How do I get to Mission Pain and Spine?

We are located in the Oso Medical Plaza Complex at:

26932 Oso Parkway, Suite 275Mission Viejo, CA 92691

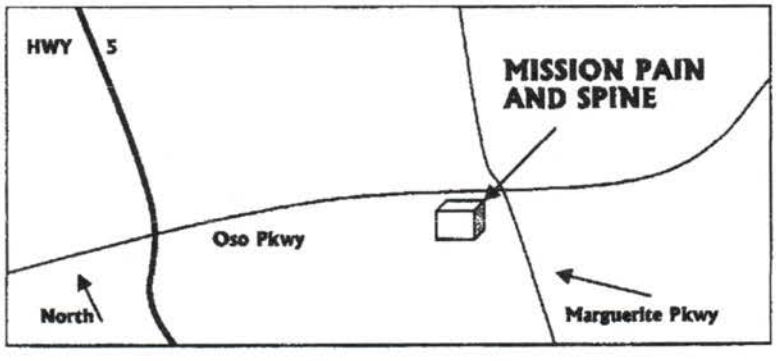
Phone: (949) 916-8100 Fax: (949) 916-8555

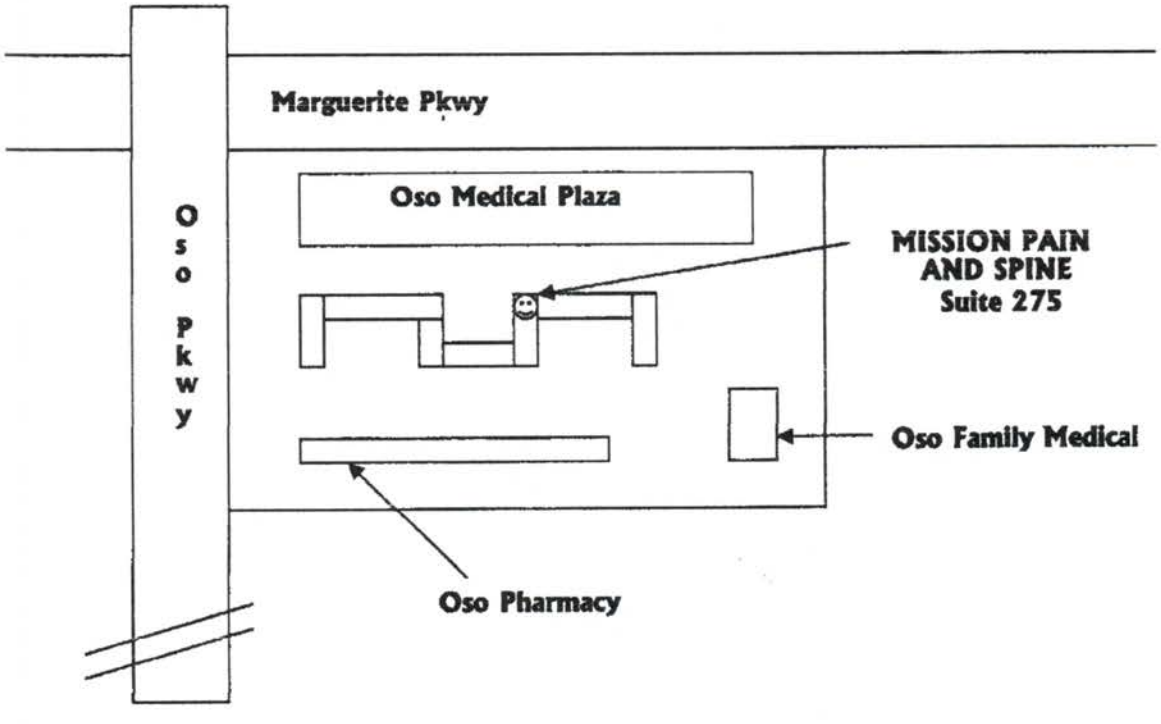
From the 5 Freeway traveling southbound: Exit Oso Parkway and go LEFT (East)

From the 5 Freeway traveling northbound: Exit Oso Parkway and go RIGHT (East)

Continue on Oso Parkway about ½ mile and turn RIGHT into the Oso Medical Plaza driveway.

