



**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.

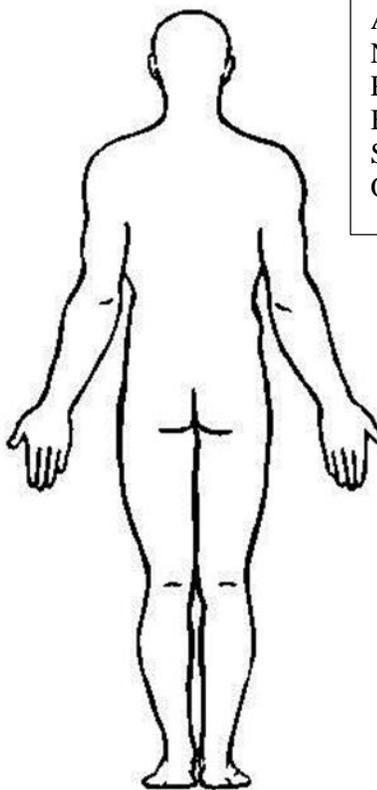
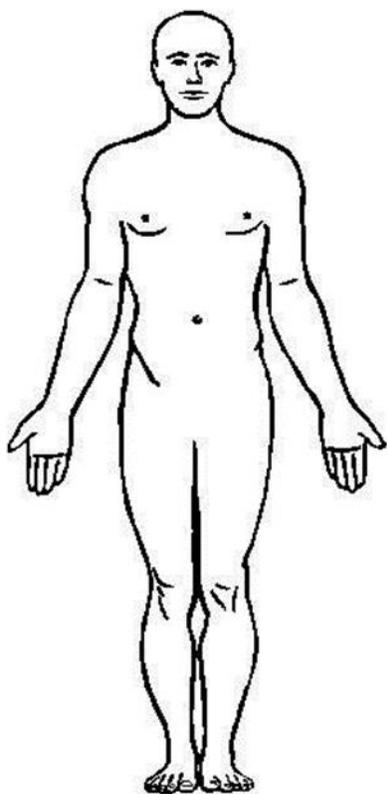
Please feel free to call our office if you need any assistance. Our main telephone number is (760) 753-1104.

Best wishes for a healthy future,

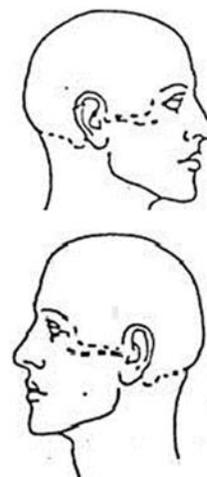
Robert E. Wailes, M.D.  
Medical Director

**PATIENT HISTORY FORM**

1. Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_
2. What problem are you here for today? \_\_\_\_\_
3. Date of onset (first episode): \_\_\_\_\_ Work related?  Yes  No
4. Explain how the pain started (i.e. suddenly or gradually)? \_\_\_\_\_
5. How did this happen? (please be specific) \_\_\_\_\_  N/A
6. How often have you been experiencing this pain? (circle) constant, frequent, intermittent, other \_\_\_\_\_
7. Have you had prior surgery for this or a similar problem?  Yes  No \_\_\_\_\_
8. Recently, is your pain getting better, worse or about the same? \_\_\_\_\_ Time frame? \_\_\_\_\_
9. Location of most significant pain: \_\_\_\_\_
10. Does your pain radiate/travel to another body region?  Yes  No Where? \_\_\_\_\_
11. Using the symbols given below, mark the areas on your body where you have your chief pain complaint.



Aching	▲▲▲▲
Numbness	====
Pins & Needles	0000
Burning	XXX
Stabbing	///
Other	●●●



12. How would you break down the components of your pain? (Total to equal 100%)

Head: _____%	Abdomen: _____%	Pelvis: _____%
Neck: _____%	Lt. Arm: _____%	Rt. Arm: _____%
Back: _____%	Lt. Leg: _____%	Rt. Leg: _____%
Other: _____%		

