Foothills Pain Management Clinic

Dharmesh Mehta, MD | Matthew Tan, MD
Joanna Acosta, PA-C | Tanya Lumbangaol, PA-C, | Veronica Sanchez, FNP-BC
Austin Chang, PA-C | Rudy Ramirez, PA-C,

"Restoring Life by Relieving Pain"

PATIENT NAME_____ D.O.B.____/____/____ AGE_____
(LAST) (FIRST) (INITIAL)

ADDRESS_____ CITY, STATE_____ ZIP_____

PHONE (___)_____CELL (___)_____ S.S.N._____

E:Mail Address: _____, **will be used for a Patient Portal**

PLEASE CIRCLE: MALE FEMALE MARRIED SINGLE DIVORCED WIDOWED

D.L.#_____PRIMARY LANGUAGE_____INTERPRETER NEEDED? Y N

HOW WERE YOU REFERRED TO OUR OFFICE?_____

IS YOUR ILLNESS OR INJURY CAUSED FROM WORK? YES NO D.O.I.____/____/____

EMPLOYER_____ PHONE (___)_____

ADDRESS_____ CITY, STATE_____ZIP_____

INSURANCE/BILLING INFORMATION

RESPONSIBLE PARTY_____RELATIONSHIP_____D.O.B.___/___/___

EMPLOYER (IF DIFFERENT)_____ PHONE (___)_____

INSURANCE CO._____ PHONE (___)_____

ADDRESS_____CITY, STATE_____ZIP_____

INSURED I.D.#_____ POLICY/GROUP#_____

CLAIM #_____ ADJUSTER_____

EMERGENCY CONTACT:

NAME_____PHONE (___)_____CELL (___)_____Relation: _____

PATIENT RESPONSIBILITY

Due to stringent rules adopted by the Federal Government (HIPAA-Health Insurance Portability and Accountability Act) with regard to patient confidentiality, the responsibility of delivery of medical testing results and medical records will be the responsibility of the patient. Many facilities will no longer provide a copy of your medical testing or records via fax or mail without an authorization signed by the patient. Our office will make every attempt to obtain your medical records for your convenience. If we are unable to do so, it is the responsibility of the patient to assure that these records are received by Foothills Pain Management Clinic prior to the appointment.

I authorize Foothills Pain Management Clinic to obtain medical records, testing, x-rays or any pertinent information to assist in the evaluation and treatment of my medical condition. This authorization shall remain in effect for 1 (one) year unless revoked by me in writing.

_____ _____
PATIENT SIGNATURE DATE

Foothills Pain Management Clinic
Dharmesh Mehta, MD | Matthew Tan, MD
Joanna Acosta, PA-C | Tanya Lumbangaol, PA-C, | Veronica Sanchez, FNP-BC
Austin Chang, PA-C | Rudy Ramirez, PA-C,
"Restoring Life by Relieving Pain"

CANCELLATION/ NO SHOW/ MISSED APPOINTMENT POLICY

If you do not give the office 24 hours' notice that you will miss your appointment, a charge will be added to your account that must be paid before we can schedule another appointment for you. **Your insurance will NOT pay for this charge.**

$25.00 if you do not provide a 24 hour notice for your office visit.
$50.00 if you do not provide a 24 hour notice for any scheduled procedure/injection.
$50.00 returned check fee.

Reminder calls are a courtesy and cannot always be provided. It is your responsibility to report for your appointment on the scheduled date and time.

Your signature below conveys that you have read and understand our policy regarding missed appointments.

_____
Patient Name Printed

_____ _____
Patient Signature or Legally Authorized individual Signature Date

Foothills Pain Management Clinic

Dharmesh Mehta, MD | Matthew Tan, MD
Joanna Acosta, PA-C | Tanya Lumbangaol, PA-C, | Veronica Sanchez, FNP-BC
Austin Chang, PA-C | Rudy Ramirez, PA-C,
"Restoring Life by Relieving Pain"

Patient Name: _____ DOB: _____

In order to comply with the highest standards for your privacy and the confidentiality of your medical information, we ask you to please complete the following:

May we contact you at this number? Regarding appointment information? (confirm, cancel, reschedule, etc,)			OK to leave a message	
( )_____ Home Phone	Yes	No	Yes	No
( )_____ Work Phone	Yes	No	Yes	No
( )_____ Cell Phone	Yes	No	Yes	No
Would you like us to TEXT your appointment Reminders?	YES	NO		
_____ E-mail Address	Yes	No	Yes	No

Would you like Access to our Patient Portal so you can access your Medical Information On-Line: _____
Our Patient Portal will be coming July 2014.

Please also list any family members or friends that you would like us to release your Personal Health Information to. If none is listed we will only release your medical treatment plan to you.

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you currently have an ADVANCED HEALTH CARE DIRECTIVE FORM? YES NO

Are you interested in obtaining an Advanced Health Care Directive? YES NO

Do you have a Surrogate Decision Maker? YES NO

Who is your Surrogate Decision Maker? _____Phone: (____) _____

_____ _____
Patient Name Patient Signature

Foothills Pain Management Clinic

Dharmesh Mehta, MD | Matthew Tan, MD
Joanna Acosta, PA-C | Tanya Lumbangaol, PA-C, | Veronica Sanchez, FNP-BC
Austin Chang, PA-C | Rudy Ramirez, PA-C,
"Restoring Life by Relieving Pain"

PAYMENT IS DUE WHEN SERVICES ARE RENDERED. We will bill most insurance companies for your as a courtesy, provided we have all the necessary information. It is your responsibility to verify with your insurance carrier as to whether you are covered for the medical services provided to, e.g. physician consults/follow-up, epidurals, facet blocks, pump refills or spinal cord stimulator. Any Deductible, co-payments, co-insurance or balances not paid by your insurance company are your financial responsibility and are DUE in full prior to services being rendered. This applies the all insurance including Medicare. **Patient Initials: _____**

