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www.americanpain.us

MIGUEL A. DOMINGUEZ, MD, FIPP
Medical Director, American Pain Institute, Inc
Diplomate of American Board of Anesthesiology
Diplomate of American Board of Pain Medicine
Diplomate of American Board of Interventional Pain Medicine
Certification in Control Substance Management, Billing, Coding and Practice Management
Fellow Interventional Pain Practice

Dear: _____ **Date: _____**

Our charge for service includes the following:

1. Meeting with you, providing an initial evaluation as well as developing a treatment plan.
2. Discussing and educating you and/or significant others on your medical care.
3. Chart review and review of records
4. Evaluation of pertinent laboratory testing/Reviewing results of your physical exam.
5. Calls from the staff and others involved with your care and treatment- with your permission.
6. Any meetings or discussions with relatives.
7. Time spent regarding in dealing and billing insurance.
8. Writing notes in your chart.
9. Writing of orders and review of medications.
10. Medication changes as appropriate.
11. Any appeal or authorization letters that need to be sent to insurance companies.
12. Involvement in discharge planning and follow up.
13. Availability regarding your care and consultation with our staff.

As you can see, meeting with you is just a small part of what is needed to co-ordinate your care and treatment. Because persistent pain can be accompanied by secondary problems such as mood disturbances, anxiety and depression, it has been necessary and required by state and federal guidelines to inquire about psychosocial questions. Moreover, this information is used to choose the appropriate treatment regimen. Fill out those items on all pages as completely as possible so that we can best evaluate your needs and develop the individualized treatment plan. ***Please read the medication agreement. It is both an informed consent and office policies that you will need to abide by in order to allow safe management of your medical problem.***

We are happy to be available to you and your relatives (with your consent) and anyone else involved with your care and treatment. Finally, if you allow a relative or significant other to be present during your evaluation you are thereby giving consent to discuss your medical information with them.

Thank you for letting us be of service to you.

GENERAL PATIENT INFORMATION

_____ _____ _____ ( )_____ ( )_____
PATIENT'S LAST NAME **FIRST NAME** MIDDLE HOME PHONE **CELL PHONE**

_____ _____ _____ _____
CURRENT STREET ADDRESS CITY STATE ZIP CODE

_____ _____ _____ SEX: ☐ MALE ☐ FEMALE
SOCIAL SECURTIY NUMBER **DATE OF BIRTH** AGE STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCE

_____
E-MAIL ADDRESS

_____ _____ ( )_____
OCCUPATION DRIVER'S LICENSE NUMBER WORK PHONE

_____ _____
EMPLOYED BY EMPLOYER'S ADDRESS

_____ _____ ( )_____
EMERGENCY CONTACT PERSON RELATIONSHIP PHONE

_____ SUBSCRIBER: ☐SELF ☐SPOUSE ☐OTHER:_____
INSURANCE COMPANY

_____ _____ (____)_____
INSURED'S ID # GROUP NUMBER INSURANCE PHONE NUMBER

_____
REFERRED BY

_____ **E-MAIL ADDRESS**:_____
DATE OF INJURY (Used for practice communication only)

COLLECTION AGREEMENT: I understand that while Dr. Dominguez may bill my insurance as a courtesy, I shall be responsible for the payment amount requested immediately upon receipt of billing for services rendered in good faith. Should this account be referred to an attorney or an agency for collection, I agree to pay for any and all expenses related to the collection of the unpaid balance knowing that these fees may be equal to or greater than the amount that is considered delinquent.

FEES CHARGED: The fees charged by doctors/staff and facility/office is based on the amount of time scheduled for dealing with patient issues. The minimum about of time scheduled/charged by our practice is for (25-30 minutes in length). If additional time beyond the scheduled time is taken to assist patients, insurance/you will be charged for the amount of time used. In addition, patients are typically charged for time spent on the telephone and time taken to write triplicate prescriptions outside of scheduled appointments, time taken to write notations in patient's chart and time taken to write reports or correspondence on the patient's behalf. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

INSURANCE BILLING: As a courtesy to our patients we bill insurance carriers for our patients. Patients/Responsible Parties are responsible for all charges whether or not they are covered by your insurance. Please advise us immediately if there are any changes in your insurance coverage.

