Pacific Coast Spine Institute and Pain Center

REGISTRATION FORM

(Please Print)

Today's date:	❑ Work Comp ❑ Auto Accident ❑ Other

PATIENT INFORMATION

Patient's last name:	First:	Middle:

❑ Mr. ❑ Mrs. ❑ Miss	❑ Ms. ❑ Dr. ❑ Other:	Marital status (circle one): Single / Married / Divorced / Separated / Widowed / Domestic Partner / Other	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home: Can we leave message **Y** **N** ( )

City:	State:	ZIP Code:	Cell: Can we leave message **Y** **N** ( )

Email address (please print clearly):		
Employer:	Employer phone no.: ( )	Empl. Fax no: ( )
Primary Care Physician:	PCP phone no: ( )	PCP Fax no: ( )

Referred by:	❑ Dr.:	Ref Dr. phone no.: ( )	Ref Dr. Fax no.: ( )

❑ Insurance Plan	❑ Family	❑ Friend	❑ Yellow Pages	❑ Internet Search	❑ Other

Ok to leave a message at your home? ❑ Yes ❑ No ❑N/A On your cellphone? ❑ Yes ❑ No ❑N/A At your work? ❑ Yes ❑ No ❑N/A

Other family members seen here:

PHARMACY INFORMATION

Pharmacy:	Pharmacy phone no.: ( )	Pharmacy fax no.: ( )

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )
Relationship to Patient:		Is this person a patient here? ❑ Yes ❑ No	

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance?	❑ Yes ❑ No	Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

Pacific Coast Spine Institute and Pain Center

ASSIGNMENT OF BENEFITS

I,_____ , hereby authorize _____
Name of Patient Name of Insurance Company

to pay directly to Pacific Coast Spine Institute and Pain Center all benefits, if any, for medical services and fees. If otherwise paid to me, I am financially responsible for all charges incurred. I also authorize the release of any medical information necessary to process claims.

_____ _____
Signature of Patient or Guarantor Date

Please read each statement and initial to confirm you understand and agree:

____ If Dr. Rahbar should need to refer me to another medical facility or doctor for any reason, I hereby give authorization to release to that entity, any information that pertains to my case.

____ If my check is returned unpaid, my signature authorizes that the amount of the check, plus all fee's, as applicable by law, will be charged to my account.

____ Should an outpatient surgical procedure become necessary, I am aware that Pacific Coast Spine Institute and Pain center, and all of its personnel, do not honor Advanced Directives, and full resuscitation is attempted.

____ I consent to have my photograph taken for my medical record for visual identification purposes only.

____ If I fail to cancel a scheduled office visit more than 24 hours prior to the appointment I understand that I may be responsible for a $25.00 cancellation fee. If I fail to cancel a scheduled procedure more than 72 hours prior to the appointment I understand that I may be responsible for a $100.00 cancellation fee.

____ I have read the HIPAA statement indicating my rights as required by recent legislation (a copy of this statement can be given upon request).

_____ _____
Signature of Patient or Responsible Party Date

_____
Print Name of Patient or Responsible Party

17742 Beach Blvd., Suite 244 Huntington Beach, CA 92647
Telephone (714) 847-3666 Fax (714) 847-7171

Maryam Rahbar M.D.
Pacific Coast Spine Institute and Pain Center

17742 Beach Blvd., Suite 244 Huntington Beach, CA 92647
Telephone (714) 847-3666 Fax (714) 847-7171

Insurance Disclosure Statement

I understand in some cases the insurance payments will be sent to the patient instead of to the doctor. If I receive the insurance payment I will either endorse the original check or write a personal check to the appropriate provider for the same amount within 3 business days. I will also attach a copy of the EOB(explanation of benefits). If the payment is not forwarded to the provider within the 3 days, I understand that I will be turned into a collection company with a 30% extra collection fee as well as be charged with interest.

_____
Print Name

_____ _____
Patient Signature Date

_____ _____
Witness Date

Pacific Coast Spine Institute and Pain Center

PATIENT TREATMENT CONTRACT

Patient Name _____ **Date** _____

As a participant in Pain Management treatment I understand that I may be prescribed medication(s), and that Pacific Coast Spine Institute and Pain Center has important policies regarding prescription treatment and general care. Treatment may not begin without this signed contract.

I agree to accept this treatment contract as follows:

1. I agree to keep and be on time to all my scheduled appointments.

2. I agree to adhere to the payment policy outlined by this office.

3. I agree to conduct myself in a courteous manner in the doctor's office.

4. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.

5. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office.

6. I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my prescriptions are filled, that the behavior will be reported to my doctor's office and could result in my treatment being terminated without any recourse for appeal.

7. I agree that my medication/prescription can only be given to me at my regular office visits. A missed visit may result in my not being able to get my medication/prescription until the next scheduled visit.

8. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost or stolen medication will not be replaced for any reason.

9. I agree not to obtain medications from any doctors, pharmacies, or other sources without telling my treating physician.