Oso Medical Plaza is located at the intersection of Oso Parkway and Marguerite Parkway





MISSION PAIN AND SPINE

Frank King, M.D. Hamid Fadavi, D.O. DATE:_____

PATIENT NAME:_____
(Last) (First) (Middle)

CHECK ONE: SEX: M☐ F☐ CHECK ONE: MARRIED☐ SINGLE☐ WIDOWED☐ DIVORCED☐

DATE OF BIRTH: _____ SOCIAL SECURITY #:_____

ADDRESS:_____
(Street) (City) (Zip)

HOME TELEPHONE #: (____) _____ CELL #: (____) _____

EMAIL:_____

EMPLOYER: _____ OCCUPATION:_____

BUSINESS ADDRESS: _____

WORK PHONE: (____)_____

EMERGENCY CONTACT:_____ RELATIONSHIP:_____

PHONE #: (____)_____ CELL #: (____)_____

PRIMARY PHARMACY: _____ PHONE #: (____)_____

PHARMACY ADDRESS: _____

PRIMARY CARE PHYSICIAN: _____ PHONE #: (____)_____

REFERRED BY:_____

RESPONSIBLE PARTY (IF PATIENT IS MINOR)_____

RELATIONSHIP TO MINOR PATIENT:_____ Phone #: (_____)_____

INSURANCE INFORMATION----------

NAME OF PRIMARY INSURANCE COMPANY:_____ HMO____ PPO ____ POS__

POLICY/ID#_____ GROUP #_____

POLICY HOLDER NAME:_____ RELATIONSHIP:_____

POLICY HOLDER'S DATE OF BIRTH:_____ SOCIAL SECURITY #:_____

SECONDARY INSURANCE COMPANY NAME:_____

POLICY/ ID#_____ GROUP #_____

POLICY HOLDER NAME:_____

RELATIONSHIP:_____ POLICY HOLDER'S DATE OF BIRTH:_____

MPS

26932 Oso Parkway, Suite 275 Mission Viejo, CA 92691 (949) 916-8100 FAX (949) 916-8555

Mission Pain and Spine F J. King H. Fadavi Date _____

PATIENT NAME_____DOB_____AGE_____

Who referred you to this office? _____
Who is you primary treating physician? _____

HPI

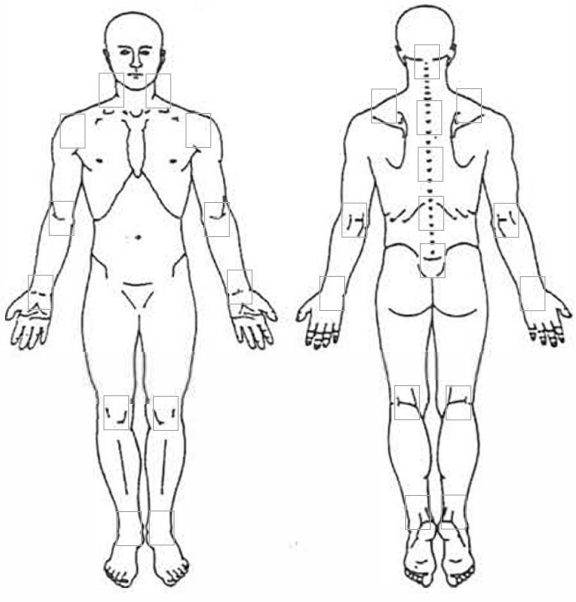
Why are you seeing the doctor today?_____

When did your problem start?_____

What caused your problem (fall, accident, etc)?_____

How has the pain changed recently? (better, worse, same, different)_____

Please use the diagram below to indicate where your pain is



Have you had any numbness or tingling? Yes or No. If yes, where? _____

Have you had any weakness associated with your problem? If so, where? _____

_____

Intensity of pain: **1-2**(tolerate without medications) **3-4**(tell someone about my pain, take a Motrin) **5-6** (mild narcotic, Tylenol #3) **7-8** (go to ER, strong narcotics) **9-10** (admit to hospital due to pain)