CO-PAYMENT; DEDUCTIBLES AND CO-INSURANCE RESPONSIBILITY ARE DUE WHEN SERVICES ARE RENDERED. Insured patients are responsible for all charges not paid by the insurance company within 45 days after the date of service. Payment arrangements will only be made on an individual basis and **AT OUR DESCRESTION.** We do not guarantee a payment arrangement will be made, we reserve the right to withdraw the extension of credit at any time. **Patient Initials: _____**

CANCELLATION POLICY. Patients who fail to cancel an appointment within 24 hours of the appointment time will be charged a $25.00 No Show/Late Cancellation fee. $50.00 for all scheduled procedures. This fee Must be paid before you can get back on the schedule.
Patient Initials: _____

RETURNED CHECKS POLICY. There will be a $50.00 fee for all returned checks and Foothills Pain Management Clinic will require another form of payment for all future payments made during your course of treatment. **Patient Initials: _____**

MEDICARE-AUTHORIZATION & BENEFIT ASSIGNMENT

I request that payment of authorized Medicare benefits be made to Foothills Pain Management Clinic for any services furnished to me by this physician/supplier. I Authorize Foothills Pain Management Clinic to release any Personal Health Information to the Health Care Financing Administration and its agents to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorize release of Personal Health Information necessary to pay the claim. In Medicare assigned cases, the physician/supplier agrees to accept the charge determination of the Medicare carrier as partial payment of Medicare allowed rate, the balance of the bill will then be billed directly to the patient. **The patient is responsible for any remaining balance not paid by Medicare, deductible, coinsurance and non-covered services.** Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. **Patient Initials: _____**

INSURANCE AUTHORIZATION & BENEFIT ASSIGNMENT

I HEREBY AUTHORIZE Foothills Pain Management Clinic to furnish Personal Health Information to insurance carriers concerning my illness and treatment and I hereby assign to Foothills Pain Management Clinic all payment for medical services rendered to my dependents or myself. I understand I am responsible for patient deductibles, coinsurance and any amount not covered by my insurance. Laboratory, radiology and other ancillary services provided in connection with Foothills Pain Management Clinic will be billed separately. Copayments must be made at the time of service. There is a charge of $50.00 for any returned checks. I understand and agree to give at least 24 hour notice if I am unable to keep an appointment. Failure to do so will result in a "No Show" charge of $25.00 for a follow-up appointment and $50.00 for any scheduled procedure.
Patient Initials: _____

CONSENT TO TREATMENT

The undersigned consents to treatment made by Foothills Pain Management Clinic including but not limited to emergency treatment or services, laboratory procedures, x-ray examination, medical or surgical treatment and/or procedures rendered to the patient under the general and specific instructions of the patient's physician. **Patient Initials: _____**

RELAEASE OF MEDICAL RECORDS

I authorize the release of any medical or past medication records to Foothills Pain Management Clinic, Dr. Dharmesh Mehta that will assist in my treatment. ie: Medical Reports; Lab Results; Diagnostic Testing; Previous Medication History prescribed and dispensed. **Patient Initials: _____**

I have read this form in completions and fully understand my responsibility as a patient of Foothills Pain Management and agree to abide by the Office Policy of Foothills Pain Management Clinic during the course of my treatment.

_____ _____/_____/_____
Patient Name Patient Date of Birth

_____ _____/_____/_____
Patient Signature Date

Foothills Pain Management Clinic
Dharmesh Mehta, MD | Matthew Tan, MD
Joanna Acosta, PA-C | Tanya Lumbangaol, PA-C, | Veronica Sanchez, FNP-BC
Austin Chang, PA-C | Rudy Ramirez, PA-C,
"Restoring Life by Relieving Pain"

Informed Consent for Opioid Patient Prescriber Agreement

This Opioid Patient Prescriber Agreement is designed to discuss the medications you will be taking for pain management and to assure that you and your physician/healthcare provider comply with all state and federal regulations concerning the prescribing of controlled substances. The physician's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the physician/patient relationship and full agreement and understanding of the risks and benefits of using opioids to treat pain.

Please Complete Opioid Therapy Monitoring- Answer ALL questions complete. Leave NO Blanks

Activity What Progress has been made in your functional goals?	A) Sitting Tolerance B) Standing Tolerance C) Walking Ability D) Ability to perform daily Living activity	**A)** **B)** **C)** **D)**
Analgesia How Do you rate your Pain Over the last 24 hours?	Average Pain Level:_____ Worst Pain Level:_____ Scale from 0-10 0= No Pain 10= Unbearable Pain	
Analgesia In General, how much Pain relief have pain medications Provided? How long does the relief last?	IE: 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% Hours ____ between Doses	
Opioid Medication may reduce pain, making it easier to:	___ Go Back to Work ___ Sleep ___ Climb Stairs ___ Daily Housework ___ Walk ___ Exercise	**Other Things Medication Improves:**
Adverse Effects Have you experienced any adverse Effects from the medication?	Constipation _____ Addiction _____ Nausea _____ Itching _____ Dizziness _____ Tolerance _____ Drowsiness _____ Breathing _____ Other:	**Other Side Effects:**
Aberrant Behaviors Is Medication taken as Prescribed? Do you exhibit any signs of the problematic behaviors or medication misuse?	How Often do you take the Medication? **How Often are you prescribed to take the medication?**	Drug Use: _____ Alcohol Use: _____ Increased Dose: _____ Multiple MD's: _____ Lost RX: _____
Affect Have there been any changes to the way the you have been feeling?	Does pain change your MOOD? YES NO Do you have Depression? YES NO Do you have Anxiety? YES NO	
Accurate Records A) What Opioid Medication are you taking? B) What is the Daily Dose? C) Physician Prescribing?	**A)** **B)** **C)**	**Pharmacy Name:** **Number:** **City:**
Previous Medications Tried **Why they Failed?**	**Name:** **Dose:** **How Long did you Try them:** **FAILED:**	**Name:** **Dose:** **How Long did you Try them:** **FAILED:**