PAYMENT POLICY: Our office requires payments for in-office services at the time services have been rendered. Payments may be made by cash, personal check or credit card (MasterCard, or Visa). Telephonic appointments must be prepaid by either personal check or credit card. As our patients are expected to maintain a zero balance, our office does not send any billing or statements.

OINTMENT CANCELLATION POLICY: We require that cancellations for scheduled appointments be received 24 hours in during regular business hours (Monday through Friday 9:00am to 4:30 pm). *Missed or cancelled appointments that do not follow this policy will be charged a missed appointment fee of $35.00.*

in appointments will have a $50 charge.

: Photos are necessary for proper identification and to document certain medical conditions for your electronic medical record. We utilized an electronic medical record system. If we have an interest in using your photo for other any other reason we will obtain your consent.

DISCLOSURE:

I have read and understand the above stated policies of Miguel Dominguez M.D. Inc. and American Pain Institute Surgical Medical Center Inc.

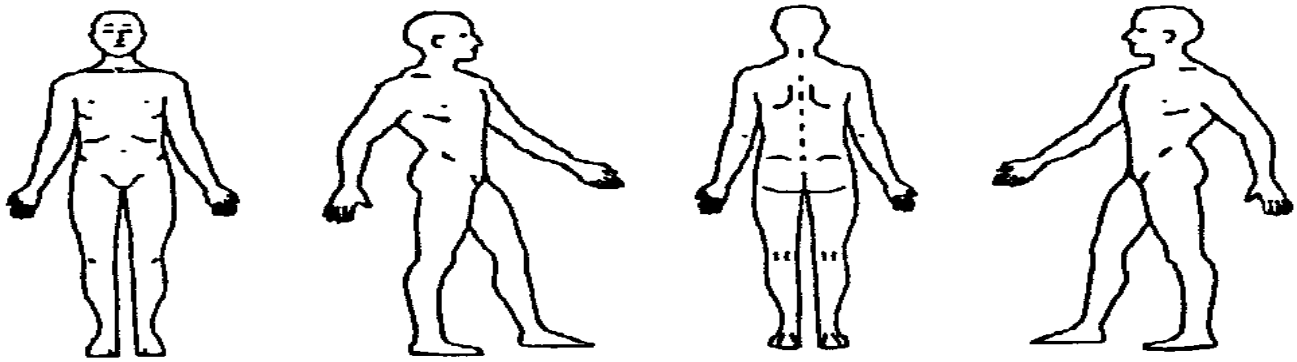
Signed: _____Dated: _____

Name:_____

PURPOSE OF EVALUATION:

What brought you to our office*…what are the main pain symptoms and things we should know about in order to best assist you? Please explain what your goals with a proposed treatment plan.* _____
_____

Where is your pain? (Please indicate by circling Location of Pain.)



Intermittently		**Continuously**		**Physician Notes**
Sharp	Burning	Sharp	Burning	
Shooting	Aching	Shooting	Aching	
Stabbing	Throbbing	Stabbing	Throbbing	
Numbing		Numbing		

CURRENT SYMPTOMS: (Check all that apply) **1 = Mild, 2 = Moderate, 3 = Severe**

___ Poor Sleep	___ Dry mouth	___ Poor attention span	___ Depression
___ Poor Appetite	___ Constipation	___ Feelings of hopelessness	___ Suicidal feelings
___ Increased appetite	___ Diarrhea	___ Irritability	___ Anger
___ Weakness	___ Weight loss	___ Anxiety	___ Paranoia
___ Decreased sex drive	___ Tiring easily	___ Socially withdrawn	___ Avoiding people
___ Blurred vision	___ Inability to have fun	___ Work problems	___ Hearing voices
___ Numbness	___ Sexual problems	___ Family problems	___ Short-tempered
___ Dizziness	___ Ringing in ears	___ Nightmares	___ Lack of interest
___ Nausea	___ Worrying a lot	___ Low self esteem	___ Inability to relax
___ Headaches	___ Crying easily	___ Seeing things	___ Fearfulness

