PACIFIC
PAIN MEDICINE
CONSULTANTS

ROBERT E. WAILES, M.D.
NATHAN PERRIZO, M.D.
JEREMY A. ADLER, MS, PA-C
MICHAEL E DAVIS, PA-C
LAWRENCE OWUSU, PA-C

The Pacific Pain Medicine Program

Welcome to the largest full service, full time comprehensive pain management program in North San Diego County. We provide state of the art treatments for a wide variety of challenging pain problems. We hope you will be pleased with our thorough efforts to reduce your pain. The first step in the process will be a complete medical evaluation with special emphasis on the history of your pain problems. You can help us by filling out the Pain Questionnaire form to the best of your ability. Also bring a complete list of your medicines, their strength, and how often you take them. If this is not possible, then just bring your medicines with you. If you have X-rays, Cat Scans or MRI's pertaining to your pain condition, please bring the report and actual files with you to your initial consultation.

If you are being referred for a procedure (i.e., and injection), please rest assured that we will provide you with a thorough explanation of plans, risks, and alternatives prior to doing any procedure. Most of the time, we will do the procedure at the Pacific Surgery Center. This facility is located within our Oceanside office of the Pacific Pain Medicine Program. Some procedures will need to be done at the hospital or other surgery center. Please be aware that any co-pays will need to be collected at the time of the visit. We will be happy to bill your insurance but you are responsible for any remaining balances. If your insurance plan requires authorizations, then these need to be obtained before we can schedule an office visit or procedure.

Pacific Pain Medicine consultants and the Pacific Surgery Center both use an Arbitration Agreement. This is designed to settle any disputes in a much more efficient and cost effective manner. We will be please to discuss this further with you if there are any questions. Please review and sign this document before your scheduled appointment.

Please feel free to call our office if you need any assistance. Our main telephone number is (760) 753-1104.

Best wishes for a healthy future,

Robert E. Wailes, M.D.
Medical Director

PACIFIC PAIN MEDICINE CONSULTANTS
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PAIN QUESTIONNAIRE

Name:_____ Date:_____ Age:_____ Ht:_____ Wt:_____

1. What problem are you here for today:_____
2. Date of onset (first episode):_____ Work related? □ Yes □ No
3. Explain how the pain started:_____
4. Any previous episodes? _____ If yes, when? _____
5. Have you had prior surgery for this or a similar problem? _____ Procedures & dates:_____
6. Over the last 1-2 weeks is your pain getting better, worse or about the same? _____
7. Location of greatest area of pain: _____
8. Radiation of pain? _____
9. How would you break down the components of your pain?

   (Total = 100%) Back: _____% Neck: _____%

   Rt. Leg: _____% Rt. Arm:_____%

   Lt. Leg: _____% Lt. Arm: _____ % Other: _____%
10. How would you describe the quality of the pain? (i.e. burning, aching, tingling, etc.) _____
11. Numbness or tingling? _____ If yes, where? _____
12. Does the pain wake you at night?_____
13. Are you able to control urination? _____
14. Are you able to control bowels? _____
15. Does coughing/sneezing/straining make the pain..... Better _____ worse _____ or no change_____
16. Does walking make the pain..... Better _____ worse _____ or no change_____
17. Does standing make the pain..... Better _____ worse _____ or no change_____
18. Does sitting make the pain ..... Better _____ worse _____ or no change_____
19. Does laying down make the pain..... . Better _____ worse _____ or no change_____
20. Does the affected extremity feel weak? _____
21. Have you had regular X-rays?_____If yes, when & where? _____
22. Have you had a C.T. scan? _____If yes, when & where? _____
23. Have you had a MRI scan? _____If yes, when & where? _____
24. What other tests have you had regarding this problem? _____
25. Please indicate previous pain therapy and results:

Medications:	Worse	No help	Some help	Moderate help	Profound help	Never tried
Anti-inflammatory (i.e. aspirin, ibuprofen)	-1	0	1	2	3	□
Name:_____						
Opiates (i.e. Tylenol #3, Vicodin)	-1	0	1	2	3	□
Name:_____						
Muscle relaxants:_____	-1	0	1	2	3	□