I understand that many medications can have interactions with opioids that can either increase or decrease their effect. Therefore, the following is expected of me as patient being prescribed Opioid medication:

1. **I am responsible for my pain medications.** I agree to take the medication only as prescribed.
   a. I must store my medication in a safe location, where other people do not have access to my medication.
   b. I understand that the opioid medication is strictly for my own use. The opioid should **never** be given or sold to others because it may endanger that person's health and is **against the law. Please Initial: _____**
   c. I understand that increasing my dose without the close supervision of my physician could lead to drug overdose causing severe sedation and respiratory depression and death. If I increase my dose without physician authorization, additional Medication will NOT be given to me EARLY for any Circumstance.
   d. **Opioid medication can ONLY be electronically prescribed by a provider. Medication CANNOT BE CALLED into the pharmacy and will ONLY be sent during a scheduled appointment. Please Initial: _____**
   e. Choosing a pharmacy is completely your choice, Staff nor providers know any pharmacies that carry your medication and we do not have access to quantities or availability at pharmacies. We will not call around to find your medication.
   f. You must bring back all opioid medications and adjunctive medications prescribed by your physician in the original containers/bottles at every visit.
   g. Prescriptions will not be written in advance due to vacations, meetings, or other commitments.

2. I will inform my physician of all medications I am taking, including herbal remedies. Medications like Valium or Ativan; sedatives such as Soma, Xanax, Fiorinal; antihistamines like Benadryl; herbal remedies, alcohol, and cough syrup containing alcohol, codeine, or hydrocodone can interact with opioids and produce serious side effects. Side Effects can include drowsiness, dangerously slowed breathing and decreased alertness.

   i. Patient Activity Reports will be run from the Department of Justice website for every visit to monitor medication being prescribed. If there are multiple providers prescribing Opioid Medication, it is made very clear that I will no longer receive prescriptions for pain management and will be expected to find a different pain management provider outside of Foothills Pain Management Clinic.

   I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from my physician at the Pain Center. Please Initial _____
   Any evidence of drug hoarding, acquisition of any opioid medication or adjunctive analgesia from other physicians (which include emergency rooms), uncontrolled dose escalations or reduction, loss of prescriptions, or failure to follow the agreement may result in termination of the doctor/patient relationship

   ii. As there is a high risk with taking Opioid Medication, I have been educated in taking Narcan/Naloxone/Evzio medication to reverse the effects of medication taken. A prescription for Narcan/Naloxone/Evzio product will be sent to your pharmacy. You can take the medication brand that is covered by your insurance and that is in stock at your pharmacy. You will keep the Narcan/Naloxone/Evzio and use the medication as required for an overdose. Narcan/Naloxone/Evzio works quickly to block the effects of opioids and temporarily reverses the breathing problems caused by the overdose, which can prevent death. Notify the provider if you need a new prescription as it is required to keep this medication.
   You can visit: https://www.youtube.com/watch?v=nurz9qPGKws for visual instructions.

3. You should not use any illicit substances, such as cocaine, marijuana, methamphetamines etc. while taking prescribed medications. This may result in a change to your treatment plan, including safe discontinuation of your opioid medications when applicable or complete termination of the doctor/patient relationship. **Please Initial: _____**
   A Prescription will NOT be prescribed if you test positive for illicit substance.

4. The use of alcohol together with opioid medications is contraindicated.
   a. If I have a history of alcohol or drug misuse/addiction, I must notify the physician of such history since the treatment with opioids for pain **may** increase the possibility of relapse. A history of addiction does not, in most instances, disqualify one for opioid treatment of pain, but starting or continuing a program for recovery **is a necessity.**

5. Possible Side Effects of using Opioid Medication are:
   a. Physical Dependance: I understand that decreasing or stopping my medication without the close supervision of my physician can lead to withdrawal. **Withdrawal symptoms** can include yawning, sweating, watery eyes, runny nose,

anxiety, tremors, aching muscles, hot and cold flashes, "goose flesh", abdominal cramps and diarrhea. These symptoms can occur 24-48 hours after the last dose and can last up to 3 weeks. If you want to stop taking the medication speak to your provider about slowly tapering off your current dose with monitoring.

b. Tolerance: is the feeling of needing more medication to achieve previous pain relief. This means that the opioid medicine may begin to feel like it's not working. Provider may change medication or start to tapper you off the medication if it proves no longer effective due to a tolerance.

c. Addiction: Intense craving for opioid medicine, even if taken as prescribed. When a person is not able to control their opioid medicine use and may continue using the medicine despite the side effects it causes, this is called addiction. If addiction occurs, medical supervision will be required to stop taking the opioid medication.

Possible Side Effects

OPIOID SIDE EFFECTS	**Percentage of Patients** ***% Patients side effects unknown**
Addiction	5-30 %
Breathing problems during Sleep; disruption of sleep	25%
Confusion	*
Constipation	30-40%
Depression	30-40%
Drowsiness	15%
Dry Mouth	25%
Intestinal Blockage	Less than 1% per year
Itching	*
Infertility and Impotence	25%-75%
Nausea or Vomiting	*
Overdose- Can lead to Death • Narcan can reverse the Effects of Opioids	30-83%
Physical Dependance	*
Tolerance	*
Unexpected Increased Pain	*

6. I agree and understand that my physician reserves the right to perform random or unannounced urine drug testing. If requested to provide a urine sample, I agree to cooperate. If I decide not to provide a urine sample, I understand that my doctor may change my treatment plan, including safe discontinuation of my opioid medications when applicable or complete termination of the doctor/patient relationship. The presence of a non-prescribed drug (s) or illicit drug (s) in the urine can be grounds for termination of the doctor/patient relationship. Urine drug testing is not forensic testing but is done for my benefit as a diagnostic tool and in accordance with certain legal and regulatory materials on the use of controlled substances to treat pain.

