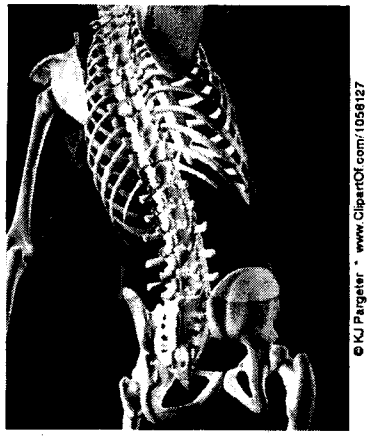


TEMECULA VALLEY PAIN MEDICAL GROUP, INC. dba

University Spine Institute

TREATMENT ADVISEMENT: The physicians of University Spine Institute are specialists in pain management. The examinations and treatments that you will receive here cannot be construed as a complete physical examination for general health purposes. Only those symptoms directly related to the pain you are experiencing will be assessed and treated at this office. You are advised to seek complete physical examinations for general health purposes from your personal physician.

Patient Name: _____ Birth date: ____/____/____

Age: _____ Social Security No._____ Sex: ☐ Male ☐ Female

Race: _____ Ethnicity: _____ Language:_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner

Home phone:(____)_____ Cell phone (____)_____ Work phone (___)_____

Where do you prefer to receive calls? ☐ Home ☐ Work ☐ Cell

Mailing Address: _____

_____

Email address: _____

If married, spouse's name: _____ Date of Birth: ____/____/____

Medicare patients only: Do you have an Advance Care Plan or Surrogate Decision Maker? ☐ Yes ☐ No

In the event of an emergency, who should we contact?

Name: _____ Relationship: _____

Work Phone: (____)_____ Home Phone (____)_____ Cell (____)_____

Are we seeing you for pain that resulted from an auto or PI case? ☐ Yes ☐ No

If yes, has a claim been filed with Auto or private Insurance company? ☐ Yes ☐ No

If yes, have you retained an attorney? ☐ Yes ☐ No

If yes, have you notified your medical insurance of the accident? ☐ Yes ☐ No

(*If yes, please explain*) _____

_____

Are we seeing you for pain that resulted from an employment related injury? ☐ Yes ☐ No

If yes, have you filed a Workers Compensation claim for this Injury? ☐ Yes ☐ No

The information I provided above is accurate, to the best of my knowledge.

_____ _____

Patient Signature Date

Insurance Information: (Please complete this form even though we copy your card.)

Primary Insurance

Insurance Company: _____

Name of Insured: _____

Relationship to Patient: _____

Insurance ID/Subscriber Number: _____

Insured's Birth date: _____

Secondary Insurance (if any):

Insurance Company: _____

Name of Insured: _____

Insurance ID/Subscriber Number: _____

Relationship to Patient: _____

Insured's Birth date: _____

AUTHORIZATION FOR RELEASE OF MEDICAL OR OTHER INFORMATION: Temecula Valley Pain Medical Group, Inc., dba University Spine Institute is authorized to contact my health insurer(s) to confirm my eligibility for certain medical benefits, and is authorized to provide my insurer(s) with details regarding any proposed treatment for me in order to determine if my insurer(s) will cover, or pay for, my treatment. In addition, I hereby authorize University Spine Institute to release any medical or other information concerning my treatment, which may be necessary to process bills and collect payments for the medical services and items I receive here.

ASSIGNMENT OF BENEFITS AUTHORIZATION: I hereby authorize that all insurance benefits for medical services and supplies provided by the physicians at Temecula Valley Pain Medical Group, Inc., dba University Spine Institute to be paid directly to Temecula Valley Pain Medical Group, Inc. / University Spine Institute

INSURANCE

I understand that any medical insurance policies I have, is a contract between me and my insurance company. I am responsible for co-payments, deductibles, co-insurance and any non-covered services. I understand that payment for my portion of all medical services received here are due within 30 days of submission of an invoice by University Spine Institute, and agree to pay all reasonable costs incurred by University Spine Institute to collect such amounts including, interest, cost of collection, and attorney fees. Under certain circumstances, I may also be responsible services deemed not medically necessary by my insurance. I am responsible for services deemed not medically necessary only if University Spine Institute has reason to believe it will be denied and informs me in writing prior to having rendered the services of the likelihood that my insurance will deny the services for medical necessity and I consent to have the services performed. University Spine Institute may not be a participating provider with my insurance company. If University Spine Institute is not a participating provider with my insurance company, I am financially responsible for the balance of fees for the services that are not paid by my insurance company. I hereby assign all benefits, checks or money to which I may be entitled directly as a result of coverage from my insurance plan benefits to University Spine Institute. I understand and agree (the above assignment of benefits notwithstanding) that I am responsible for full and timely payment to University Spine Institute even if the insurance claim is pending