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	Worse	No help	Some help	Moderate help	Profound help	Never tried
Antidepressants:_____	-1	0	1	2	3	☐
Oral steroids (i.e. prednisone, Medrol Dosepak)	-1	0	1	2	3	☐
Name: _____						
Tylenol: _____	-1	0	1	2	3	☐
Neurontin: _____	-1	0	1	2	3	☐
Ultram: _____	-1	0	1	2	3	☐
Other meds: Name:_____	-1	0	1	2	3	☐
Heat:_____	-1	0	1	2	3	☐
Ice: _____	-1	0	1	2	3	☐
Bed rest: _____	-1	0	1	2	3	☐
Physical Therapy: _____	-1	0	1	2	3	☐
TENS (neurostimulator): _____	-1	0	1	2	3	☐
Daily exercises:_____	-1	0	1	2	3	☐
Pain clinic: Name:_____	-1	0	1	2	3	☐
Biofeedback:_____	-1	0	1	2	3	☐
Psychological counseling:_____	-1	0	1	2	3	☐
Chiropractic treatments:_____	-1	0	1	2	3	☐
Acupuncture/Acupressure:_____	-1	0	1	2	3	☐
Injections: What type:_____	-1	0	1	2	3	☐
Massage:_____	-1	0	1	2	3	☐
Surgery (dates):_____	-1	0	1	2	3	☐
Other: _____	-1	0	1	2	3	☐

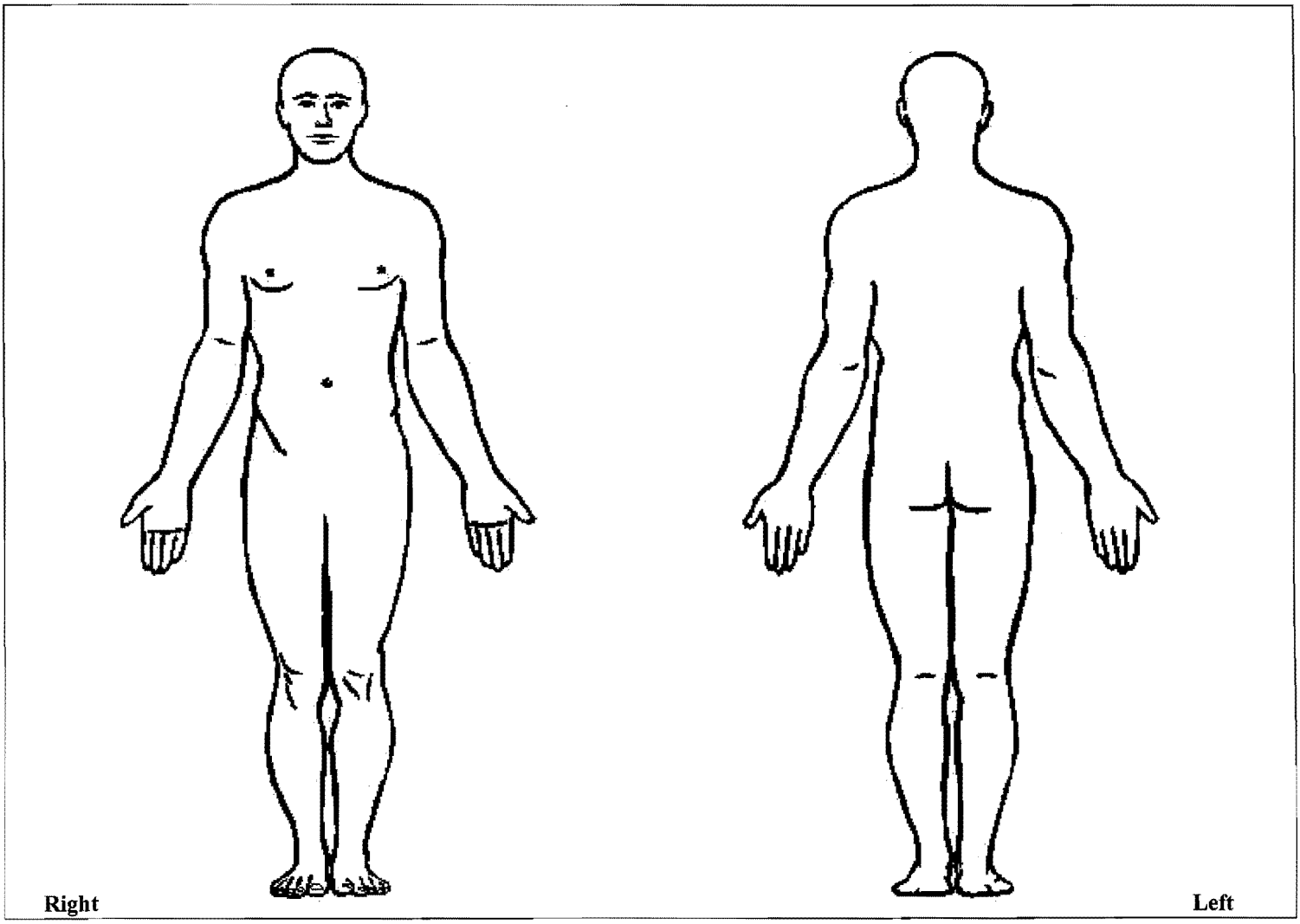
26. Have you been evaluated by:

Orthopedic surgeon?	YES	NO	Name:_____
Rheumatologist?	YES	NO	Name:_____
Psychiatrist (M.D.)?	YES	NO	Name:_____
Psychologist (M.D.)?	YES	NO	Name:_____
Neurologist?	YES	NO	Name:_____
Pain Management M.D.?	YES	NO	Name:_____
Neurosurgeon?	YES	NO	Name:_____
Other specialist?	YES	NO	Name:_____

PATIENT PAIN DRAWING

Using the symbols given below, mark the areas on your body where you feel the described sensations. Include all affected areas.

Aching	Numbness	Pins & Needles	Burning	Stabbing	Other
▲▲▲	= = =	0 0 0	XXX	/ / /	●●●



Please mark your pain on the following pain scales:

Pain at this moment:	0	1	2	3	4	5	6	7	8	9	10
	no pain		mild pain			moderate pain			severe pain		excruciating pain
What is the best you feel on a daily basis?	0	1	2	3	4	5	6	7	8	9	10
	no pain		mild pain			moderate pain			severe pain		excruciating pain
What is the worst you ever feel on a daily basis?	0	1	2	3	4	5	6	7	8	9	10
	no pain		mild pain			moderate pain			severe pain		excruciating pain

PACIFIC PAIN MEDICINE CONSULTANTS
PATIENT HISTORY FORM

Name:_____ Date:_____

When completed, the medical history included here can be of critical importance to you and your physician. It provides a general synopsis of your entire health background, points up areas worthy of additional investigation and analysis and materially increases the effectiveness of your physician's personal contact with you.

Please list all medication (including non-prescription drugs) which you are taking now. Give dose and frequency. (*If necessary please check bottle label or consult your pharmacist)*:

Medication / Drug:	Amount or Dose:	Frequency:

ALLERGIES (INCLUDE ALL DRUG ALLERGIES): _____

_____

Past Surgical History: Please list any operations and indicate the approximate date or your age at the time of the procedure.

Operation:	Date:

List current and past medical problems including hospitalizations and dates such as high blood pressure, ulcers, stroke, etc.:

_____

_____

Review of systems: Please draw a circle around any symptoms or conditions in this section which you have had or now have. If your symptoms or condition is not in the list, please write it in.

General Anemia, bleeding disorder, blood clots, phlebitis, psoriasis or other skin problem, osteoporosis, arthritis, neck pain, low back pain, sciatica, HIV or Aids.
Others:_____

Eyes, ears, nose & throat: Loss or change of vision; eye pain or redness; excessive watering; double vision; loss of hearing; buzzing or noises in ears; ear infection or drainage; hoarseness; excessive sneezing; blocked nasal passages; nosebleeds; frequent running nose; difficulty swallowing; other than listed:_____

Respiratory: Wheezing; large quantity of sputum; bloody sputum; excessive cough; shortness of breath with little exercise or at rest; night sweats; pain with breathing; pneumonia, emphysema, asthma, tuberculosis, other than listed:_____

Cardiovascular: Chest pain; abnormal or fast heartbeat; abnormally low blood pressure; calf cramps with walking; excessive sensitivity of fingers & toes to cold; varicose veins; frequent & marked swelling of ankles & feet; rheumatic fever, high blood pressure, heart murmur, fibrillation, heart attack, other than listed:_____