7. I agree to allow my physician/healthcare provider to contact any healthcare professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about my care or actions *if the physician feels it is necessary.*

8. I agree to a family conference with a close friend, significant other or a family member *if the physician feels it is necessary.*

9. I understand that non-compliance with the above conditions may result in a re-evaluation of my treatment plan and discontinuation of opioid therapy. I may be gradually taken off these medications, or even discharged from the clinic.

10. I understand that I am expected to treat providers and staff with respect and agree that yelling, cursing, and name calling is not appropriate behavior in a medical office. If I become, rude, irate, belligerent or defer medical advice, I agree to be discharged from medical treatment and will seek treatment elsewhere for my Pain Management needs.

Foothills Pain Management Clinic
Dharmesh Mehta, MD | Matthew Tan, MD
Joanna Acosta, PA-C | Tanya Lumbangaol, PA-C, | Veronica Sanchez, FNP-BC
Austin Chang, PA-C | Rudy Ramirez, PA-C,
"Restoring Life by Relieving Pain"

I will communicate fully with my physician to the best of my ability at the initial and all follow-up visits what my pain level is and functional activity along with any side effects of the medications. This information allows my physician to adjust my treatment plan accordingly.

Other Options for Pain Management treatment other than Medication can also include:

A) Non-Opioid Medicines such as Tylenol, Motrin, Aleve
B) Physical Therapy, Required to be completed 2-3 Sessions for 4-6 weeks every 6 months to a year
C) Acupuncture
D) Self-management techniques and coping strategies such as meditation, stress reduction, counseling and coaching, massage therapy, social support group, and attention to proper sleep
E) Interventional Pain Management Procedures
F) Clinicians at Foothills Pain Management Clinic follow all CDC and Medical Board recommendations and will NOT prescribe more than 90 Morphine Milligram Equivalence of Opioid Medication for short term use. Opioid Medication is not medically necessary for Long Term Pain Management.

[ ] I _____ have read the above information or it has been read to me and all of my questions
Print Patient Name
regarding the treatment of pain with opioids have been answered to my satisfaction. I hereby give my consent to participate in the opioid medication therapy & acknowledge receipt of this document.

[ ] After reviewing and discussing all of my options, I, _____ have decided that medication is not
Print Patient Name
an option I would not like to proceed with it at this time. I would like to decline the prescribing of Opioid medication and will proceed with _____ to assist in managing my pain.

I also understand that by signing this agreement the clinicians at Foothills Pain Management Clinic are under no obligation to prescribe Opioids or Narcotics. Being seen at Foothills Pain Management Clinic is NOT a GUARANTEE that a prescription will be written. A Medical Evaluation will be performed, and the best course of medical treatment will be offered. The clinicians at this office will prescribe medication according to the guidelines set forth by the Medical Board in conjunction with California State and Federal Laws according to Centers for Disease Control and Prevention (CDC) recommendations.

Patient's Signature_____ DOB: _____ Date_____

Witness's Signature_____ Date_____

Foothills Pain Management Clinic
Dharmesh Mehta, MD | Matthew Tan, MD
Joanna Acosta, PA-C | Tanya Lumbangaol, PA-C, | Veronica Sanchez, FNP-BC
Austin Chang, PA-C | Rudy Ramirez, PA-C,
"Restoring Life by Relieving Pain"

Acknowledgement of Receipt of Notice of Privacy Practices (NPP)

In compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Foothills Pain Management Clinic, PC is required to provide the patient the Notice of Privacy Practices. The notice describes how health information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

En conformidad con el acto de la Portabilidad y de la Responsabilidad del seguro medico de 1996 (HIPPA), Foothills Pain Management Clinic, PC es requerido que laproporcione al paciente el Aviso de la salud sobre usted puede ser utilizada y ser divulgada, y com ousted puede tener el acceso a esta informacion. Por favor lea esta information cuidadosmente.

I hereby acknowledge that I have received a copy of Foothills Pain Management Clinic's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. In addition, a Notice of Privacy Practices is posted in the patient waiting area.

I understand that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

_____ _____
Signature Date

_____
Print Name

If not signed by patient, please indicate relationship:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this receipt of Notice of Privacy Practices form but was unable to do so as documented below:

Date:_____ Initials:_____ Reason:_____

Foothills Pain Management Clinic

Dharmesh Mehta, MD | Matthew Tan, MD
Joanna Acosta, PA-C | Tanya Lumbangaol, PA-C, | Veronica Sanchez, FNP-BC
Austin Chang, PA-C | Rudy Ramirez, PA-C,
"Restoring Life by Relieving Pain"

Patient Name/Nombre: _____**Patient DOB**/Fecha de Nac: ____/____/____ **Gender**/Género: Male Female

Weight/Peso: _____**Height**/Altura: _____**Ethnicity**/Raza: _____**Language Preference**/Preferencia de idioma: _____

Describe why you are being seen by Dr. Mehta/ Explicar por qué están siendo vistos por el Dr. Mehta:

_____

Who do you live with at home?/¿Con quién vives en casa con? ( ) live alone/solo _____
Living Arrangement/Arreglo de vivienda: House/Casa Apartment/apartamento Care Facility/Instalacion de Atencion Other/Otro: _____
Are you/ ¿Está: Married/Casado Single/Soltero Divorced/Divorciado Widowed/Viudo
Number of Children/ Número de niños: _____ **Highest level of Education**/Nivel mas alto de education: _____