_____ _____

Patient Signature Date

_____

Printed Name

SCHEDULE OF FEES

The following is a list of fees for missed appointments and services that we are often asked to perform. These are fees that are not insurance billed/reimbursed and would be due from you.

Missed appointments (*for the benefit of all our patients, we require 24 hours advance notice for cancelled appointments*)	$75.00
Forms 1-3 pages (please allow 5 business days for us to complete) • Note- additional fees apply if medical records also requested	$45.00
Forms >3 pages	Fee based on Form length & work required
Letters (please allow 5 business days for us to complete)	$75.00/page
Chart copies to the patient	25¢/page + $5.00 admin charge
Chart copies to another provider	no charge
Returned checks/charge payments	$25.00

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

A copy of Temecula Valley Pain Medical Group, Inc., dba University Spine Institute Notice of Privacy Practices has been made available to me. The notice advises me as to how my personal medical information is used at Your Pain Care and how I may assess that information.

_____ _____

Patient/Representative Name (print) Date

_____ _____

Patient/Representative Signature Relationship to Patient

I AUTHORIZE THE FOLLOWING NAMED INDIVIDUAL _____ TO OBTAIN MY PROTECTED HEALTH INFORMATION. I AM AWARE IT IS MY RESPONSIBILITY TO NOTIFY THIS OFFICE OF ANY CHANGES TO THE ABOVE INFORMATION.

_____ _____

Patient Signature Printed Name

_____/_____/_____

Date

UNIVERSITY SPINE INSTITUTE
VANCE Z. JOHNSON, MD / BEN THOMAS, DO
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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

AUTHORIZATION

I hereby authorize: _____
Physician/Healthcare Facility

To release information on _____ (Patient's Name) _____ (Patient's DOB) regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To: _____
Name

_____
Address

_____ _____ _____
City State Zip Code

The medical information/records will be used for the following purpose:

_____

This authorization is:

[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)

[ ] Limited to the following medical information:

_____

_____

_____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse	_____ (initial)
Psychiatric/Mental Health	_____ (initial)
Tests for Antibodies to HIV	_____ (initial)
HIV Diagnosis/Treatment	_____ (initial)
Genetic Information	_____ (initial)

DURATION:

This authorization shall be effective immediately and remain in effect until _____
Date

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

_____ _____
Signature of patient *or legal/personal representative* | Relationship *if other than patient*

_____ _____
Patient's Name (PRINT) | Date

_____ _____
Patient's Social Security Number | Patient's Date of Birth

_____ _____
Witness Name | Witness Signature

Patient Portal Authorization

University Spine Institute

Patient Name: _____

Email (Print): _____

IN EVENT OF AN EMERGENCY, DIAL 911.
Do Not Use the Patient Portal for Urgent or Emergent Matters.

Purpose of this Form
Our Medical Office offers secure electronic access to your medical record and secure electronic communications between our office and you for those patients who wish to participate. Secure messaging can be a valuable communications tool, but certain precautions should be used to minimize risks. In order to manage these risks we have imposed some terms and conditions of participation. Your signature on this form will demonstrate that you have been informed of these risks and the conditions of participation and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works
A secure web portal is a webpage that uses encryption (a form of electronic security) to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the Portal site. Using the connection channel between your computer and the Web site, you can read, view, or send information on or from your computer. It is automatically encrypted in transmission between the Web site and your computer.