PATIENT HISTORY FORM

Name: \_\_\_\_\_ Date: \_\_\_\_\_

13. What does the pain feel like? (i.e. burning, aching, stabbing, throbbing, etc.) \_\_\_\_\_
14. Do you have numbness or tingling? \_\_\_\_\_ If yes, where? \_\_\_\_\_
15. Does the affected extremity feel weak? \_\_\_\_\_ If yes, where? \_\_\_\_\_
16. Does the pain wake you at night? \_\_\_\_\_
17. Are you able to control urination?  Yes  No Are you able to control bowels?  Yes  No
18. What makes your pain **WORSE**? (Circle any that apply) Walking, standing, sitting, laying down, lifting, rotation, coughing, loud noises, bright lights, smells, other \_\_\_\_\_
19. What makes your pain **BETTER**? (Circle any that apply) Walking, standing, sitting, laying down, or other \_\_\_\_\_
20. Please describe what activities are being limited by your pain? \_\_\_\_\_
21. Please describe your average daily/weekly exercise /activity level \_\_\_\_\_
22. Do you currently have difficulties with any of the following? Walking, dressing, bathing, grooming, household activities? \_\_\_\_\_
23. List any assistive devices that you utilize i.e. cane, wheelchair, walker, back brace, etc. \_\_\_\_\_
24. Have you had X-rays? \_\_\_\_\_ If yes, when & where? \_\_\_\_\_
25. Have you had a C.T. scan? \_\_\_\_\_ If yes, when & where? \_\_\_\_\_
26. Have you had a MRI scan? \_\_\_\_\_ If yes, when & where? \_\_\_\_\_
27. What other tests have you had regarding this problem? \_\_\_\_\_

**Please circle the most accurate score with each question: (0=no pain 10=worst pain imaginable)**

Worst pain in the last 24 hours? 0 1 2 3 4 5 6 7 8 9 10

Least pain in the last 24 hours? 0 1 2 3 4 5 6 7 8 9 10

What is the average pain you 0 1 2 3 4 5 6 7 8 9 10

How satisfied are you with your pain treatments/medications? 0 1 2 3 4 5 6 7 8 9 10  
Not at all Completely

**Recently, how much has your pain interfered with the following? 0 = Does not interfere 10= Completely interferes**

General activity? 0 1 2 3 4 5 6 7 8 9 10

Mood? 0 1 2 3 4 5 6 7 8 9 10

Walking Ability? 0 1 2 3 4 5 6 7 8 9 10

Normal work? 0 1 2 3 4 5 6 7 8 9 10

Personal Relationships? 0 1 2 3 4 5 6 7 8 9 10

Sleep? 0 1 2 3 4 5 6 7 8 9 10

Enjoyment of Life? 0 1 2 3 4 5 6 7 8 9 10

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Medications: Please indicate CURRENT and PREVIOUS pain medication therapies and results:**

Check if currently taking. Check if the medication was helpful or not helpful and list any side effects you experienced.

	Currently Taking	Helpful	Not Helpful	Side Effects (if any)
<b>Anti-inflammatory</b>				
<input type="checkbox"/> Ibuprofen (Motrin, Advil)				
<input type="checkbox"/> Naproxen (Naprosyn, Aleve, Naprelan)				
<input type="checkbox"/> Diclofenac (Lodine, Voltaren)				
<input type="checkbox"/> Meloxicam (Mobic)				
<input type="checkbox"/> Celecoxib (Celebrex)				
<b>Short Acting Opioids</b>				
<input type="checkbox"/> Codeine (Tylenol #3, #4)				
<input type="checkbox"/> Tramadol (Ultram)				
<input type="checkbox"/> Tapentadol (Nucynta)				
<input type="checkbox"/> Hydrocodone (Vicodin, Norco)				
<input type="checkbox"/> Oxycodone (Percocet, Roxicet, Endocet)				
<input type="checkbox"/> Oxymorphone (Opana IR)				
<input type="checkbox"/> Hydormorphone (Dilaudid)				
<input type="checkbox"/> Morphine (MS IR)				
<input type="checkbox"/> Fentanyl (Actiq, Fentora, Subsys, Abstral)				
<b>Long Acting Opioids</b>				
<input type="checkbox"/> Tramadol (Ultram ER, Conzip)				
<input type="checkbox"/> Buprenorphine (Butrans)				
<input type="checkbox"/> Morphine SR (MS Contin, Kadian)				
<input type="checkbox"/> Oxycodone CR (Oxycontin, Xartemis)				
<input type="checkbox"/> Fentanyl patch (Duragesic)				
<input type="checkbox"/> Hydrocodone (Zohydro)				
<input type="checkbox"/> Hydormorphone (Exalgo)				
<input type="checkbox"/> Oxymorphone (Opana ER)				
<input type="checkbox"/> Methadone (Dolophine, Methadose)				
<input type="checkbox"/> Buprenorphine/Naloxone (Suboxone)				
<input type="checkbox"/> Tapentadol (Nucynta ER)				
<b>Muscle Relaxants</b>				
<input type="checkbox"/> Cyclobenaprine (Flexeril, Amrix)				
<input type="checkbox"/> Metaxalone (Skelaxin)				
<input type="checkbox"/> Methocarbamol (Robaxin)				
<input type="checkbox"/> Baclofen				
<input type="checkbox"/> Tizanidine (Zanaflex)				
<input type="checkbox"/> Carisoprodol (Soma)				
<b>Anti-Neuropathics</b>				
<input type="checkbox"/> Gabapentin (Neurontin, Gralise, Horizant)				
<input type="checkbox"/> Pregabalin (Lyrica)				
<input type="checkbox"/> Topiramate (Topamax)				
<input type="checkbox"/> Tegretol/Trileptal				
<b>SNRIs</b>				
<input type="checkbox"/> Duloxetine (Cymbalta)				
<input type="checkbox"/> Venlafaxine (Effexor)				
<input type="checkbox"/> Milnacipran (Savella)				