How would you describe your pain? constant, intermittent, dull, sharp, aching, cramping, hot-burning, numb, pressure-like, shooting, stabbing, throbbing, tingling, twisting, deep, superficial, heavy, gnawing, other:_____

At what **time of day** is your pain the worst? _____

What makes your pain **WORSE**? _____

What makes your pain **BETTER**? _____

Current PAIN medications: (if you have a medication list, you may attach it to this form)

Medication	Dose	Frequency	% of relief from medication

Please list any allergies you may have: (medications or environmental)

Allergy	Reaction

Have you had any of the following treatments for your current condition? (circle all that apply)

Epidurals, Facet Blocks, Ablations, Spinal Cord Stimulator, Pump, Physical Therapy, Chiropractic, TENS, Acupuncture, Other: _____

Please list any recent Procedures or EMG: _____

Please list any recent MRI, CT scan or X-rays: _____

Past Medical History (please circle all that apply to you)

High blood pressure Heart disease Pacemaker Diabetes Thyroid problems Arthritis Rheumatoid

Nerve Disorders Multiple Sclerosis Spinal cord injury Migraines Headaches Stroke Gastritis

Ulcers GERD Liver disease Hepatitis Sleep apnea Asthma COPD TB Kidney disease

Enlarged prostate Prostate cancer Pelvic pain Endometriosis Blood clots Blood vessel disease

Anemia Bleeding problems Cancer Depression Anxiety ADHD PTSD Claustrophobia

Alcoholism Opioid dependency Illicit drug use/abuse Chronic pain

Other: _____

Have you ever been diagnosed with fibromyalgia? _____ Chronic fatigue syndrome?____
Are you pregnant?_____

Surgical History (please list all surgeries, with dates if possible)

_____ _____ _____
_____ _____ _____
_____ _____ _____

List medication for other medical conditions:

Medication	**Strength**	**Dose**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History
Do any of the following diseases/conditions run in your family? (please circle all that apply)

☐ **Low Back Pain** ☐ Low back Surgery ☐ **Neck Pain** ☐ Neck Surgery ☐ **Psychiatric illness**
☐ Alcoholism ☐ **Opioid dependency** ☐ Drug abuse ☐ **Diabetes** ☐ Cancer ☐ **Heart Disease**
☐ Nerve Disease ☐ **Bleeding Disorder** ☐ Muscle Disease

Social History (answer/circle all that apply)
Marital Status: ☐ Married ☐ **Single** ☐ Divorced ☐ **Separated** ☐ Widowed ☐ **DP**

How many children do you have?_____

I am currently: ☐ **In School** ☐ Working ☐ **Unemployed** ☐ **Retired**

Are you on disability?_____ Date disability began_____

Education level_____ What kind of work do you do?_____

How long have you worked there?_____When did you last work there?_____

List your hobbies or pastimes:_____

Do you smoke?_____ Packs per day?_____ Years smoking? _____

Do you drink alcohol? _____How often? _____

Do you use illicit drugs?_____ Type_____

Review of Systems (Please circle any symptom listed below that **currently** applies to you)

General: ☐unexpected weight loss or gain, ☐fever, ☐chills, ☐fatigue, ☐appetite changes, ☐night sweats

Eyes: loss of vision, double vision, blurred vision, blind spots, drainage from eyes, pain from light, corrective lenses/contacts, redness

Head: pain, jaw pain, nose bleed

Ears: ringing in ears, vertigo, loss of hearing

Heart: chest pain, palpitations, chest pressure, murmurs, irregular heartbeat, fainting

Lungs: shortness of breath, cough, wheezing, bloody sputum, chest tightness, snoring

Gastrointestinal: abdominal pain, constipation, diarrhea, bloating, nausea, vomiting, difficulty swallowing, heart burn, bloody or tarry stools

Urological: frequency, urgency, burning/painful urination, difficulty voiding, bloody urine, incontinence

Musculoskeletal: joint pain, joint swelling, joint instability, stiffness, redness, heat, muscle pain.