What treatments have you received for your pain problem? Were these treatments helpful?
Medications__(Motrin/Tylenol/Alieve/Vicodin/Marijuana) Chiropractic__ Physical Therapy__ Heat___ Ice___ Acupuncture__

Injections: Type_____

*Other: Explain;*_____

WORK RESTRICTIONS: Mark & fill out those that apply to you or: ____ I cannot work

___ Cannot lift/carry anything heavier than _____ lbs
___ Cannot perform any rigorous work.
___ Need to take breaks during the day as needed
___ No Climbing ___ No Sitting longer than _____ minutes/hours continuously
___ No Squatting ___ No Standing longer than _____ minutes/hours continuously
___ No Kneeling ___ No Excessive Bending
___ No Gripping ___ No Extraneous Twisting
___ No Pushing/Pulling anything heavier than ____ pounds
___ No walking longer than _____ miles

___ Other: _____

Name:_____

DISCLOSURE REGARDING THE USE OF OFF LABEL MEDICATIONS

Medications are developed and approved by the Food and Drug Administration (FDA). They are given specific indications. Often times we have found that medications are effective when used in situations called off-label. This means that they are not FDA approved, but have been shown to be helpful and much literature exists to support the usage of these medications.

In addition mild and potent analgesics (opioid/"narcotics") we use caution to use combinations of medications that are helpful and result in increased effectiveness for a multitude of conditions, such as unusual pain disorders and associated Anxiety Disorder, Depression and others. Furthermore, combinations of medications are often better than a high dose of one medication. In this practice we utilize injection modalities to decrease or minimize increases in medications.

Though side effects are common with all medication, it is important to distinguish between side effects that are inconvenient and those that are dangerous. Inconvenient would be a slight bit of nausea or transient trouble falling asleep. Dangerous side effects can cause irreversible damage. So we try to be as careful with you as we would be with our own family, even if the chances of a problem are rare. If you have any unusual symptoms that are very mild, they will most likely go away. If you have any questions that concern you please discuss them during your visit. If ever you cannot reach us, go directly to an emergency room.The medications we use are to help relieve pain transmission and thus allow the patient to improve function and quality of life. We never have the goal of turning someone into a “zombie”.

Examples:

1. **Mood Stabilizers…**originally used for epilepsy.
    a. Depakote…requires blood tests to check blood level, blood and liver function.
    b. Tegretal… requires blood tests to check blood level, blood and liver function.
    c. Gabitril…no tests required
    d. Neurontin…no tests required
    e. Topamax…no tests required
    f. Lamictal…no tests required…can rarely cause a rash…notify us at once.
    g. Zonegran, Keppra, Lyrica and others; requires blood tests to check blood level, blood and liver function.

2. Atypical Anti-psychotic Medications: These are used for severe psychiatric disorders in high doses. They have been shown to be effective in low doses in combination or alone for many of the disorders I have noted previously. These medications include:

    a. Risperdal
    b. Zyprexa
    c. Seroquel
    d. Elavil, Trazodone, Cymbalta, Savella
    e. Celexa, Prozac, Lexapro, Effexor, Paxil, or Zoloft, Pristiq.
    f. Thorazine (chlorpromazine) and others
    g. Wellbutrin

3. Medications usually used for blood pressure control:

    a. Clonidine (catapress) and calcium channel blockers
    b. Beta Blockers, such as inderol, propranolol, atenolol, and others for impulse control and rapid heart beat.

4. I may also use medications for sleep, such as trazodone (antidepressants), Seroquel or muscle pain (muscle relaxants), and various other medicine for potential withdrawl symptoms.

5. I may also use medication that may include a combination of medications such as stimulant, a mood stabilizer, or an SSRI like Prozac, Paxil, Effexor, Celexa, Zoloft, Provigil and other medications that are appropriate.

There are other examples and we will explain if we use any others. This list is not inclusive and I or my physician assistant may use unusual combinations of medications to achieve goals which we will discuss. We will always be happy to explain what we are doing and why. Just ask.

ALWAYS LET US KNOW WHAT HERBS OR OVER THE COUNTER MEDICATIONS OR VITAMINS YOU USE.

