodine)
☐ Naproxen (Naprosyn)
☐ Flector patch

Foad Elahi MD
California Center of Pain Medicine and Rehabilitation

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

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

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

Other medications
☐ Axert ☐ Hydroxyzine ☐ Lyrica ☐ Tegretol ☐ Zonegran ☐ Buspar ☐ Imitrex ☐ Maxalt ☐ Topamax ☐ Frova ☐ Keppra ☐ Gabapentin (Neurontin) ☐ Vistaril ☐ Gabitril ☐ Lidoderm Patch ☐ Relpax ☐ Zomig ☐ Other:

16. Do you drink alcoholic beverages?

☐ Never ☐ Rarely ☐ Daily Please describe_____

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

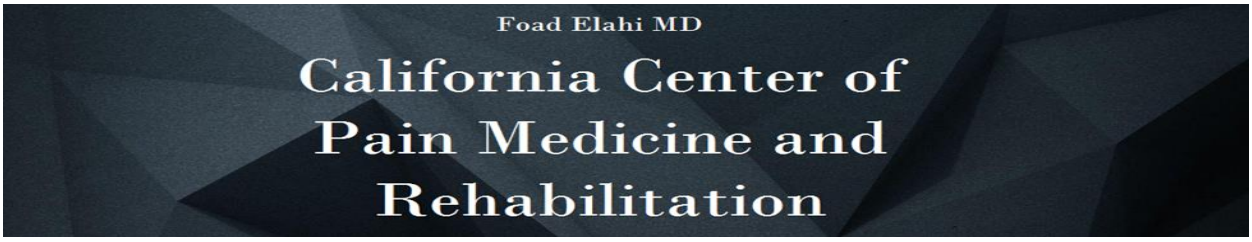
18. Do you currently smoke? ☐ Yes ☐ No If Yes: ____ pack(s) per day

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

Family History:

20. Are there any diseases that run in your family? 1. Yes 2. No

If yes, please explain.



21. 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

22. Please indicate if any members of your family have any of the following diseases:

☐ Diabetes ☐ Heart Disease ☐ Migraine Headaches

☐ Cancer ☐ Stroke ☐ Hypertension

☐ Epilepsy ☐ Arthritis ☐ Bleeding disorder

Social History:

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

24. What is your current work status?

☐ Employed _ ☐ Retired _ ☐ Disabled _ ☐ Unemployed

If you are not working now, when was the last time you worked?

What type of work were you doing?

What are your current work restrictions, if any?

25. What is the highest level of your education?

☐ High School ☐ College ☐ Graduate school

☐ Degree: Please describe

26. How do you spend your free time? (Hobbies, interests, sports, etc.)

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

Review of Systems:

28. Height: _____ 29.Weight: _____

30. Have you had a recent weight change? ☐ Yes ☐ No

If your answer to number 30 is yes: You have gained/lost _____ lbs over the past 3/6 months.

Please circle the symptoms that best describe your condition:

31. Have you had a recent change in your appetite? ☐ Yes ☐ No

32. Head, Eyes, Ears, Nose, Throat and Neck:

Change in vision ☐ Yes ☐ No **Dizziness** ☐ Yes ☐ No

Double vision ☐ Yes ☐ No **Hard of hearing** ☐ Yes ☐ No

Jaw pain ☐ Yes ☐ No **Loss sense of smell** ☐ Yes ☐ No

Please explain:

33. Hematological:

Bleeding Problems ☐ Yes ☐ No **Anemia** ☐ Yes ☐ No

Blood Disease ☐ Yes ☐ No **Bruise easily** ☐ Yes ☐ No

Please explain:

34. Locomotor-Musculoskeletal:

Varicose Veins ☐ Yes ☐ No **Phlebitis** ☐ Yes ☐ No

Swelling at joints ☐ Yes ☐ No **Pain in arms** ☐ Yes ☐ No

Numbness in arms ☐ Yes ☐ No **Pain in hand** ☐ Yes ☐ No **Pain in legs** ☐ Yes ☐ No