Alcohol Use/Alcohol: Daily/Diario Weekly/Semanal Socially/Socialmente NEVER/Nunca
Number of Years Drinking Alcohol/Numero de anos que bebe:_____

Tobacco Use/Tabaco: Daily/Diario Weekly/Semanal Socially/Socialmente NEVER/Nunca
Number of Years Smoking/Numero de Anos de fumar: _____/Pack/day(Paquete/dia) _____
If you are a CURRENT Smoker, Have your Tried to QUIT in the past 3 Years? YES NO
Why were you unsuccessful in Stopping? _____

Illegal Drug Use/Ilicito de dogas: Daily/Diario Weekly/Semanal Socially/Socialmente NEVER/Nunca
Number of Years using Illegal Drugs/Numero de usar drogas ilegales: _____

List doctors you have previously seen/ Los médicos que ya ha visto Lista . INCLUDING REFERRING DOCTOR/Referirse a medico:

Name of Doctor/Nombre el Medico	Specialty/ Especialidad	Phone Number/Numero de Telefono	City/Ciudad

When did the pain start?/¿Cuándo fue la fecha de inicio?_____( ) Unknown
What made the pain start?/Lo que hizo que comenzo el dolor?_____ ( ) Unknown
What makes the pain **worse**?/¿Qué hace que el dolor empeore?_____( ) Unknown
What makes the pain **better**?/¿Qué hace que el dolor se alivie?_____ ( ) Unknown
What is your pain Level on a scale 1-10? Please Mark your pain level on the Pain Intesnity Scale Below: _____

|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
0 1 2 3 4 5 6 7 8 9 10

Please Make your Pain 0=NO PAIN 5= Moderate Pain 10= Worst Possible Pain

¿Qué tan malo es su dolor en una escala de 1-10 (Uno de ellos es el menor y 10 el peor) _____
Level of Pain/Nivel de dolor: Mild/Leve Moderate/Moderada Severe/Severo
How often Are you in Pain?/¿Con qué frecuencia siente dolor: _____
Out of a 24 hour day How Many Hours does your pain Last? _____
Is the pain: **CONSTANT COMES AND GOES ONLY IN MORNING ONLY IN AFTERNOON ONLY AT NIGHT**

Are you able to?/¿Es usted capaz?( ) Walk/Caminar ( ) Stand/Parada ( ) Daily Activities/Actividades Diarias ( ) Drive/Conducir
( ) Work/Trabajo ( )Sleep/Dormir ( ) Sex/Sexo ( ) Sit/Sentar ( ) Laying Down/Acostado ( ) Movement/Movimiento

Is this Work Related/¿Es esto relacionado de trabajo?: YES/Si NO Last Date Worked/Última fecha de trabajo: ___/___/_____
What type of work do you do?/¿Qué tipo de trabajo hace usted?**:** _____
Are you on Disability/¿Está usted en la discapacidad?: YES/Si NO Who put you on Disability?/¿Quién te puso en la discapacidad? _____
Is/Was there a lawsuit regarding this injury?/¿Es/fue alli una demanda por esta lesion?: YES/Si NO
Attorney Name/Nombre del abogado: _____ Phone/Teléfono: (_____) _____-_____

Use any of the following WORDS to describe your Pain:

Foothills Pain Management Clinic

Dharmesh Mehta, MD | Matthew Tan, MD
Joanna Acosta, PA-C | Tanya Lumbangaol, PA-C, | Veronica Sanchez, FNP-BC
Austin Chang, PA-C | Rudy Ramirez, PA-C,
"Restoring Life by Relieving Pain"

Tender/Tierno	Swollen/Hinchado	Weakness/Debilidad
Paralyzed/Paralizado	Dulling/Embotamiento	Throbbing/Palpitante
Spasm/Espasmo	Straining/Esfuerzo	Nauseous/náusea
Burning/Ardor	Numbness/ entumecimiento	Tingling/Hormigueo
Stabbing/ puñalada	Cramp/Calambre	Sore/Adolorido
Sharp/Agudo	Constant Shooting/Tiro Constante	Crushing/Apalstante
Pressure/presión	Muscle Spasms/Espasmos musculares	Freezing/congelación
Unbearable/inaguantable	Stiffness/Rigidez	Excruciating/agudísimo
Ache/Dolor/Tightness/opresión	Crushing/Aplastante	Electric Shock/Descarga eléctrica

Indicate where the pain is and what the pain feels like/Indique donde esta el dolor y lo que se siente el dolor:

	Describe the Pain/Describa el dolor	When did pain start	Pain Level from 1-10
Headaches/dolor de cabeza			
Migraines			
Occipital Neuralgia			
Shoulders/Hombro: RIGHT LEFT			
Arm/Brazo: RIGHT LEFT			
Elbow/Codo: RIGHT LEFT			
Wrist/Muñeca: RIGHT LEFT			
Hand/Mano: RIGHT LEFT			
Neck/Cuello:			
Mid-Back/Media de la Espalda:			
Pelvic/Pelvico:			
Low Back/Parte Baja de la Espalda:			
Buttocks/Asentaderas			
Hip/Cadera: RIGHT LEFT			
Leg/Pie: RIGHT LEFT			
Knee/Rodilla: RIGHT LEFT			
Ankle/Tobillo: RIGHT LEFT			
Foot/Pie: RIGHT LEFT			
Toes/Dedos de los pies: RIGHT LEFT			

Please mark any of the following treatments that you may have had in the past, and tell is who performed them; when and the outcome:

Treatment Done/Trato Hecho	Who/Quién/Where/Donde	When/Cuando	What was the outcome/cuál fue el resultado
Physical Therapy/Terepia Fisica			
Pool Therapy/Piscina Terapeutica			
Biofeedback			
Tens Unit/ Decenas Unidad			
Acupuncture/Acupuntura			
Trigger Point/En Los Puntos Gatillo			
Epidural Steroid/Epidural de esteroides			
Surgery/Cirugia			
Detox/Rehabilitation:			
Hospitalized for Pain/Hospitalizado por dolor			
Other Specialist/Otro Especialista:			
Chiropractic Manipulation			
Psychological Counseling For Pain			
X-Rays/Rayos X:			
MRI:			
CT Scan:			

Foothills Pain Management Clinic

Dharmesh Mehta, MD | Matthew Tan, MD
Joanna Acosta, PA-C | Tanya Lumbangaol, PA-C, | Veronica Sanchez, FNP-BC
Austin Chang, PA-C | Rudy Ramirez, PA-C,

"Restoring Life by Relieving Pain"

Please MARK any medical problems that you have experienced since the onset of your PAIN to current.

Medical Problem/Problemas Medicos	X	When/Cuando	Treating Physician/ Tratamiento Medico	Family History/ Historia Familiar	Family Member/ Miembro de la Familia
AIDS/SIDA					
Alcoholism/alcoholism					
Anesthesia Reaction/anesthesia reaccion					
Aneurysm/Aneurisma					
Anxiety/Ansiedad					
Arthritis/Artritis/ Rheumatoid/Reumatoide					
Asthma/Asma					
Bleeding Disorder/Desangramiento					
Bloody Stool/Sangre en las Heces					
Breast Cancer/Cancer de Mama					
Broken Bone/Fractura de Huesos:					
Carpal Tunnel Syndrome					
Cancer/Cancer:					
Cardiovascular Problems/Problemas de Cora					
Cellulites/Celulitis					
Cervical (Neck)Pain:					
Change in: Bladder/Cambio en: Vejiga					
Change in: Bowel/Cambio en: Heces					
Constipation/Estrenimiento					
Crohn's Disease/Enfermedad Corona					
Cyst:Quiste					
Degenerative Joint/Articular Degenerativa					
Depression/Depresion					
Diabetes/Diabetico					
Difficulty Sleeping/Dificil Dormir					
Dizziness/Mareo					
Fatigue/Fatiga					
GERD/ERGE					
Glaucoma					
Feeling Hopeless/Sentimientos de Desespera					
Feeling Worthless/Sentirse sin Valor					
Headaches/Dolores de Cabeza					
Heart Attack/Ataque del Corazon					
Hepatitis A					
Hepatitis B					
Hepatitis C					
High Blood Pressure/Presion Arterial Alta					
Hypoglycemia/La Hipoglucemia					
Hypothyroid/Hipotiroidismo					
Insomnia/ Insomnio					
Irregular Heartbeats/irregular palpitacion del					
Kidney Problems/Problemas Renales					
Leukemia/Leucemia					
Liver Problems/Problemas Hepaticos					
Low Back Pain/Dolor de Espalda					
Loss of Interest/Perdida de interes:					

Foothills Pain Management Clinic

Dharmesh Mehta, MD | Matthew Tan, MD
Joanna Acosta, PA-C | Tanya Lumbangaol, PA-C, | Veronica Sanchez, FNP-BC
Austin Chang, PA-C | Rudy Ramirez, PA-C,
"Restoring Life by Relieving Pain"

Medical Problem/Problemas Medicos	X	When/Cuando	Treating Physician/ Tratamiento Medico	Family History/ Historia Familiar	Family Member/ Miembro de la Familia
Menopause/Menopausia					
Migraine/Migraña					
Multiple Sclerosis/Esclerosis Multiple					
Muscular Dystrophy/Distrofia Muscular					
Night Sweats/Sudores Nocturnos					
Numbness/Entumecimiento					
Obesity/Obesidad					
Panic Attack:					
Preadolescent Sexual Abuse					
Reiter's Syndrome					
Restless Leg Syndrome/Síndrome de las pie					
Schizophrenia/Esquizofrenia					
Sciatica/Ciática					
Seizures/Incautación					
Sleep Apnea/Apnea del sueño					
Stroke/Embolia					
Swelling/Hinchazón					
Substance Abuse:					
Tendonitis/Tendinitis					
Trigeminal Neuralgia					
Tuberculosis					
Tumor:					
Ulcers/úlceras					
Unexplained Crying/llanto inexplicable					
Urinary Incontinence/Incontinencia Urinaria					
Weakness/Debilidad					
Weight Gain/Ganancia de peso					
Weight Loss/la pérdida de peso					
Other/Otro:					

List ALL CURRENT & PAST medications/ Los medicamentos Actuales y Pasados

Name of Medication/Nombre Del Medicinas	Dose/Dosis	Frequency/Frecuencia	Prescribing Doctor/ prescripción médica

ARE YOU TAKING ANY BLOOD THINNING MEDICATION: YES NO : _____
Example: Plavix, Coumadin, Pradaxa etc: What Dr Prescribes it: _____ Why: _____

Allergies/Alergias: ( ) None/Ninguno ( ) Latex/ Látex ( ) IV Dye/Contrast ( ) Penicillin/Penincilina
( ) Morphine/Morfina ( ) Codiene/Codeina ( ) **Other**/Otro: _____

Allergic Reaction/ Reacción de Alergias:_____

Foothills Pain Management Clinic
Dharmesh Mehta, MD | Matthew Tan, MD
Joanna Acosta, PA-C | Tanya Lumbangaol, PA-C, | Veronica Sanchez, FNP-BC
Austin Chang, PA-C | Rudy Ramirez, PA-C,
"Restoring Life by Relieving Pain"