Medication Agreement: Long-Term Controlled Substances Therapy for Chronic Pain

Excerpts from a Statement from the American Academy of Pain Medicine Executive Committee

PLEASE INITIAL AFTER READING:

The following is an agreement for those who consent to be treated with medications. This agreement is to protect your access and our ability to prescribe controlled substances for pain management. This agreement refers to the long-term use of controlled substances that include opioids (narcotic analgesics), benzodiazepines tranquilizers, and barbiturate sedatives. There use is controversial because of the uncertainty regarding the extent to which they provide long term benefit. There is also a risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. If you have a history of substance abuse, family history substance abuse. Alcohol or tobacco/marijuana abuse there is a higher risk for developing the addictive disorder. Addiction is a behavioral mental disorder. Addiction has a negative impact on mental and physical function. Addiction ***is not*** physical dependence or tolerance.

__Due to the potential for abuse or diversion for these drugs, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed by you, THE PATIENT, as consideration for, and a condition of, the willingness of the physician/physician assistant to initiate and/or continue prescription of controlled substances to treat your chronic pain.

__I fully understand that if I am given opioids I can develop physical dependence, or as commonly referred to as "physical addiction". Patients can also develop tolerance. Abruptly stopping the medication can lead to a withdrawal syndrome "abstinence syndrome". These symptoms may include one or all of the following; and runny nose, yawning, goose-bumps, diarrhea, nausea, vomiting, abdominal cramping, irritability, muscle aches, "flulike" feeling and increased pain.

__I agree that I will use my medicine as directed by the physician. I will not self medicate. If I mismanage the prescribed directions I may experience withdrawal symptoms. If I do not comply with directions, the medication will not be replaced and may result in discharge from this practice. For continued noncompliance, you may be eligible for prescription drug detoxification utilizing buprenorphine. Changes in medications regimens may require weekly or bimonthly visits.

__ I agree to only obtain these medications from only one physician/physician assistant.

___With rare exception, LOST< STOLEN OR DAMAGED medication will not be replaced.

__ I will ***not share, sell, permit others*** to have access to these medications or use will use any illegal substances. **Due to some common side effect of these controlled substances, such as dizziness or drowsiness, do not drive or operate machinery until you know how you will react to the medication. Using this medication alone or with other agents can lessen your ability to drive or operate machinery**. It is expected for patient's to take the highest possible degree of *responsibility* and judgment with your medications. These drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child; you must keep them out of reach their reach. You are required to purchase a safe and lockup tour medications.

__The prescribing physician/physician assistant has permission to discuss all diagnostic, our records of controlled substances administration and treatment details with legal authorities, including dispensing pharmacists or other health professionals who provide your health care for maintenance of accountability. I also understand that due to the potential side effects from these medications, significant others may discuss with us observed detrimental consequences for optimal care.

__I am aware that there are many ways to relieve chronic pain, including: acupuncture, electric stimulation, physical therapy, biofeedback, hypnosis, nerve block, psychological therapy, and non-opioid drugs. These methods have either been unsuccessful or are unacceptable to me.

__To the best of my ability I will honestly communicate fully with my doctor about the character and intensity of my pain, the effect of the medication on my daily activities of life, medication side effects or any new medications or medical condition.

__ I will comply with urine drug screens to assess metabolism and compliance with the medicine. Presence of unauthorized substances shall be considered non-compliant behavior and may lead to discharge from the practice.

__I understand that any medical treatment is initially a trial. Continued prescription is contingent on evidence of benefit; improved function and quality of life.

__If requested, I will bring all unused pain medicine as directed.

__I will make every effort to utilize one designated pharmacy. If at any time I need to change my pharmacy, I will notify the office. Multiple sources can lead to dangerous drug interactions or poor coordination of treatment. I agree to only use

Pharmacy: Located at _____, Telephone number _____.

__I understand that failure to adhere to these written agreement policies may result in cessation of therapy with controlled substance prescribing by this office.

__I fully understand the Pain Center will not do any of the following:

*Refill my prescription by telephone, evenings, weekends or holidays.
*Refill my prescription before my scheduled appointment. Early refills would generally not be given. Prescriptions may be issued early by the physician if the patient will be out of town when the refill is due. These prescriptions will contain instructions to the pharmacist that they may not fill it prior to the appropriate date.