Pain in feet ☐ Yes ☐ No **Numbness in feet** ☐ Yes ☐ No

Please explain:

35. Respiratory:

Coughing ☐ Yes ☐ No **Spitting up blood** ☐ Yes ☐ No

Difficulty with Breathing ☐ Yes ☐ No

Please explain:

36. Cardiovascular:

Heart attack ☐ Yes ☐ No **High blood pressure** ☐ Yes ☐ No

Heart Murmur ☐ Yes ☐ No **Chest pain at rest** ☐ Yes ☐ No

Chest pain with activity ☐ Yes ☐ No **Swelling of hands/feet** ☐ Yes ☐ No

Shortness of breath ☐ Yes ☐ No

Please explain:

37. Gastrointestinal:

Change in ability to taste food ☐ Yes ☐ No **Difficulty swallowing** ☐ Yes ☐ No

Vomiting blood/food ☐ Yes ☐ No **Jaundice** ☐ Yes ☐ No

Painful bowel movements ☐ Yes ☐ No

Bleeding w/ bowel movements ☐ Yes ☐ No

Recent change in bowel habits ☐ Yes ☐ No

Cramping/pain in abdomen ☐ Yes ☐ No

Please explain:

38. Neuropsychiatric:

Convulsions ☐ Yes ☐ No **Loss of Consciousness** ☐ Yes ☐ No

Fainting Spells ☐ Yes ☐ No **Prior Psychiatric history** ☐ Yes ☐ No

Please explain:

39. Gynecologic (women only):

Are you still menstruating? ☐ Yes ☐ No

Are your periods regular? ☐ Yes ☐ No

Do you have pain with your periods? ☐ Yes ☐ No

Is there a chance you may be pregnant? ☐ Yes ☐ No

Please explain:

Do you currently have an implanted ICD, pacemaker, or defibrillator? ☐ Yes ☐ No

Have you ever had a problem with prescription medications (misuse, abuse, addiction, etc)?

☐ Yes currently ☐ Yes in the past ☐ No, never

Have you ever used any drugs that are illegal in California? (Cocaine, marijuana, intravenous drugs, etc)?

☐ Yes , Currently ☐ Yes , in the past ☐ No, never

Have you ever been treated for addiction or alcoholism? ☐ Yes ☐ No

Have you ever had psychiatric, psychological, or social work treatments/evaluations for any diagnosis/problem, including your current pain? ☐ Yes ☐ No

If yes, for what diagnosis or problem were you treated?

When were you treated? _____

Therapist's name:_____

Have you considered suicide? ☐ Yes ☐ No

Have you ever planned suicide? ☐ Yes ☐ No

Have you ever attempted suicide? ☐ Yes ☐ No Date: _____

Foad Elahi MD

California Center of Pain Medicine and Rehabilitation

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

If you were diagnosed with sleep apnea, are you currently using a CPAP

or BiPAP machine? ☐ Yes ☐ No

TREATMENT GOALS

We are dedicated to helping you improve your function in everyday life. Please list goals (i.e. running, gardening, riding a bike, attending church, socializing with friends, etc…) that you would like to achieve.

My Goals are:

1)

2)

3)

Do you currently have an Advanced Directive: ☐ Yes ☐ No

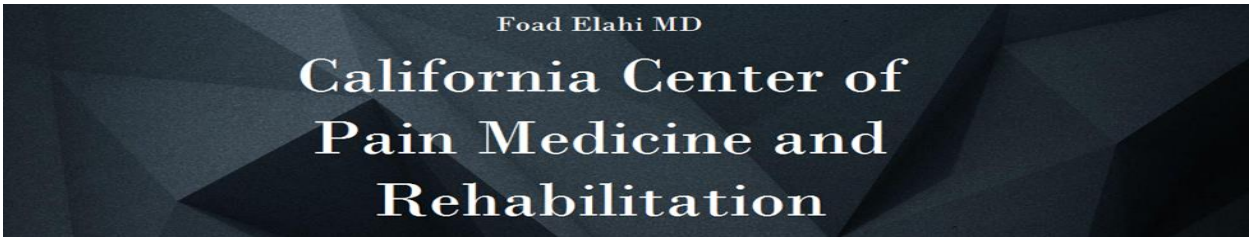
I acknowledge that I have provided you with the most accurate and complete information about my medical history to the best of my ability.We would like to access your pharmacy records and drug formulary information through a third party database. This service provides accurate prescription information from other prescribing physicians and will allow our system to check which medications are on your drug formulary.