Neurological: weakness, loss of balance, numbness, tingling, seizures, dizziness, fainting, loss of consciousness, deafness, pins and needles, headache, loss of consciousness

Psychiatric: nervousness, anxiety, depression, hallucination, anger, panic attacks, difficulty sleeping, suicidal thoughts, homicidal thoughts

Hematology: easy bleeding, easy bruising, swollen glands, bleeding problems,

Allergy/Immunology: infections, seasonal allergies, latex

Endocrine: very hungry, very thirsty, tremors, hot/cold intolerability

Skin: rash, scars, skin ulcers, pigmentation, bruising, bleeding under skin, spots, lesions, itching

Are you considering harming yourself or harming others? _____

Patient Signature_____ Date_____

For office use:

HT_____ WT_____ BP_____ Temp_____ Pulse_____

Please Print Patients Full Name AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO MISSION PAIN AND SPINE, FRANK KING, M.D., INC, HAMID FADAVI, D.O., INC. & CONSENT FOR TREATMENT

I hereby authorize MISSION PAIN AND SPINE (MPS) and its employees and agents to release my medical records documenting me examination and treatment, including AIDS related testing, psychiatric or substance abuse information, upon valid request.

I hereby assign payment directly to Mission Pain and Spine and its physicians for any medical/surgical procedures performed. I agree that this authorization shall be valid until rescinded in writing or replaced be one of a later date. I agree to be financially responsible to Mission Pain and Spine and its physicians for all charges in the event that I have no insurance or my insurance is rejected, and for any balance or fee not covered by my insurance and/or determined to be my responsibility. I understand and acknowledge that if Mission Pain and Spine and its physicians file my insurance claim, I will remain responsible for the account, and I will be expected to pay any amount due if my insurance does not pay the claim within 45 days. I acknowledge that any amounts quoted as my "out-of-pocket" costs are only an estimate and that the exact determination of my financial responsibility will be made after my insurance company processes the claim. Payment is expected at the time of service. Methods of payment include check, cash, and credit card.

I further agree to pay all costs of collection, including reasonable attorneys' fees, at the legal rate of interest on the account until paid in full, and I agree to waive all rights of exemption under the Constitution and the laws of the State of California.

I hereby request and authorize all doctors, nurses, technicians or affiliated medical personnel, hospitals, and health care facilities to furnish all records and reports, including x-rays, photostatic copies, and abstracts or excerpts of all records, and any other information requested relating to any hospitalizations, examinations, treatments, tests or opinions concerning any condition for which I am presently being treated, including AIDS related testing, psychiatric or substance abuse information. A copy of this authorization shall be as valid as the original of this document.

I understand that my MPS physicians have a financial interest in the California Specialty Surgery Center to which I may be referred. I acknowledge that I may receive these services at an MPS facility or other facilities whose names and addresses I have been provided.

GENERAL CONSENT TO TREATMENT

By signing below, I (or my authorized representative on my behalf) authorize MPS physicians, practitioners and their staff to conduct any diagnostic examinations, test and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test, or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

RIGHT TO REFUSE TREATMENT

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy, or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

_____ _____

Please Print Patients Full Name **Patients Signature**

_____ _____

Date **Witness Signature**

MISSION PAIN AND SPINE

26932 Oso Parkway, Suite 275

Mission Viejo, CA 92691

(949) 916-8100 FAX (949) 916-8555

INFORMED CONSENT AGREEMENT FOR TREATMENT OF INTRACTABLE PAIN WITH NARCOTIC MEDICATION

I understand that there are alternatives to narcotic drug therapy which I have discussed with my doctor.

The goal of my therapy is to reduce my pain to a level that is tolerable and that will allow me to improve my daily function.

I understand that any narcotic use may increase certain risks, which include, but are not limited to:

- Addiction
- Nausea, vomiting, and constipation
- Impair judgement, sleepiness, and confusion
- Allergic reactions, overdose, and fatal complications
- Breathing problems
- Dizziness
- Impaired ability to operate machines or drive motor vehicles
- Development of tolerance, physical dependence, and opioid induced hyperalgesia (increased pain due to chronic use of narcotics)

I agree to the following guidelines (initial):

____I will take this medication as prescribed by my provider. I will not vary the dose or interval without approval from my provider.