	Currently Taking	Helpful	Not Helpful	Side Effects
<b>Adjuvants</b>				
<input type="checkbox"/> Amitriptyline (Elavil)				
<input type="checkbox"/> Nortriptyline (Pamelor)				
<input type="checkbox"/> Desipramine (Norpramin)				
<input type="checkbox"/> Imipramine (Tofranil)				
<b>Topical patches and creams</b>				
<input type="checkbox"/> Lidocaine (Lidoderm)				
<input type="checkbox"/> Diclofenac (Flector, Pennsaid, Voltaren)				
<input type="checkbox"/> Compounded creams				
<b>Migraines medications</b>				
<input type="checkbox"/> Ergotamine (Cafergot)				
<input type="checkbox"/> Midrin				
<input type="checkbox"/> Sumatriptan (Imitrex, Sumavel)				
<input type="checkbox"/> Rizatriptan (Maxalt)				
<input type="checkbox"/> Frovatriptan (Frova)				
<input type="checkbox"/> Naratriptan (Amerge)				
<input type="checkbox"/> Fioricet/Fiorinal				
<input type="checkbox"/> Cambia				
<input type="checkbox"/> BOTOX ®				
<b>Other</b>				
<input type="checkbox"/>				

**Please indicate previous pain therapy:**

	Relief					N/A
	Worse	None	Mild	Moderate	Profound	
Heat or Ice: _____	-1	0	1	2	3	<input type="checkbox"/>
Physical Therapy: _____	-1	0	1	2	3	<input type="checkbox"/>
TENS (neurostimulator): _____	-1	0	1	2	3	<input type="checkbox"/>
Home exercises: _____	-1	0	1	2	3	<input type="checkbox"/>
Biofeedback: _____	-1	0	1	2	3	<input type="checkbox"/>
Psychological counseling: _____	-1	0	1	2	3	<input type="checkbox"/>
Chiropractic treatments: _____	-1	0	1	2	3	<input type="checkbox"/>
Acupuncture/Acupressure: _____	-1	0	1	2	3	<input type="checkbox"/>
Massage: _____	-1	0	1	2	3	<input type="checkbox"/>
Injections: What type: _____	-1	0	1	2	3	<input type="checkbox"/>
Surgery: _____	-1	0	1	2	3	<input type="checkbox"/>

**Have you been evaluated by:**

Orthopedic surgeon?	YES	NO	Name: _____
Rheumatologist?	YES	NO	Name: _____
Psychiatrist?	YES	NO	Name: _____
Psychologist?	YES	NO	Name: _____
Neurologist?	YES	NO	Name: _____
Pain Management?	YES	NO	Name: _____
Neurosurgeon?	YES	NO	Name: _____
Other specialist?	YES	NO	Name: _____

PATIENT HISTORY FORM

Name: \_\_\_\_\_ Date: \_\_\_\_\_

*This medical history can be of critical importance to you and your provider. Please complete it to the best of your ability.*

**PAST MEDICAL HISTORY:** List current and past medical diagnoses

Neurologic: (i.e. Migraines, Stroke, Seizures, Neuropathy, etc.) \_\_\_\_\_

Respiratory: (i.e. COPD, Asthma, Sleep Apnea, etc.) \_\_\_\_\_

Cardiac: (i.e. High Blood Pressure, Heart Attack, Arrhythmia, CHF, etc.) \_\_\_\_\_

Gastrointestinal: (i.e. Ulcers, IBS, Colitis, Hepatitis, Liver Disease, etc.) \_\_\_\_\_

