PACIFIC
PAIN MEDICINE
CONSULTANTS

ROBERT E. WAILES, M.D.
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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 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 with you. If you have X-rays, CT Scans or MRI's pertaining to your pain conditions, please bring the report and actual films with you to your initial consultation.

If you are being referred for a procedure (i.e. an 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.

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

477 N El Camino Real, Suite B-301, Encinitas, CA 92024
3998 Vista Way, Suite 108, Oceanside, CA 92056
Phone: (760) 753-1104 Fax: (760) 943-6494
www.pacificpainmed.com

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.

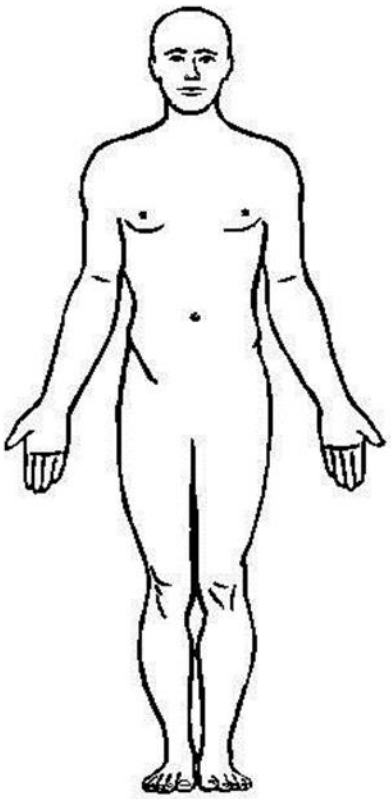
_____

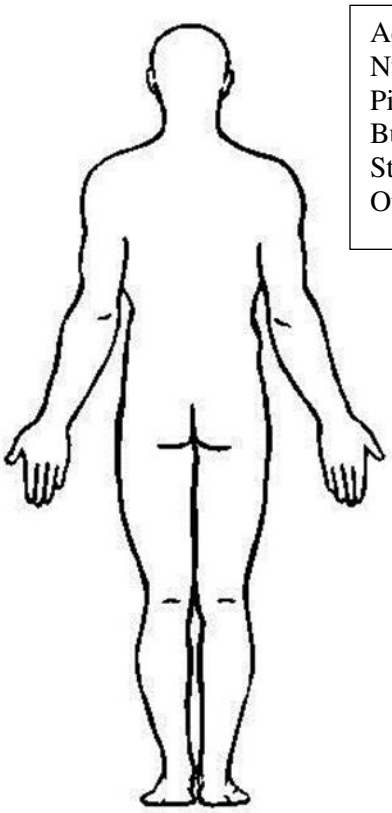
SIGNATURE: **DATE:**

PACIFIC PAIN MEDICINE CONSULTANTS

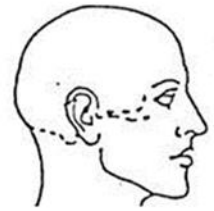
PATIENT HISTORY FORM

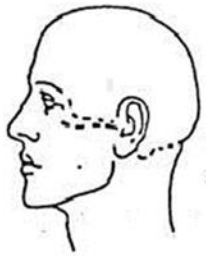
1. Name:_____ Date:_____ Age:_____Ht:_____Wt:_____
2. What problem are you here for today?_____
3. Date of onset (first episode):_____ Work related? □ **Yes** □ **No**
4. Explain how the pain started (i.e. suddenly or gradually)?_____
5. How did this happen? (please be specific)_____□ N/A
6. How often 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	0 0 0
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 <u>WORSE</u>? (Circle any that apply) Walking, standing, sitting, laying down, lifting, rotation, coughing, loud noises, bright lights, smells, other_____
19. What makes your pain <u>BETTER</u>? (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)