____I will submit random urine and blood tests if requested by my provider to assess my compliance.

____I will obtain all my prescriptions for pain through providers of Mission Pain and Spine and will fill my prescriptions at _____pharmacy.

____Due to the potential for misuse, I know that I will be unable to obtain early refills or replacements of lost or stolen medication. Refills will only be made during regular business hours.

____I agreed to see providers of Mission Pain and Spine and for ongoing pain management and will schedule regular appointment as long as I am taking narcotic medication.

____If I do not follow these guidelines I understand my narcotic treatment may be terminated.

____I understand that driving a motor vehicle or heavy machinery is not recommended while using controlled narcotic medication and I will not hold Mission Pain and Spine or its Physicians responsible for any injuries resulting in any type of accident, vehicle, or otherwise. It is my full responsibility to comply with the laws of the state of California while taking controlled narcotic medication.

_____	_____	_____	_____.
Patient Signature	Date	Provider Signature	Date

_____	_____
Print Name	Date of Birth

CONFIDENTIAL COMMUNICATION REQUEST AUTHORIZATION

Many of our patients allow family members such as their spouse, parents, or others to call and request medical or billing information. Under the requirements of HIPPA, we are not allowed to give this information to anyone without the patients consent. If you wish to have information released, you must complete and sign below.

I authorize the use of the following means of communication for information related to my personal health, medical treatment, or payment of treatment/billing information.

PLEASE SELECT ALL THAT APPLY:

☐ Phone Phone Numbers:

Home:_____

Cell: _____

Work:_____

☐ You have my consent to leave a message regarding my treatment on my voicemail.

☐ Do not leave a message regarding my treatment on my voicemail.

☐ Written communication to mailing address:_____

Please specify the person(s) allowed to receive medical information:

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

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected information to be disclosed.

I understand that the information disclosed to any above recipient is no longer protected by federal or state law and may be subject to disclosure by the above recipient.

I have the right to revoke this consent in writing.

Signature:_____ Date of Birth: _____ Date: _____

Print Name_____

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

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

AUTHORIZATION

I hereby authorize: _____

Physician/Healthcare Facility

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax or other electronic medical records.

To: _____
Name **MISSION PAIN AND SPINE**

_____
Address 26932 Oso Parkway #275
Mission Viejo, CA 92691
(949) 916-8100 (949) 916-8555

_____ _____ _____
City State Zip Code

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) Tests for antibodies to HIV_____ (initial)
Psychiatric/mental health _____ (initial) HIV diagnosis/treatment _____ (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 of 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

_____ _____
Patients Name (Print) Date

_____ _____
Patients Social Security Number Patients Date of Birth

_____ _____
Witness Name Witness Signature

MISSION PAIN AND SPINE
26932 Oso Parkway, Suite 275
Mission Viejo, CA 92691
(949) 916-8100 FAX (949) 949-8555

Payment policy

Payment is expected at that time of service. Your co-pay, coinsurance and/or deductible is due at the time of visit. For your convenience, we accept cash, checks, Visa or MasterCard as a form of payment. Please note that hospitals and surgery centers charge additional and separate fees for any procedure at their facilities. You will be responsible for payment of any remaining balance for both entities after your insurance is billed.

Insurance policy:

If we're covered as one of your insurance companies' network providers, you are required to submit your copayment in advance of your appointment. We will also require a digital scan of your insurance card. We will bill your insurance company. Any deductible, co-insurance non- covered services will be your responsibility. For those plans that are non-contracted with our office, as a courtesy, we will submit claims to your carrier; any deductible, co-insurance or non-covered services will be your responsibility. Monthly statements will be sent to collect those balances. Please inform our staff immediately of any insurance changes.

Non-covered Service Policy

Certain services performed by our office are NOT COVERED by all insurance plans. Some of these services include Urine Drug Tests (UDT) and injections. We suggest you contact your insurance carrier to verify your benefits and to understand that any non-covered services will be your financial responsibility and payment will be required prior to your appointment. Medicare requires a signature on an Advanced Beneficiary Notice (ABN) for non-covered services.