Kidney: (i.e. Renal Failure, Renal Stones, etc.) \_\_\_\_\_

Rheumatologic: (i.e. Rheumatoid Arthritis, Lupus, Fibromyalgia) \_\_\_\_\_

Orthopedic: (i.e. Osteoporosis, Osteoarthritis, etc.) \_\_\_\_\_

Cancer: \_\_\_\_\_

Bleeding: (i.e. Blood Clots, Anemia) \_\_\_\_\_

Endocrine: (i.e. Diabetes, Thyroid disease, Hormone Abnormalities, Low Testosterone, etc.) \_\_\_\_\_

Dermatologic: (i.e. Shingles, Psoriasis, Eczema, etc.) \_\_\_\_\_

Psychologic: (Depression, ADHD, Schizophrenia, Bipolar, Substance Abuse, etc.) \_\_\_\_\_

Infectious Diseases: (MRSA, VRE, etc.) \_\_\_\_\_

**PAST SURGICAL HISTORY:** Please list any operations and indicate the approximate date or your age at the time of the procedure.

Operation:

Date:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**MEDICATION ALLERGIES:** (Please include iodine or x-ray contrast)

Medication:

Effect (i.e., hives, swelling, itching):

_____	_____
_____	_____
_____	_____

**MEDICATIONS:** List all medications (including non-prescription) which you are taking now. Give dose and frequency. (*check bottle if necessary.*) **Please print**

Medication / Drug:

Amount or Dose:

Frequency:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT HISTORY FORM

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Are you taking any blood thinning medications? Please check the appropriate box

- Coumadin (Warfarin)
- Plavix (Clopidogrel)
- Aggrenox (Dipyridamole/ASA)
- Lovenox (Enoxaparin)
- Fragmin (Dalteparin)
- Heparin

- Ticlid (Ticlopidine)
- Arixtra (Fondaparinux)
- Pletal (Cilostazol)
- Effient (Prasugrel)
- Pradaxa (Dabigatran)
- Xarelto (Rivaroxaban)

Not taking any blood thinners

- Agrylin (Anagrelone)
- Elmiron (Pentosan)
- Reopro (Abciximab)
- Trental (Pentoxifyline)
- Brilinta (Ticagrelor)
- Aspirin

Have you ever stopped the medication for a procedure in the past?  Yes  No

Which provider is currently prescribing the blood thinner for you? \_\_\_\_\_

ADDITIONAL HISTORY

1. Do you have a history of Substance abuse?
  - a. Alcohol  Yes  No
  - b. Prescription Drugs (taken for non medical purpose)  Yes  No
  - c. Illegal Drugs  Yes  No
2. History of preadolescent sexual abuse?  Yes  No
3. Do you have suicidal thought?  Yes  No
4. Are you a danger to yourself or others?  Yes  No

SOCIAL HISTORY

Married  Single  Divorced  Widowed

Spouse's name: \_\_\_\_\_

Living situation (alone, with family, nursing facility, etc.) \_\_\_\_\_

Please indicate your approximate use or intake of the following:

Coffee: \_\_\_\_\_ cups/day

Tobacco Use:  Cigarettes/Cigar/Pipe  E-Cig/Vape  Smokeless Tobacco  Never Used Tobacco/Smoked

Current Smoker/Tobacco user \_\_\_\_\_ per day  Former Smoker When quit? \_\_\_\_\_

Recreational Drugs, Toxic or Potentially Harmful Substances (Methamphetamine, Heroin, Cocaine, Ecstasy, Others)

Never  Former  Current Substances Used \_\_\_\_\_

Marijuana Use:  Recreational  Medicinal Last use: \_\_\_\_\_  Never used

Alcohol Use: # Alcohol drinks per week? \_\_\_\_\_  Beer  Wine  Liquor

Have you ever had a DUI?  Yes  No Have you ever considered your drinking problematic?  Yes  No

Have you ever been in a drug or alcohol treatment program?  Yes  No

Have you ever attended?  AA  NA  Alanon

Do you currently attend?  AA  NA  Alanon # meetings per week? \_\_\_\_\_

Have you ever taken controlled medications that were not prescribed to you?  Yes  No

PATIENT HISTORY FORM

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Occupation:  Current  Former \_\_\_\_\_ Do you enjoy your job: \_\_\_\_\_

Type of physical activity at work: \_\_\_\_\_

Have you ever been on disability? \_\_\_\_\_

Hobbies: \_\_\_\_\_

**Work Compensation Claim or Litigation Involving Illness or Injury:** Prior, present, pending or anticipated? \_\_\_\_\_