How to Participate
You may compose, pick up, and reply to secure messages or view information sent to you through the Patient Portal. Once you have reviewed, agreed to, and signed our policies and procedures regarding use of the Patient Portal, we will assign you a username and password. You may then login to the Patient Portal directly by going to www.XXXXXXX.com

Protecting Your Private Health Information and Risks
This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, no transmission system is perfect. We will do our best to maintain electronic security. Keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to have access to it. You are responsible for ensuring that we have your current email address and you agree to inform us immediately if it changes. Protect your username and password information as you would protect your banking information. Safeguard this information so that only you or someone you authorize has access to this information. If you believe someone has learned your password, you should immediately go to the Web site and change it. You agree not to share your username and password with unauthorized persons and to maintain that username and password in a secure place at all times. Access to the Patient Portal is a free service but we reserve the right to change this policy if needed. We strive to keep all of your protected health care information completely confidential. Please read our Notice of Privacy Practices for additional information on uses and disclosures.

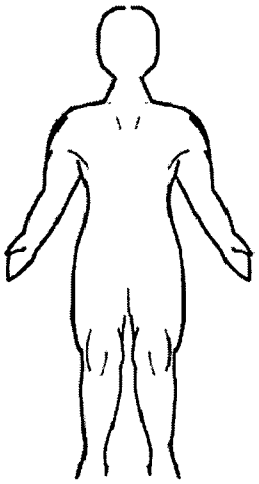
Conditions of Participating in the Patient Portal
Access to the secure web portal is a service, and we may suspend or discontinue it at any time and for any reason. If we do suspend or discontinue this service we will notify you as promptly as we reasonably can. You agree to not hold University Spine Institute any of its staff or physicians liable for network or security infractions beyond their control. By signing this agreement, you acknowledge that you understand the policies and procedure, agree to comply with them and all of your questions have been answered to your satisfaction. If you do not understand, or do not agree to comply with our policies and procedures, do not sign this agreement and do not request a username and password. **If you have questions we will gladly provide more information.** *Policies & Procedures are subject to change without notice.*

Patient/Patent/Guardian Acknowledgement

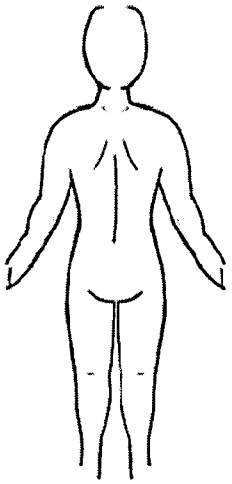
_____ _____
Patient Signature **Date**

PAIN CHART

Patient Name: _____ Age_____ Today's date: _____
Current height ___ft. ___inches weight _____lbs. Your weight at age 21 _____lbs.
On the pictures shown below, please **mark "X" on each area that hurts TODAY**. Draw arrows to where any pain radiates. ❑Right handed or ❑Left handed. Primary Physician_____
Referring Physician_____



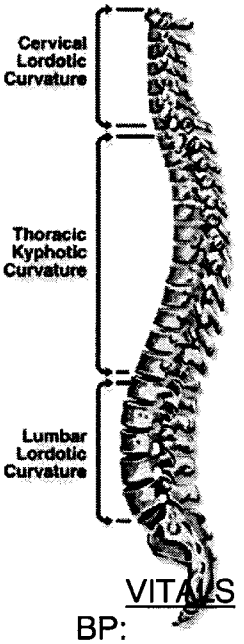
Front



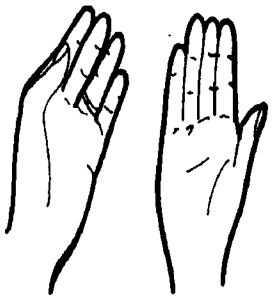
Back

Left side

Right side



VITALS
BP:
P:
T:
RR:
WT:



Circle the number below that best describes your **USUAL** pain:

NO Pain 0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10 Worst Pain of my life!

Circle the number below that describes your pain **TODAY**:

NO Pain 0 ------- 1 ------- 2 ------- 3 ------- 4 ------- 5 ------- 6 ------- 7 ------- 8 ------- 9 ------- 10 Worst Pain of my life!