10. I understand that mixing medications, especially benzodiazepines (for example, Valium, Klonopin, or Xanax), can be dangerous. I also recognize that several deaths have occurred among persons mixing buprenorphine and benzodiazepines (especially if taken outside the care of a physician, using routes of administration other than sublingual or in higher than recommended therapeutic doses).

11. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.

PATIENT TREATMENT CONTRACT (CONTINUED)

12. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my doctor and specified in my treatment plan.

13. I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (excepting nicotine).

14. If I have been prescribed narcotics, I agree to submit blood or urine samples to detect the use of other medications and/or substances or other health effects whenever my physician deems it necessary.

15. I understand that violations of the above may be grounds for termination of treatment.

_____ Date _____

Patient Signature

Confidentiality of Alcohol and Drug Dependence Patient Records

The confidentiality of alcohol and drug dependence patient records maintained by this practice/program is protected by federal law and regulations. Generally, the practice/program may not say to a person outside the practice/program that a patient attends the practice/program, or disclose any information identifying a patient as being alcohol or drug dependent unless:

1. The patient consents in writing;
2. The disclosure is allowed by a court order, or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or practice/program evaluation.

Violation of the federal law and regulations by a practice/program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the practice/program or against any person who works for the practice/program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services

_____
Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Physician's or Authorized Representative's Signature (Date)

_____
Print or Stamp Name of Physician, Medical Group, or Association Name

Pacific Coast
SPINE INSTITUTE AND PAIN CENTER
Maryam Rahbar M.D., Inc.

By: _____ _____
Patient's or Patient Representative's Signature (Date)

By: _____
Print Patient's Name

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

(2-08)

M Rahbar MD Inc
17822 Beach Blvd Suite 152
Huntington Beach CA 926476854
Ph: 714-847-3666 Fax:714-847-7171

ALCOHOL MISUSE/ABUSE (AUDIT C)

Name: _____ Date:

Did you have a drink containing alcohol in the past year?

☐ Yes

☐ No

If 'Yes' : How often did you have a drink containing alcohol in the past year?

☐ Never (0 points)

☐ Monthly or less (1 point)

☐ Two to four times a month (2 points)

☐ Two to three times per week (3 points)

☐ Four or more times a week (4 points)

If 'Yes' : How many drinks did you have on a typical day when you were drinking in the past year?

☐ 1 or 2 (0 points)

☐ 3 or 4 (1 point)

☐ 5 or 6 (2 points)

☐ 7 to 9 (3 points)

☐ 10 or more (4 points)

If 'Yes' : How often did you have six or more drinks on one occasion in the past year?

☐ Never (0 points)

☐ Less than monthly (1 point)

☐ Monthly (2 points)

☐ Weekly (3 points)

☐ Daily or almost daily (4 points)

Points 0

Interpretation

☐ Positive

☐ Negative

Interpretation

The AUDIT-C is scored on a scale of 0-12 (scores of 0 reflect no alcohol use).

- In men, a score of 4 or more is considered positive.
- In women, a score of 3 or more is considered positive.

Pacific Coast Spine Institute and Pain Center

Patient Name:_____ Date:_____

1. Where is your pain? O head O neck O right arm O left arm O right shoulder
O left shoulder O low back O right hip O left hip O left knee O right knee O right buttock
O left buttock O right foot O left foot O Abdomen O Pelvic O other_____

2. What do you believe to be the cause of your pain? O Fall O heavy lifting O trauma
O accident O job injury O other_____

3. Check all the words that describe your pain: O constant O episodic O electric O sharp
O burning O achy O dull O throbbing O shooting O numbness O tingling
O hot O cold O other_____

4. How long have you had this pain? O less than a month O more than 6 weeks O less than 6 months O more than 6 months O more than 1 year O more than 5 years O more than 10 years

5. Overall your pain is? O mild O moderate O severe

6. When is your pain worse? O morning O midday O afternoon O night O all the time

7. What activities make your pain worse? O coughing O sneezing O sitting O driving O walking
O standing O lying down O bending O other_____

8. What activities make your pain better? O walking O standing O sitting O lying down O heat
O ice O medication O nothing O other_____

9. To treat the pain you have tried: O Over the counter medication O prescription medication
O chiropractor treatment O physical therapy O heat O ice O psychotherapy/behavioral therapy
O acupuncture O traction O TENS O massage therapy O nerve blocks O epidural injections
O other_____

10. To evaluate your pain, you have had: O X-ray O MRI O CT scan O myelography
O nerve conduction study O bone scan O none of the above O other_____

11. Is pain effecting your: O sleep O daily function O job performance O thinking ability O mood

12. On a scale of 1 to 10 what is your pain level (10 being the highest) _____

13. Have you had any falls within the last year? O Yes / O No, How Many_____ O W/ Injury O W/O Injury

Past Medical History

Hypertension	O Yes	O No
Heart Disease	O Yes	O No
Diabetes	O Yes	O No
Lung Disease	O Yes	O No
Asthma	O Yes	O No
Stroke	O Yes	O No
Liver Disease	O Yes	O No