I authorize California Center of Pain medicine and Rehabilitation to access my prescription history through my pharmacy, pharmacy benefits manager.

Patient name: **Date:**

Signature:

Drug Abuse and Diversion:
We are interested and dedicated to treating patients in true pain and with other debilitating conditions. If you are such a patient, and are committed to working to get better, we are prepared to help you. If you have other intentions in mind, do not come to our practice. We are strongly opposed to any type of drug abuse and diversion and work hard to eliminate this possibility from our practice, and we will not hesitate to alert law enforcement in appropriate circumstances if we discover conduct in violation of law.



FINANCIAL AGREEMENT

"SIGNATURE ON FILE" CLAIM AUTHORIZATION

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 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.

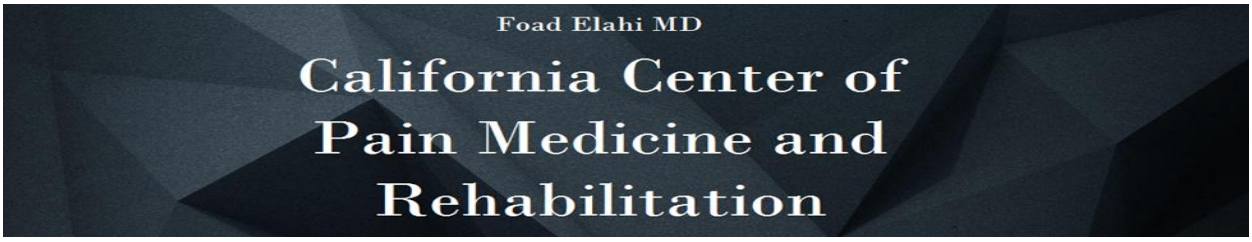
Auto Accidents- We will bill your auto insurance if you have "Med Pay" on your policy. If you are represented and you lose your case you are fully responsible for all charges.

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.

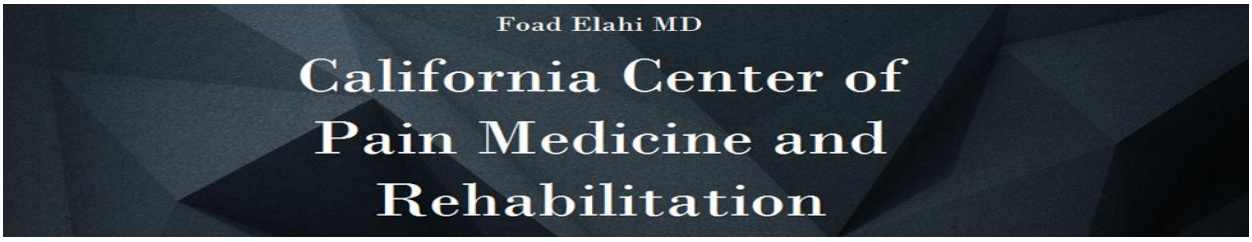


Foad Elahi MD California Center of Pain medicine and Rehabilitation, A Medical Corporation, will bill your insurance company for services provided by your doctor. If you wish us to do so, we will need your consent.

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.

Name: **Date:**

Signature:



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.