When did the pain start? _____ Circle any that apply: Numbness Burning Aching Radiating Weakness Shooting Sharp

Circle your responses to the following:
What is the frequency of your pain? Daily Weekly Monthly Random
What is the duration of your pain? Constant Intermittent
What aggravates your pain? Sitting Standing Walking Bending Lifting Reaching Twisting Lying down
What reduces your pain? Medications Sitting Lying down Massage Acupuncture Other _____

Circle the treatments you have tried for this pain: Physical Therapy Medications Chiropractic Bracing Trigger Point Injections Acupuncture Electrical Stimulator Traction Injections into your Spine
HOW LONG HAVE THESE TREATMENTS BEEN TRIED? _____

PAIN MEDICINE CONSULTATION

Name: _____ Date:_____

What is the reason for today's visit? ❑ Back pain with ❑ Leg pain. ❑ Neck pain with ❑ arm pain
❑ Knee pain ❑ shoulder pain ❑ hip pain ❑ other (please list): _____
_____

Personal History-Have you have ever had?

Illness/Injury	Yes	No
☐COPD ☐ Emphysema ☐Asthma		
High blood pressure		
Heart dz- angina? attack? bad rhythm		
Diabetes- how long?		
Bleeding tendency -		
Thyroid problems		
Stomach disease ☐ Ulcer ☐ Reflux		
Circulation problem		
HIV/Aids		
Arthritis – where? _____		
Cancer – where? _____		
Blood Clot		
Anemia- when?		
Hepatitis- since when?		
Addiction to drugs___ / alcohol___		
Other medical problems?		
Any falls within the last 12 months?		
If yes, how many falls? _____		
Were you injured? _____		
List Surgeries		

Family History- Has any blood relative had any of the following. If yes, indicate relationship.

Illness	Which Relative(s)?
Anemia	
Bleeding Tendency	
Heart disease	
Chronic lung disease	
High blood pressure	
Kidney disease	
Arthritis	
Migraine headaches	
Diabetes	
Thyroid problems	
Cancer type _____	

What exercise regimen are you unable to perform due to your pain? _____
_____
_____

Are you currently employed? _____
If so, what type of work do you do?_____

Are you ❑married_____ yrs ❑divorced
❑ separated ❑ single ❑ widowed
❑ a committed significant other?

_____
Kids?_____
Is there a chance you might be pregnant?_____
Who lives with you?_____

Alcohol- how much?_____
Smoking- how much?_____
Caffeine- how much?_____
Have you used illegal drugs? _____
When?_____

Place an X by any that apply to you?

Problem	X
General	
Tire easily	
Recent weight gain ____ lbs	
Recent weight loss ____ lbs	
Night sweats- how long?	
Persistent fever- how long?	
Sensitivity to heat	
Sensitivity to cold	
Skin	
Rashes- where?	
Eyes	
Eye pain- how long?	
Red eyes- how long?	
Double vision- how long?	
Ears	
Hearing loss	
Ringing in ears	
Nose	
Loss of smell	

Frequent colds- last one?_____	
Nosebleeds- how often?_____	
Mouth	
Sores- where?_____	
Dental problems	
Cardio-Respiratory	
High blood pressure	
Chest pain/discomfort	
Shortness of breath	
Swelling of ankles	
Persistent cough	
Heart palpitations	
Digestive & Urinary	
Decrease in appetite- how long?_____	
Constipation- last stool?_____	
Heartburn- how long?_____	
Nausea- when?_____	
Rectal bleeding- when?_____	
Blood in urine – when?_____	
Diarrhea- how long?_____	
Musculoskeletal	
Muscle weakness	
Joint pain – which?_____	
Swollen joints	
Neck pain	
Back pain	
Hip pain	
Muscle tension- where?_____	
Nervous system	
Headaches	
Fainting– when?_____	
Poor coordination	
Nervousness	
Depression – suicidal?_____	
Memory loss	
Weakness- where?_____	
Sleep Hygiene	
Insomnia	
Sleep apnea	
Excessive sleepiness	
Endocrine	
Thyroid problems	
Adrenal problems	
Cortisone treatments- when?_____	
Diabetes	

_____

Patient Signature

_____

Print Name Date

Please list your current medicines (include vitamins and over the counter remedies)

Medication Name	Dosage	Frequency

Have you had an Influenza Vaccination? ____
If yes, when? _____

Are you allergic to anything? Please list all allergies and your reaction:

Allergic to	Your reaction

_____
Patient Signature Date

_____
Print Name

*Future Appointments Only

Sign & Date: _____

Sign & Date: _____

Sign & Date: _____

Sign & Date: _____

Sign & Date: _____