<u>Worst</u> pain in the last 24 hours?	0	1	2	3	4	5	6	7	8	9	10
<u>Least</u> pain in the last 24 hours?	0	1	2	3	4	5	6	7	8	9	10
What is the <u>average</u> pain you	0	1	2	3	4	5	6	7	8	9	10
How satisfied are you with your pain treatments/medications?	0 Not at all	1	2	3	4	5	6	7	8	9	10 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)
Anti-inflammatory				
□ Ibuprofen (Motrin, Advil)				
□ Naproxen (Naprosyn, Aleve, Naprelan)				
□ Diclofenac (Lodine, Voltaren)				
□ Meloxicam (Mobic)				
□ Celecoxib (Celebrex)				
Short Acting Opioids				
□ Codeine (Tylenol #3, #4)				
□ Tramadol (Ultram)				
□ Tapentadol (Nucynta)				
□ Hydrocodone (Vicodin, Norco)				
□ Oxycodone (Percocet, Roxicet, Endocet)				
□ Oxymorphone (Opana IR)				
□ Hydormorphone (Dilaudid)				
□ Morphine (MS IR)				
□ Fentanyl (Actiq, Fentora, Subsys,				
Long Acting Opioids				
□ Tramadol (Ultram ER, Conzip)				
□ Buprenorphine (Butrans)				
□ Morphine SR (MS Contin, Kadian)				
□ Oxycodone CR (Oxycontin, Xartemis)				
□ Fentanyl patch (Duragesic)				
□ Hydrocodone (Zohydro)				
□ Hydormorphone (Exalgo)				
□ Oxymorphone (Opana ER)				
□ Methadone (Dolophine, Methadose)				
□ Buprenorphine/Naloxone (Suboxone)				
□ Tapentadol (Nucynta ER)				
Muscle Relaxants				
□ Cyclobenaprine (Flexeril, Amrix)				
□ Metaxalone (Skelaxin)				
□ Methocarbamol (Robaxin)				
□ Baclofen				
□ Tizanidine (Zanaflex)				
□ Carisoprodol (Soma)				
Anti-Neuropathics				
□ Gabapentin (Neurontin, Gralise,				
□ Pregabalin (Lyrica)				
□ Topiramate (Topamax)				
□ Tegretol/Trileptal				
SNRIs				
□ Duloxetine (Cymbalta)				
□ Venlafaxine (Effexor)				
□ Milnacipran (Savella)				

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

Please indicate previous pain therapy:

	Relief					
	Worse	**None**	**Mild**	**Moderate**	**Profound**	**N/A**
Heat or Ice:_____	-1	0	1	2	3	□
Physical Therapy: _____	-1	0	1	2	3	□
TENS (neurostimulator): _____	-1	0	1	2	3	□
Home exercises:_____	-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	□
Massage:_____	-1	0	1	2	3	□
Injections: What type:_____	-1	0	1	2	3	□
Surgery:_____	-1	0	1	2	3	□

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.) _____

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 <u>taking now</u>. 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 □ Not taking any blood thinners

□ Coumadin (Warfarin) □ Ticlid (Ticlopidine) □ Agrylin (Anagreline)

□ Plavix (Clopidogrel) □ Arixtra (Fondiparinux) □ Elmiron (Pentosan)

□ Aggrenox (Dipyridamole/ASA) □ Pletal (Cilostazol) □ Reopro (Abciximab)

□ Lovenox (Enoxaparin) □ Effient (Prasugrel) □ Trental (Pentoxifyline)

□ Fragmin (Dalteparin) □ Pradaxa (Dabigatran) □ Brilinta (Ticagrelor)

□ Heparin □ Xarelto (Rivaroxaban) □ 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, Heroine, Cocaine, Ecstacy, 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							

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? _____

_____

_____

_____

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CONSULTANTS

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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.

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)

OPEN PAYMENT DATABASE

The Open Payments database is a federal tool used to search payment made by drug and device companies to physicians, physician assistants, advanced practice nurses and teaching hospitals. For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public at https://openpaymentsdata.cms.gov.

Please print your name and sign below indicating you accept and acknowledge our appointment policy and received notification of the Open Payment Database, Sunshine Act.

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: http://www.cms.hhs.gov/center/ombudman.asp/
  Local CMS office Contact info: 7575 Metropolitan Drive, Suite 104, San Diego, CA 92108 Telephone # 619-278-3700

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: http://www.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 & Dr. Perrizo has a financial interest in Pacific Surgery Center. Please feel free to ask Dr. Wailes any questions you may have about this.
- NPI number: 1154362630

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 _____

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:_____ to release information on
Physician/Healthcare Facility
_____(Patient's Name)_____(Patient's DOB)
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: _____
Physician/Healthcare Facility
_____
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)
Psychiatric/Mental Health	_____(initial)
Tests for Antibodies to HIV	_____(initial)
HIV Diagnosis/Treatment	_____(initial)
Genetic Information	_____(initial)

DURATION:

This authorization shall be effective immediately and remain in effect

until_____.

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.

_____	_____
Patient Signature or *legal representative*	Relationship *if other than*
_____	_____
Patient's Name (PRINT)	Date
_____	_____
Patient's Social Security Number	Patient's Date of Birth
_____	_____
Witness name	Witness signature