Signed: _____Date: _____

If not signed by the patient, please indicate relationship:

____ Parent or guardian of minor patient.

____ Guardian or conservator of patient.

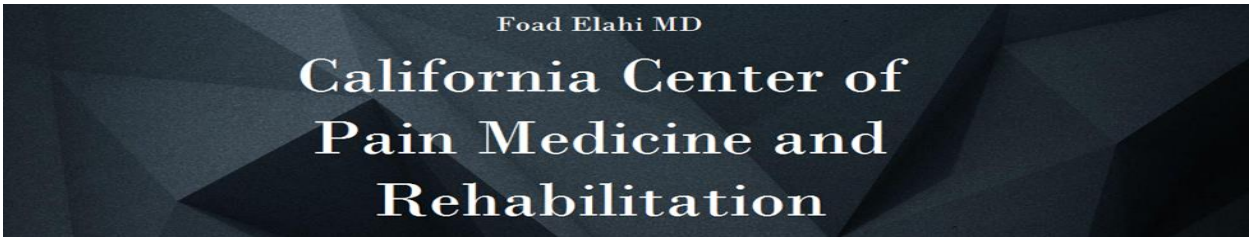
____ Beneficiary or personal representative of deceased patient.

____ Spouse or person financially responsible.

This form should be completed and signed by the patient, and if the patient is a minor, or the policy otherwise required another signature, by the appropriate patient representative. Also, a copy of the assignment should be attached to the claim form when it is submitted to the payer. A third-party payer has no obligation to physician to pay them absent notice of the assignment - this form serves as notice.

FAILURE TO PAY DESPITE ASSIGNMENT

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.



Summary of 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 received 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, I _____, acknowledge that Foad Elahi MD California Center of Pain medicine and Rehabilitation has provided a (printed name of patient or personal representative) written copy of their summary Notice of Privacy Practices to (check one) Myself _____ or Specify _____.

Signature of Patient or Personal Representative

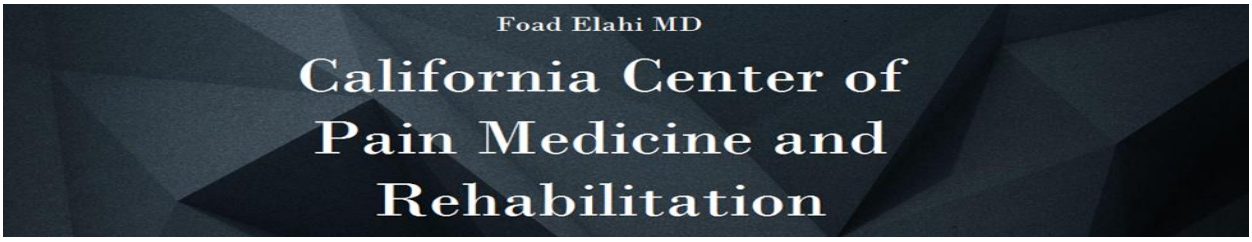
Date

Relationship to Patient

Foad Elahi MD California Center of Pain medicine and Rehabilitation has made a good faith attempt to provide the above named patient with a copy of our summary Notice of Privacy Practices, but we were not successful for the following reason:

_____

Signature of Representative Date



DISCLOSURE OF PROTECTED HEALTH INFORMATION

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.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Foad Elahi MD California Center of Pain medicine and Rehabilitation reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Foad Elahi MD California Center of Pain medicine and Rehabilitation.

With this consent, Foad Elahi MD 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 MD 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.