Brief Pain Inventory

Patient Name: _____ DOB: _____

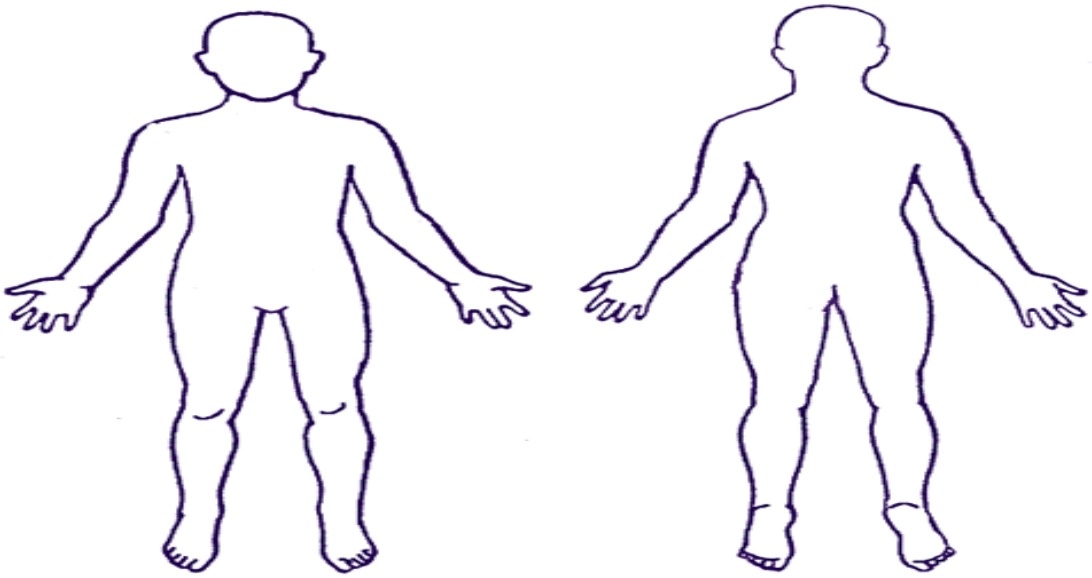
Brief Description of what YOU hope to get out of today's Visit (In your own words) (Breve descripción de lo que espera obtener de la visita de hoy (En sus propias palabras): _____

_____

Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches.) Have you had PAIN other than these everyday kinds of pain today? (A lo largo de nuestras vidas, la mayoría de nosotros hemos tenido el dolor de vez en cuando (como dolores de cabeza leves, esguinces y dolores de muelas.) ¿Ha tenido dolor aparte de este tipo todos los días de dolor hoy?)
1. YES/ sí 2. NO

On the below Diagram, shade in the areas where you feel pain. Put an X on the area that hurts MOST.
En el siguiente diagrama, sombra en las áreas donde se siente dolor. Ponga una X en la zona que más duele.

Right/ Derecha **Front/Frente** **Left/izquierdan** **Left/Izquierd** **Back/Espalda** **Right/Derecha**



Please rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.
Por favor califique su dolor rodeando con un círculo el número que mejor describe su dolor en su peor en las últimas 24 horas.

|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| **Please Make your Pain 0=NO PAIN 5= Moderate Pain 10= Worst Possible Pain**
0 1 2 3 4 5 6 7 8 9 10 Por favor, hacer que su dolor 0 = NO PAIN 5 = Dolor Moderado 10 = peor dolor posible

Please rate your pain by circling the one number that best describes your pain at its LEAST in the past 24 hours.
Por favor califique su dolor rodeando con un círculo el número que mejor describe su dolor en su MENOS en las últimas 24 horas.

|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| **Please Make your Pain 0=NO PAIN 5= Moderate Pain 10= Worst Possible Pain**
0 1 2 3 4 5 6 7 8 9 10 Por favor, hacer que su dolor 0 = NO PAIN 5 = Dolor Moderado 10 = peor dolor posible

Foothills Pain Management Clinic

Dharmesh Mehta, MD | Matthew Tan, MD
Joanna Acosta, PA-C | Tanya Lumbangaol, PA-C, | Veronica Sanchez, FNP-BC
Austin Chang, PA-C | Rudy Ramirez, PA-C,
"Restoring Life by Relieving Pain"

Please rate your pain by circling the one number that best describes your pain on the AVERAGE.
Por favor califique su dolor rodeando con un círculo el número que mejor describe su dolor en la media.

|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| **Please Make your Pain 0=NO PAIN 5= Moderate Pain 10= Worst Possible Pain**
0 1 2 3 4 5 6 7 8 9 10 Por favor, hacer que su dolor 0 = NO PAIN 5 = Dolor Moderado 10 = peor dolor posible

Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.
Por favor califique su dolor circundando en el número que indica la cantidad de dolor que tienes ahora.

|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| **Please Make your Pain 0=NO PAIN 5= Moderate Pain 10= Worst Possible Pain**
0 1 2 3 4 5 6 7 8 9 10 Por favor, hacer que su dolor 0 = NO PAIN 5 = Dolor Moderado 10 = peor dolor posible

What treatment or medications are you receiving for your pain?(¿Qué tratamiento o medicamentos está recibiendo por su dolor?)
_____

In the past 24 hours, how much relief have pain treatments or medication provided? Please circle the one percentage that most shows how much RELIEF you have received. (En las últimas 24 horas, la cantidad de alivio han proporcionado tratamientos para el dolor o medicamentos? Por favor circule el porcentaje que la mayoría muestra cuánto alivio que ha recibido.)