If so, please explain: \_\_\_\_\_

**SLEEP HISTORY**

Do you snore?  Yes  No

Are you excessively tired during the day?  Yes  No

Have you been told that you stop breathing or gasp of breath during sleep?  Yes  No

Do you use a CPAP machine during sleep?  Yes  No

**LIFESTYLE**

Explain your activity level on an average day: \_\_\_\_\_

**FAMILY HISTORY:** Please mark an "X" in the appropriate boxes for each person.

PROBLEM	Grandfather	Grandmother	Father	Mother	Son(s)	Daughter(s)	Sibling
Diabetes							
Heart Disease							
Cancer							
Neurological Diagnosis							
Rheumatologic							
Chronic Pain							
Fibromyalgia							
Mental Illness							
Alcohol abuse							
Illicit Drug abuse							
Prescription Drug abuse							
Suicide							

PATIENT HISTORY FORM

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**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** Diabetes, Anemia, bleeding disorder, blood clots, phlebitis, psoriasis or other skin problem, osteoporosis, arthritis, neck pain, low back pain, sciatica, HIV/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, others: \_\_\_\_\_

**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, others: \_\_\_\_\_

**Cardiovascular:** Chest pain, abnormal or fast heartbeat, high/low blood pressure, calf cramps with walking, excessive sensitivity of fingers & toes to cold, varicose veins, frequent swelling of ankles & feet, rheumatic fever, heart murmur, heart attack, others: \_\_\_\_\_

**Gastrointestinal:** digestion difficulties, frequent nausea or vomiting, bloody vomit, lack of appetite, frequent stomach or abdominal pain, frequent belching, frequent loose bowel movement/diarrhea, blood in the stool, hemorrhoids, gallbladder trouble, frequent or severe constipation, diabetes, hepatitis, jaundice, ulcers, hiatal hernia, pancreatitis, others: \_\_\_\_\_

**Neurological:** Severe or frequent headaches, strokes, dizziness, fainting spells, seizures, convulsions, tremors or twitching, paralysis of limbs, frequent or constant numbness or tingling of parts of body, severe lapses of memory, other than listed: \_\_\_\_\_

**Genital-Urinary:** urinary incontinence or dribbling, blood in urine, increased frequency of urination, urgency of urination, difficulty starting or passing urine, painful urination, flank pain, excess urine, others: \_\_\_\_\_

**Genital-Urinary (Male patients):** Penile pain, infection or sores, abnormality of testicles, scrotal swelling, varicocele, prostatitis, stricture, sterility, difficulty in sexual functioning, others: \_\_\_\_\_

**Genital-Urinary (Female patients):** Breast lumps, pain or infection, nipple changes or irritation or discharge, 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, painful intercourse, others: \_\_\_\_\_

Date of last menstrual period: \_\_\_\_\_ # of pregnancies: \_\_\_\_\_ # of live births: \_\_\_\_\_

Is it possible that you are pregnant:  Yes  No Do you plan to become pregnant in the next few months?  Yes  No

**Psychological:** Do you have a history of any of the following (circle all that apply): Emotional illness, depression, constant unhappiness, recurrent feelings of loneliness or hopelessness, feelings of worthlessness, frequent crying, recurrent fear, severe tension, excessive worry, nervous breakdown, panic attacks, insomnia, frequent nightmares, others: \_\_\_\_\_

**What are your pain management goals?** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PACIFIC PAIN MEDICINE CONSULTANTS  
PATIENT REGISTRATION

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**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: \_\_\_\_\_

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**Responsible Party Information:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Employer: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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**Work Comp Patient Information:**

Claim #: \_\_\_\_\_ Adjuster: \_\_\_\_\_ Adjuster Phone #: \_\_\_\_\_  
Date of Injury: \_\_\_\_\_ Work Comp Carrier: \_\_\_\_\_  
Work Comp Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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**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 #: \_\_\_\_\_

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**Relative NOT living in same household or local contact:**

Name: _____	Attorney: _____
Address: _____	Name: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Phone: _____	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.

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**SIGNATURE:**

**DATE:**

## **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:**

- 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)

## **APPOINTMENT POLICY**

**You will be charged the following fee for missed appointments (no show or late arrival) or failure to give 24-hours notice of cancellation or re-scheduling of your appointment or procedure. Payment in full is due prior to your next appointment.**

- 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 inquiries 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 sensitivities.
- 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 transport 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/](http://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/AHCDSI.pdf](http://ag.ca.gov/consumers/pdf/AHCDSI.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