Delinquent Accounts Policy

Delinquent accounts may be reported to our collection agency following normal collection procedures. If an account is reported to our collection agency, a collection fee of 25% will be added to any outstanding balance. If a balance is over 61 days late, a 1.5% monthly interest fee will be added to the outstanding balance. Please inform our billing staff if you know your payment will be late in arriving or if payment arrangements are needed.

Medical Records

Should you request a copy of your medical records, please allow 7 to 10 business days for completion.

Forms Policy

Should you request our office to complete forms on your behalf for disability, work status, FMLA, etc., there will be a charge of $25.00 per form. Payment of this charge is expected at time of completion.

Prescriptions

Please contact our office a minimum of five days prior to your scheduled refill date

Returned checks

Our office charges a $25 dollar fee for all accounts closed, stop payments or returned checks due to insufficient funds.

Referrals and Authorizations

If a referral is required by your insurance carrier you'll be asked to obtain the referral prior to your appointment. If no referral exists on file or if the referral has not been received, your appointment might be canceled. Our office will obtain authorization for your procedure prior the scheduling your appointment. We suggest that you contact your insurance carrier to verify your coverage, benefits and pre-authorization requirements prior to having any procedures performed. Claims are paid based on medical necessity. Please be aware that authorizations and referrals are not a guarantee of payment.

Worker's Compensation

Our office will require you to inform us of any changes regarding your workers compensation claim. The following information is required: adjuster's name, claims status (litigation, supportive care, claimed close, new injury), date of injury, carrier, claim number and claim's address. Please have this information available prior to your appointment time.

Missed appointments

Please notify the office **at least** 24 hours before cancelling your appointment. You will be charged $25.00 for missed appointments if you fail to notify us at least 24 hours prior to cancellation.

Patient name _____ DOB _____

_____ _____

Patient/Guarantor Signature Date

Data on Race and Ethnicity

Why am I being asked for this information?

Collecting data on race and ethnicity is part of "Meaningful Use." The American Recovery and Reinvestment Act of 2009 requires that physicians use a certified electronic health record (HER) in a 'meaningful way', such as e-prescribing medications. Once Meaningful Use requirement is that physicians collect and report on the following demographic data: preferred language, gender, race, ethnicity, and date of birth.

Why is this data important?

According to the federal government, data on race and ethnicity is used to monitor equal access in housing, education, employment, and other areas for populations that historically had experienced discrimination and differential treatment because of their race and ethnicity. These questions are included in the census, in household surveys, on administrative forms (e.g. school registration and mortgage lending applications), in medical and other research.

Do I have a right to decline this information?

Yes, you may decline to provide all or part of the demographic information you are being asked.

Race Categories:

□ American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation of community attachment.

□ Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

□ Black or African American: A person having origins in any of the black racial groups of Africa. Terms such as "Haitan" can be used in addition to "Black or African American."

□ Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

□ White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Ethnicity Categories:

□ Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture of origin, regardless of race. The term, "Spanish Origin" can be used in addition to "Hispanic or Latino."

□ Not Hispanic of Latino

Sources:

http://www.whitehouse.gov/sites/default/files/omb/assets/information_and_regulatory_affairs/re_guidance2000update.pdf
http://www.cms.gov/EHRincentivePrograms/30_Meaningful_Use.asp
http://www.whitehouse.gov/omb/fedreg_1997standards/

Patients Name (print) _____

Patients Signature_____

Mission Pain and Spine
26932 Oso parkway, Suite 275
Mission Viejo, CA 92691
(949) 916-8100
FAX: (949) 916-8555

Name _____

Date _____ King Fadavi

Mark each box that applied	Female	Male
Family History of substance abuse	☐	☐
Alcohol	☐	☐
Illegal drugs	☐	☐
Prescription drugs	☐	☐
Personal history of substance abuse		
Family History of substance abuse	☐	☐
Alcohol	☐	☐
Illegal drugs	☐	☐
Prescription drugs	☐	☐
Age between 16 and 45 years		
History of preadolescence sexual abuse	☐	☐
Psychological disease		
ADD, OCD, Bipolar, schizophrenia	☐	☐
Depression	☐	☐
Total		