_____
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Circle the once number that describes how, during the past 24 hours, pain has interfered with your:(Circule el número una vez que describe cómo, durante las últimas 24 horas, el dolor ha interferido con su:)

A. GENERAL ACTIVITY: ACTIVIDAD GENERAL:

_____
0 1 2 3 4 5 6 7 8 9 10
Does Not Interfere Completely Interferes

B. MOOD: EL ESTADO DE ánimo

_____
0 1 2 3 4 5 6 7 8 9 10
Does Not Interfere Completely Interferes

C. WALKING ABILITY: capacidad para caminar

_____
0 1 2 3 4 5 6 7 8 9 10
Does Not Interfere Completely Interferes

D. NORMAL WORK (includes both outside the home and housework): TRABAJO NORMAL (incluye tanto fuera de la casa y las tareas domésticas)

_____
0 1 2 3 4 5 6 7 8 9 10
Does Not Interfere Completely Interferes

E. RELATIONS WITH OTHER PEOPLE: RELACIONES CON OTRAS PERSONAS:

_____
0 1 2 3 4 5 6 7 8 9 10
Does Not Interfere Completely Interferes

F. SLEEP: DORMIR:

_____
0 1 2 3 4 5 6 7 8 9 10
Does Not Interfere Completely Interferes

G. ENJOYMENT OF LIFE: DISFRUTE DE LA VIDA:

_____
0 1 2 3 4 5 6 7 8 9 10
Does Not Interfere Completely Interferes

Foothills Pain Management Clinic
Dharmesh Mehta, MD | Matthew Tan, MD
Joanna Acosta, PA-C | Tanya Lumbangaol, PA-C, | Veronica Sanchez, FNP-BC
Austin Chang, PA-C | Rudy Ramirez, PA-C,
"Restoring Life by Relieving Pain"

REFILL REQUESTS will NOT be Approved without an appointment. Do NOT CALL the Office and ask for a REFILL under any circumstance a refill will NOT be approved.

Prescription Policy

NO EARLY REFILLS will be **APPROVED, under any Circumstances**
ALL Refills/Prescriptions will ONLY be given during a scheduled **OFFICE VISIT**
ORIGINAL PRESCRIPTION BOTTLES MUST be brought to EVERY appointment if you forget your prescription bottle a prescription may not be given.

It is the patient's responsibility to know their own benefits. If a prescribed medication is NOT covered by your insurance the office will NOT obtain a Prior Authorization, the Medication will be changed to a covered medication or you can pay cash for the non-covered medication. **PRIOR AUTHORIZATIONS** will **NOT** be done in the **OFFICE** YOU MUST choose a PHARMACY that will process the Authorization. If you choose a pharmacy that will NOT process the Authorization YOU will need to PAY out of your pocket for the medication.

THE OFFICE WILL NOT HELP YOU FIND A PHARMACY THAT HAS YOUR PRESCRIBED MEDICATION IN STOCK or that will complete a Prior Authorization.

If your pharmacy only fills part of your prescription

For Example: your prescription is for 120 pills but your pharmacy only wants to give you 90 and you take the 90, the remaining 30 is lost.

The office will NOT write you a NEW Prescription for the remaining balance of medication. NO EXCEPTIONS will be given for this policy.

The physician will NOT write a prescription for more than 4 pills a day of Opioids/Narcotics. They will not write prescriptions for Anti-Anxiety, Anti-Depressant Medication or Soma.

Foothills Pain Management Clinic, the Doctors and Staff are here to assist you with living a pain free life, however we are bound by the laws of the
State of California Department of Justice
and will NOT make EXCEPTIONS under any circumstances.

PATIENT NAME	PATIENT SIGNATURE
MATTHEW TAN, MD	
DOCROR'S NAME	DOCTOR'S SIGNATURE

Foothills Pain Management Clinic
Dharmesh Mehta, MD | Matthew Tan, MD
Joanna Acosta, PA-C | Tanya Lumbangaol, PA-C, | Veronica Sanchez, FNP-BC
Austin Chang, PA-C | Rudy Ramirez, PA-C,
"Restoring Life by Relieving Pain"

Pedidos para llenar recetas de medicamentos no se daran sin cita previa. Por favor de no llamar para llenar receta de medicamento por telefono ya que no se aprovara.

No se Daran Recetas Temprano.
Todas las receas se daran solamente durante su visita a la officinal.
Todas las botellas de sus medicaments originals tienen que ser traidos a todas sus visitas a la officinal.**Si no cumple con esto no se le daran sus medicamentos**.

Es la responsabilidad de los pasientes desaber de sus beneficios propios. Si el medicamento recetado no es cuvierto por la aseguranza no se le dara autorizacion prebia por la officinal si no el medicamento sera cambiado por un medicatmento que la aseguranza cobra oh que usted pueda pagar en efectivo por ellos**.Autorizaciones prebias para medicamentos no se haran en la officina**, usted tiene que escojer la farmacia para que ellos agan la autorizacion prebia. Si usted escoje una farmacia que no proceda la authorizacion prebia tendra que pagar por sus medicamentos.

LA OFFICINA NO LE ALLUDARA A BUSCAR UNA FARMACIA QUE TENGA SUS MEDICAMENTOS oh que pueda completer una Autorizacion Prebia.
Si su farmacia solamente llena parte de su receta, la officina no le dara una nueva receta por el resto de el medicamento. NO EXCEPCIONES se daran por esta póliza
Por ejemplo: si su receta es por 120 pastillas pero la farmacia le da 90 solamente y usted acepta las 90, el resto de 30pastillas seran perdidas.

El médico no dara recetas para mas de **4 pastillas al dia** para Opioides/Narcoticos.
El médico **NO** dara recetas de medicamentos para la ansiedad, depression oh Soma.

Foothills Pain management Clinic, los Doctores y el personal atan aquí para ayudarle a vivir una vida libre de dolor, sin embargo estamos obligados por las leyes del
Departamento de Justicia del Estado de California
y pore so **NO** se haran **Excepciones** bajos estas circunstancias.

_____ _____
NOMBRE DE PACIENTE FIRMA DE PACIENTE

MATTHEW TAN, MD _____
NOMBRE DE DOCTOR FIRMA DE DOCTOR