_____

Gastrointestinal: digestion difficulties; frequent nausea or vomiting; bloody vomitus; lack or loss of appetite; frequent stomach or abdominal pain; frequent belching; frequent loose bowel movement; recurring diarrhea; blood in the stool; hemorrhoids or piles; gallbladder trouble; frequent or severe constipation; persistent anal itch; diabetes, hepatitis, jaundice, ulcers, hiatal hernia, pancreatitis, anemia, other than listed:_____

Genital-Urinary: urinary incontinence or dribbling; blood in urine; increased frequency of urination; chronic urgency of urination; difficulty starting or passing urine; painful urination; narrowing of urinary stream; flank pain; excess urine; other than listed:_____

Genital-Urinary (Male patients): Penile pain; infection or sores; abnormality of testicles; scrotal swelling; varicocele; prostatitis; stricture; sterility; difficulty in sexual functioning; other than listed:_____

Continued: (page two)

Genial-Urinary (Female patients): Breast discharge; swelling; lumps; pain or infection; nipple changes or irritation; vaginal pain, infection, discharge or itch; known uterine fibroids or tumors; tubal infections; abnormality of menstrual flow; painful menses; infertility or difficulty in becoming pregnant; marked change in body hair distribution; difficulty in sexual function; other than listed:_____

Date of last menstrual period:_____ Number of pregnancies:_____ Number of live births:_____

Is it possible that you are pregnant:_____ If so, please notify the Doctor.

Neurological: Severe or frequent headaches; unusual head or neck tension; strokes; dizziness; fainting spells; seizures; fits or convulsions; shaking or twitching spells; paralysis of limbs; frequent or constant numbness or tingling of parts of body; severe lapses of memory; blackouts; other than listed:_____

Emotional or Psychological: Emotional illness; depression; recurrent feelings of loneliness or hopelessness; excessive worry; severe tension; feelings of worthlessness; recurrent fear; nervous exhaustion; frequent crying; insomnia; nervous breakdown; frequent nightmares; hysterical attacks; constant unhappiness; other than listed:_____

Work Compensation Claim or Litigation Involving Illness or Injury: Prior, present, pending or anticipated?_____

If so, please explain:_____

Other Medical or Surgical Conditions Not Already Listed: Include hospitalizations not previously noted:_____

Family History: Please complete the following and enter all medical conditions of each person. Refer to "List of Conditions" under Past History Section and also add any orthopedic conditions or symptoms that you now have and any member of your family has not or did have.

	Deceased or living	Age now or at time of death	Medical conditions including cause of death, if deceased
Father			
Mother			
Brothers			
(list)			
Sisters			
(list)			
Children			
(list)			

□ Married □ Single □ Divorced □ Widowed

Spouse's name:_____ Years Married:_____

Please indicate your approximate use or intake of the following:

Coffee:_____

Tabacco Products:_____

If not presently, have you ever smoked in the past?_____ When did you quit? _____

Other Recreational Drugs, Toxic or Potentially Harmful Substances:_____

Alcohol use per week?_____

Occupation:_____ Do you enjoy your job:_____

Type of physical activity at work:_____

Have you ever been on disability?_____

Last grade completed or degree (i.e. 12 grade, college degree, masters):_____

Hobbies:_____

PACIFIC PAIN MEDICINE CONSULTANTS
PATIENT REGISTRATION

Patient Information:

Name:_____ Date of Birth_____ Age:_____ Sex:_____

Address:_____ City:_____ State:_____ Zip:_____

Preferred Phone #:_____ Alternate Phone #: _____

□ check box if ok to leave a voice message □ check box if ok to leave a voice message

Social Security #:_____ Marital Status:_____ Spouse's Name:_____

Race:_____ Ethnicity:_____ Language: _____ Email:_____

Employer:_____ Phone:_____ Address:_____

Referring Physician:_____ Primary Care Physician:_____

Responsible Party Information:

Name:_____ Relationship:_____ Social Security #:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Employer:_____

Employer Address:_____ City:_____ State:_____ Zip:_____

Work Comp Patient Information:

Claim #:_____ Adjuster:_____ Adjuster Phone #:_____

Date of Injury:_____ Work Comp Carrier:_____

Work Comp Address:_____ City:_____ State:_____ Zip:_____

Insurance Information:

Primary Insurance:_____ Phone:_____

Address:_____ City:_____ State:_____ Zip:_____

Subscriber:_____ Relationship:_____

Policy or ID #:_____ Group #:_____

Secondary Insurance:_____ Phone:_____

Address:_____ City:_____ State:_____ Zip:_____

Subscriber:_____ Relationship:_____

Policy or ID #:_____ Group #:_____

Relative NOT living in same household or local contact:

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____

Attorney:_____

Name:_____

City:_____ State:_____ Zip:_____

Phone:_____

PAYMENT OF FEES IS YOUR RESPONSIBILITY AND IS EXPECTED AT THE TIME OF SERVICE. Private insurance patients: Many insurance companies are now requiring prior authorization before procedures and/or second opinions for surgery. Please know if your insurance requires this. In the event you need surgery or hospitalization, you will need to let us know if this is required. Assignment of insurance benefits and release of information: My signature below authorizes the doctor or physician's assistant to release all or any part of my medical records to hospitals, other doctors, medical service companies, insurance companies, worker's compensation carrier or welfare agencies. I hereby authorize my insurance company/fund to pay benefits to Pacific Pain Medicine Consultants, Pacific Surgery Center, Dr. Robert E. Wailes, and or associates. I understand that I am financially responsible for any amounts not covered by the insurance. Disclosure: Dr. Wailes has a financial interest in the Pacific Surgery Center. Please feel free to ask Dr. Wailes any questions you may have about this.

_____

SIGNATURE: **DATE:**

PACIFIC
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ROBERT E. WAILES, M.D.
NATHAN A. PERRIZO, D.O.
JEREMY A. ADLER, MS, PA-C
MICHAEL E. DAVIS, PA-C
LAWRENCE OWUSU, PA-C

Patient Acceptance of Financial Responsibility

Pacific Pain Medicine (PPM) will bill your insurance company for services rendered as a courtesy. However, you are ultimately responsible for all charges for services rendered. In the event services rendered are not covered by your insurance company, we will require that you remit payment to PPM.

Your insurance company may require an authorization or pre-certification for certain procedures, services, drugs and supplies. We will contact your insurance company for authorization for services. It is your responsibility to understand what your insurance policy covers and assure that you have authorization for services. We may request your assistance in following up on our authorization requests and delayed insurance payments. Your assistance in contacting your insurance company will often facilitate a more timely approval of services, prevent delays in treatment, and expedite payment for your services.

We are not contracted or affiliated with the following insurance plans and networks:

- Aetna PPO (excluding Medicare Advantage Plans)
- Beech Street PPO Network
- Interplan Corporation
- Multiplan
- PHCS
- Premier Provider Network
- Great West Life
- Pacific Health Alliance
- GEHA
- Medi-Cal
- CMS
- San Diego City Schools
- Humana (excluding Medicare Advantage Plans
- **All Covered California Plans**

APPOINTMENT POLICY

You will be charged the following fee for missed appointments (no show) or failure to give 24-hours notice of cancellation or re-scheduling of your appointment or procedure.

- New Patient Visit: $50
- Follow-Up Visit: $25
- Procedure/Surgery: $100 (Out-Patient Surgery Center)

Please print your name and sign below indicating you accept and acknowledge our appointment policy and received notification of our non-contracted insurance plans and networks.

Print Patient Name: _____ Patient Signature & Date _____

PACIFIC PAIN MEDICINE CONSULTANTS
477 N El Camino Real, Suite B-301, Encinitas, CA 92024
3998 Vista Way, Suite 108, Oceanside, CA 92056

Acknowledgement of Receipt of Notice

Candace Irons (760) 753-1104 Privacy Officer

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Yes No (circle one) I would like to receive a copy of any amended Notice of Privacy Practices

by e-mail at: _____

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate your relationship to the patient:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

Name of Patient: _____

I authorize Pacific Pain Medicine to discuss the below indicated topics with the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

- ☐ Billing related topics, including balance, payments and inquires.
- ☐ Prescriptions and dosage.
- ☐ Appointments, pre-op instructions, post-op calls.
- ☐ Medical Records

Please note if a family member or attorney requests the above information without your written authorizations or a subpoena we will not release any of the above information.