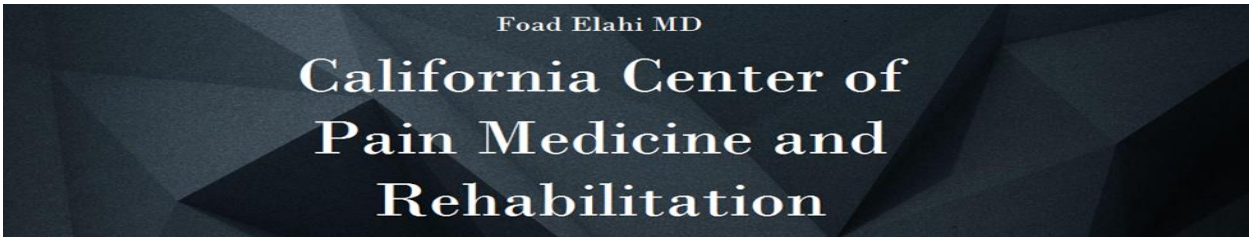
With this consent, Foad Elahi MD California Center of Pain medicine and Rehabilitation may e-mail to my home or other alternative locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Foad Elahi MD California Center of Pain medicine and Rehabilitation restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Foad Elahi MD California Center of Pain medicine and Rehabilitation use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Foad Elahi MD California Center of Pain medicine and Rehabilitation may decline to provide treatment to me.

Signature of Patient or Legal Guardian: _____

Patient Name: _____Date: _____



MEDICAL RECORDS RELEASE

Date:

I authorize any physician, hospital, clinic, or any medically related facility to furnish to Foad Elahi MD California Center of Pain medicine and Rehabilitation, A Medical Corporation, any medical information, including copies of all my medical records and diagnostic tests/films. A copy of this authorization shall be considered as effective and valid as the original.

Signature:

Name (please print):

Date of birth:

RELEASE OF MEDICAL INFORMATION TO FAMILY MEMBERS

I authorize Foad Elahi MD California Center of Pain medicine to discuss and release all medical information to those persons named below, including medical records, x-rays, history, findings and prognosis pertaining to the medical condition, services rendered, or treatment given to me. This authorization complies with the Confidentiality of Medical Information Act, Section 56 et seq. of the California Civil Code.

Name: _____Relationship:_____

Name: _____Relationship:_____

Name: _____Relationship:_____

AUTHORIZATION FOR RELEASE OF INFORMATION

☐ **Patient to pickup** ☐ **Fax** ☐ **Mail**

For Your Information:

☐ **A charge of $20.00 will be assessed to copy your chart. Doctor to Doctor – no charge.**

☐ **Please allow 7 days for completion of all record copying requests.**

☐ **I understand that my records are protected and cannot be disclosed without my written permission.**

Foad Elahi MD

California Center of Pain Medicine and Rehabilitation

Requested By:

Name of Patient: **Phone Number:**

Address: **SSN:**

City, State, Zip: **Date of Birth:**

Records From:

Name of Doctor: _____ Phone Number: _____

Address: _____ Fax Number: _____

City, State, Zip: _____ Date Requested: _____

Information Requested:

☐ Lab Reports ☐ X-Ray Reports ☐ Office Visit Notes

☐ Operative Notes ☐ EKG ☐ Other: _____

Reason for Request:

☐ Send to Doctor ☐ For Own Use ☐ Other: _____

Release Records To:

Name: _____ Phone Number: _____

Address: _____ Fax Number: _____

City, State, Zip: _____ Date Requested: _____

I hereby also release the above named clinic or physician from all legal liability that may arise from the release of this information. This authorization is valid for 90 days.

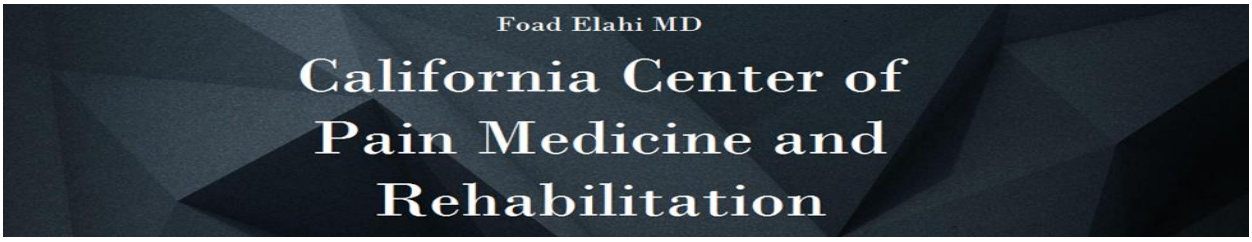
Signature of Patient or Legal Guardian

_____

Witness

_____

Date of Request



SPECIFIC AUTHORIZATION:

☐ AIDS/HIV Testing Information

☐ DRUG/ALCOHOL Information

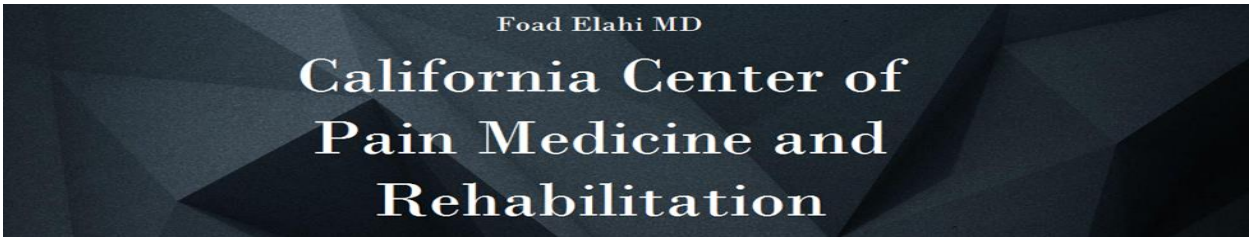
☐ MENTAL HEALTH Information

I acknowledge that records to be released may include material that is protected by federal regulation 42 CFR, part 3 and that it is applicable to ANY of the above. My signature below authorizes the release of all information.

Patient name

Signature

Date



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.

Patient Signature

Date

Patient Name (please print)

Patient Rights & Responsibilities

- Each Patient has the right to be treated with respect and recognition of his or her dignity and need for privacy.
- Each Patient seeking advice or assistance has the right to be assisted in a prompt, courteous, and responsible manner.
- Each Patient has the right to be provided with information concerning his or her diagnosis, treatment, and prognosis in terms that are understandable to him or her. When it is not medically advisable or feasible to be given to the Patient, the information will be made available to the next-of-kin or other person designated by the Patient, except when existing laws do not permit the release of information without the written consent of the Patient.
- Each Patient has the right to decline treatment. In this event, the Patient has the right to be informed of the medical consequences of this action. In the care of a Patient who is mentally incapable of making a rational decision, approval will he obtained from the Guardian, next-of-kin, or other person legally entitled to give such approval.
- Each Patient has the right to have his or her medical record and all other information held confidential unless disclosure is required or permitted by Pain Medicine Consultants, the law, or if he or she consents to its release.
- In the event of any experimental/investigational procedures (e.g., research), the Patient will be provided with an informed consent. The Patient has the right to not be included in the investigational procedure if such information/consent is not given. No attempt will be made to influence the Patient to give consent if he or she is reluctant to participate. In the case of Patients who are considered mentally incapable of executing an informed consent, approval will he obtained from the Guardian, next-of-kin, or other person legally entitled to give consent.
- Each Patient has the right to he provided with appropriate guidance and recommendations for additional medical care if coverage is terminated.
- Each patient has the responsibility to be considerate and respectful of all treatment staff.

- Each Patent has the responsibility to cooperate with his or her treatment staff. If the Patient has questions or disagrees with the treatment plan, he or she has the responsibility to discuss it with his or her treatment staff.

- Each Patient has the responsibility to keep all scheduled diagnostic or treatment appointments on time.

- Each Patient has the responsibility to provide, to the extent possible, information needed by the treatment staff to care for him or her.

- Each Patient has the responsibility to follow instructions and guidelines given by the treatment staff.

- Each Patient has the responsibility to understand what medications he or she is taking and whether he or she is scheduled for follow-up visits.

- Each Patient has the responsibility to be considerate of other Patents and to be undemanding and tolerant if delays are encountered.

Each patient has the responsibility to express opinions, concerns, or complaints regarding his or her health care and rights and responsibilities in a constructive manner to Pain Medicine Consultants