__***Females:*** If I should become pregnant, I understand that my baby will also become physically dependent on the medication. Birth defects can occur whether or not the mother is on medicines and there is always a possibility that the pregnancy can result in a birth defect(s) while taking these medications.

__***Males:*** In particular with the chronic use of opiates there has been an association with low testosterone level in males. This may affect mood, stamina, sexual drive and sexual/physical performance. I understand that testosterone levels may be monitored.

__ THC (marijuana) is not available in a controlled fashion or monitored in this State (where it is allowed for medical purposes) but has potential adverse interactions with many medications that we prescribe and continues to be an illegal substance by federal law. With a few extenuating circumstances (2 other physicians must recommend it); the current policy of this office is generally not to prescribe controlled substances together with centrally acting medications. As noted, this includes controlled substances such as opioids (narcotics), sleeping pills, hypnotics and anxiolytics (Xanax, Ativan, Valium etc).

Addendum: January 1, 2010

1). Be prepared to pay your co-payment and deductible financial responsibility.
2). Advise us immediately if there are any changes in your insurance coverage.
3). Schedule your appointment before leaving the office, as there will be no guarantee of being able to be seen upon your immediate request.
4). Please be reminded that "same day walk-in appointments" have a $50 charge.
5). Remember that if you do not call to change your scheduled appointment and failed to keep your appointment, there will be a $35 charge.
6). Except for unforeseen circumstances, there will be no telephone call/pharmacy Refills for all controlled substances. This includes opioids (narcotics), Sleeping pills and anxiolytics i.e. Xanax, Lorazepam-Ativan, Valium etc. *Please do not exceed you interim medication supply. Potential problems with this occurring is obvious; increased pain, withdrawal, etc.*
7). All other non-controlled & non-opioids refills will be worked on Tues & Thurs.
8). Please be reminded that if you allow a relative or significant other to be present during your evaluation you are thereby giving consent to discuss your medical information with them.
9). Please discuss any concerns or questions regarding our risk management program; medication agreement, CURES patient activity report, blood chemistry or urine sampling.
10). Please bring in your unused pain medication(s) and inform our staff of all prescribed pain medication (especially if prescribed by other providers) and over-the-counter medication. BRING THEM EVEN IF WE DO NOT LOOK AT THEM.

On behalf of my staff and me, we look forward in achieving a mutual goal; to safely, effectively, and judiciously provide care that can maintain a level of function and thus quality of life. It has been my pleasure in hopefully making a difference in your life.

MEDICATION INFORMED CONSENT:

This is consent about the utilization of ***controlled medications*** and of medications as described above that may be ***used off label*** for managing your pain problem.

__I have read this document in it's entirely and understand. I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

Patient Signature:_____ Date ___/___/___Witnessed by:_____ Date ___/___/_____

Physician: _____ Date ___/___/_____

Name:_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records, including photography and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This includes any electronic digital information that may consist of "digital" photographs. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are requires to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive and accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

The notice is effective as of April, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:
Or to file a complaint:

American Pain Institute, A Surgical Medical Center, Inc
Facility Administrator/Patient Advocacy
10610 Lower Azusa Rd
El Monte, Ca 91731
626-279-1855

For more information about HIPAA
Or to file a complaint:

The U.S. Department of Health & Human Services,
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
Toll Free: 1-877-696-6775

PATIENT PRIVACY CONSENT FORM

I understand that, under the Health Insurance Portability & Accounting Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment, directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to requested restrictions, but if you do agree then you are bound to abide by such restrictions.
I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

A). Except for unforeseen circumstances, there will be no telephone call/pharmacy refills for all controlled substances. This includes opioids (narcotics), sleeping pills (with the exception of Rozerem) and anxiolytics i.e. Xanax, lorazepam-Ativan, Valium etc.
B). All other non-controlled & non-opioids refills will be worked on Tues & Thurs.

On behalf of my staff and I, we look forward in achieving a mutual goal; to safely, effectively, and judiciously provide care that can maintain a level of function and thus quality of life. It has been my pleasure in making a difference in your life.

Signature: _____Date: _____