Patient Name:_____ Date:_____

Kidney Disease	O Yes	O No
Gastritis	O Yes	O No
GERD	O Yes	O No
Psychiatric Disorder	O Yes	O No
Depression	O Yes	O No
Substance Abuse	O Yes	O No
Alcohol Abuse	O Yes	O No

Family History

Has anyone in your family been diagnosed with any of the following? O diabetes O hypertension O chronic pain O depression O substance abuse O alcohol abuse O psychiatric disorder O arthritis O none

Social History

Marital Status O Married O Divorced O Single O Widowed O Life partner

Do you have children? O Yes O No

Do you have family issues? O Yes O No

What is your alcohol consumption O never O occasionally O regularly

Do you smoke? O never O occasionally O regularly

Do you use illicit drugs? O never O occasionally O regularly

What is your job status? O full time O part time O student O retired O not working due to pain O disabled

Are you involved in a litigation (lawsuit)? O Yes O No

Review of Systems

Constitutional		
Weight Gain	O Yes	O No
Loss of Appetite	O Yes	O No
Fever	O Yes	O No
Weakness	O Yes	O No
Weight Loss	O Yes	O No
Fatigue	O Yes	O No
Insomnia	O Yes	O No

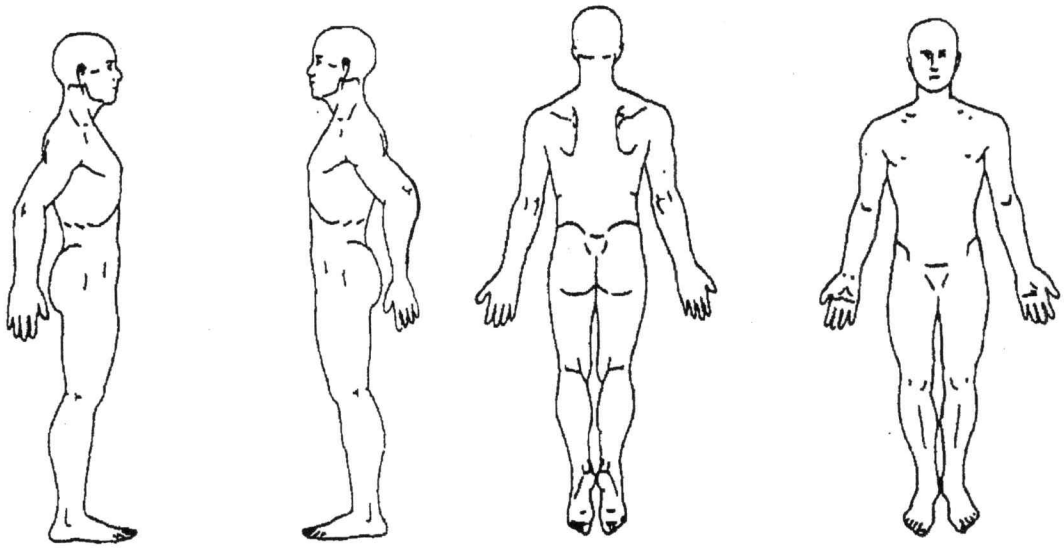
Pacific Coast Spine Institute and Pain Center

Patient Name:_____ Date:_____

Urology		
Urinary Incontinence	O Yes	O No
Frequent Urination	O Yes	O No
Difficulty Urinating	O Yes	O No
ENT		
Hearing Difficulty	O Yes	O No
Cardiology		
Dizziness	O Yes	O No
Chest Pain (Angina)	O Yes	O No
Irregular Heartbeats (Palpitations)	O Yes	O No
Leg Edema	O Yes	O No
Shortness of Breath	O Yes	O No
Cold Extremities	O Yes	O No
Palpitations	O Yes	O No
Gastroenterology		
Blood in Stool	O Yes	O No
Diarrhea	O Yes	O No
Vomiting	O Yes	O No
Constipation	O Yes	O No
Nausea	O Yes	O No
Heartburn	O Yes	O No
Neurology		
Memory Loss	O Yes	O No
Tremors	O Yes	O No
Loss of Balance	O Yes	O No
Ophthalmology		
Blurring of Vision	O Yes	O No
Respiratory		
Shortness of Breath	O Yes	O No
Wheezing	O Yes	O No
Cough	O Yes	O No
Hematology/Lymph		
Abnormal Bruising	O Yes	O No
Abnormal Bleeding	O Yes	O No
Varicose Veins	O Yes	O No
HEENT		
Change In Vision	O Yes	O No
Double Vision	O Yes	O No

Patient Name:_____ Date:_____

1) Where is your pain? Circle all that apply:



Patient Name:_____ Date:_____

Medications and Allergies

Medications

O None

Please list current medications taken with dosage and frequency:

Drug	Strength	Frequency
Over the Counter Meds:		

Allergies

O No Known Drug Allergies

Please list any known drug allergies including the reaction:

Name of Drug	Allergic Reaction

Patient Name:_____ Date:_____

Surgeries

Please list all surgeries:

Date of Surgery	Surgery