***For Office Use Only*:**

- ☐ Signed form received by: _____
- ☐ Acknowledgment refused:

Efforts to obtain: _____

Reasons for refusal: _____

Patient Rights and Responsibilities

Pacific Surgery Center has adopted the following lists of Rights and Responsibilities for Patient

Patient Rights:

- Exercise these rights without regard to sex or culture, economic, educational, or religious background or the source of payment for his/her care.
- Treated with respect, consideration and dignity.
- Provided with appropriate personal privacy, care in a safe setting, and free from all forms of abuse and harassment.
- Knowledge of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians who will see him/her.
- Receive information from his/her physician about his/her illness; his/her course of treatment and his/her prospects for recovery in terms that he/she can understand.
- Receive as much information from his/her physician about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse this course of treatment. Except in emergencies this information shall include a description of the procedure or treatment, the medically significant risks involved in each and to know the name of the person who will carry out the procedure or treatment.
- Actively participate in decisions regarding his/her medical care to the extent permitted by law, this includes the right to refuse treatment or change his/her primary physician.
- Disclosures and records are treated confidentially, except when required by law, patients are given the opportunity to approve or refuse their release.
- Information for the provision of after-hour and emergency care.
- Information regarding fees for service, payment policies and financial obligations.
- The right to decline participation in experimental or trial studies.
- The right to receive marketing or advertising materials that reflects the services of the Centers in a way which is not misleading.
- The right to express their concerns and receive a response to their inquires in a timely fashion.
- The right to self-determination including the right to accept or to refuse treatment and the right to formulate an Advance Directive.
- The right to know and understand what to expect related to their care and treatment.

Patient Responsibilities:

- Provide complete and accurate information to the best of his/her ability about his/her health, any medications, including over-the-counter products and dietary supplements and any allergies or sensitivies.
- Ask for explanation if you do not understand papers you are asked to sign or anything about your own care.
- Gather as much information as you need to make informed decisions.
- Be available so staff can reach you on how to care for yourself; we want to share our knowledge with you, but you must be prepared to learn.
- Follow the care prescribed or recommended to you by the physicians, nurses, and other members of the health care team; remember, if you refuse treatment or do not follow instructions, you are responsible for your actions.
- Respect the rights and privacy of others.
- Assure the financial obligations associated with your care are fulfilled.
- Responsible for being respectful of his/her personal property and that of other persons in the Center.
- Take an active role in ensuring safe patient care. Ask questions or state concerns while in our care. If you don't understand, ask again.
- Provide a responsible adult to trtansport you home from the facility and remain with you for 24-hours, if required by your provider.
- Inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.

Patient Concerns and/or Grievances:

- Patients who have a concern or grievance regarding Pacific Surgery Center, including but not limited to, decisions regarding admission, treatment, discharge, denial of services, quality of services, courtesy of personnel or any other issue are encouraged to contact the Clinic Director or write a state to: Clinical Director, Pacific Surgery Center 3998 Vista Way, Suite 106, Oceanside, CA 92056.
- Medicare patients should visit the CMS website to understand your rights and protections. Visit: *www.cms.gov/*

Advance Directives:

- An "advanced Directive" is a general term that refers to your oral and written instructions about your future medical care, in the event that you become unable to speak for yourself. Each state regulates the use of advance directives differently. There are two types of advance directives: a living will and medical power of attorney. If you would like a copy of the official State advance directive forms, visit: *ag.ca.gov/consumers/pdf/AHCDS1.pdf*

Directive Policy:

- The majority of procedures performed at the Pacific Surgery Center are considered to be minimal risk, of course, no surgery is without risk. You and your surgeon will have discussed the specifics of your procedure and the risk associated with your procedure, the expected recovery and the care after your surgery. It is the policy of the Pacific Surgery Center, regardless of the contents of any advance directive or instructions from a health care surrogate or attorney in fact, that if an adverse event occurs during your treatment at the Surgery Center, the personnel at the Surgery Center will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, advance directive, or health care power of attorney.

Physician Disclosure:

- Dr. Wailes has a financial interest in Pacific Surgery Center. Please feel free to ask Dr. Wailes any questions you may have about this.

Patient Statement:

I received information on patient rights, patient responsibilities, physician disclosure, advance directive policy and grievance policy at least one day in advance of my surgery.

_____

PATIENT NAME

_____ _____

PATIENT SIGNATURE DATE

PACIFIC
PAIN MEDICINE
CONSULTANTS

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 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

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)	HIV Diagnosis/Treatment	_____(initial)
Psychiatric/Mental Health	_____(initial)	Genetic Information	_____(initial)
Tests for Antibodies to HIV	_____(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*

_____ _____
Patient's Name (PRINT) Date

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

_____ _____
Witness name Witness signature

Rev Nov 2013