KIUMARS ARFAI, M.D.
MEDICAL CORPORATION
Dedicated to a Multidisciplinary Approach to Pain Management

375 Rolling Oaks Dr. Ste. 200
Thousand Oaks, CA 91361
Tel: (818) 359-8833 Fax: (877) 727-9225

19871 Nordhoff St.
Northridge, CA 91324
Tel: (818) 359-8833 Fax: (877) 727-9225

PATIENT INFORMATION

Today's date: ____________________________

First Name: ______________________________ Last Name: ____________________ Middle I: ___

Date of Birth: ________/________/________ Gender:_______________ Age: ________________

Marital Status: ___________________________ Social Security Number: ______-_______-______

Home Address: ___________________________City:_______________ State: ______ Zip:________

Home Phone: (____)__________________ Cell: (___)_______________ Work: (___)____________

Email Address: ____

Referring Physician: __________________________ Address: _______________________________

City: ______________ State: _______ Zip:_______ Tel:(___)_____________ Fax: (____)_________

Primary Care Physician: ______________________ Address: _______________________________

City: ______________ State: _______ Zip:_______ Tel:(___)_____________ Fax: (____)_________

INSURANCE INFORMATION:

Primary Insurance: ___________________________ Group Number: _________________________

Policy Number: ______________________________ Insurance Phone: (___)___________________

Secondary Insurance: _________________________ Group Number: _________________________

Policy Number: ______________________________ Insurance Phone: (___)___________________

EMERGENCY CONTACT:

Name:_______________________________________ Relationship: ___________________________

Phone Number: (___)________________________Alternate Number: (___)___________________

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Name____ Date ________________________________

Age ___________ Job Description____

Please answer the following questions to the best of your ability.

1. Where is your pain? ____
2. How and when did your pain start? ____
3. Did you have similar pain problems before your current one? Please explain:
____
4. Please describe your pain: ☐ Constant ☐ Intermittent ☐ Dull ☐ Throbbing ☐ Sharp ☐ Stabbing ☐ Shooting ☐ Burning
   Indicate with an "x" your level of pain 0____10.
   Numbness ☐ Yes ☐ No If yes, where: ____
   Weakness ☐ Yes ☐ No If yes, where: ____
5. What aggravates your pain? ____
6. What relieves your pain? ____
7. Have you had any of the following tests done? ☐ MRI ☐ CT Scan
   ☐ X-ray ☐ EMG ☐ Bone Scan ☐ Other: ____
8. Have you had treatments for your pain? ☐ Medications ☐ Epidural Injections ☐ Nerve Blocks
   ☐ Physical Therapy ☐ TENS Unit ☐ Acupuncture
9. Did your previous treatments help? ☐ Yes ☐ No
10. Do you sleep well at night? ☐ Yes ☐ No _______Interrupted ______ Uninterrupted
11. Are you frustrated with the pain?
    ☐ Yes ☐ No
12. Are you depressed?
    ☐ Yes ☐ No
13. How is the stress in your life?
    ☐ Average ☐ Above ☐ Below
14. Do you have suicidal thoughts?
    ☐ Yes ☐ No If yes, state the last time: _____________
15. Have you attempted suicide?
    ☐ Yes ☐ No
16. Do you now see, or have you seen a psychiatrist/psychologist?
    ☐ Yes ☐ No If so, why? _________________________
17. Are you married?
    ☐ Yes ☐ No Number of children? _________________
18. Do you smoke cigarettes?
    ☐ Yes ☐ No How many cigarettes per day? _________
19. Do you drink alcohol?
    ☐ Yes ☐ No How many drinks per day? __________

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20. Do you now use, or have you ever used illicit drugs?
 ☐ Yes ☐ No If yes, which drugs? ____
21. Do you have any problems with any of the following: ☐ Heart ☐ Lungs ☐ Stomach/Ulcer
 ☐ Kidneys ☐ Diabetes ☐ High Blood Pressure ☐ Liver ☐ Stroke ☐ Cholesterol
 ☐ Thyroid ☐ Other: ____

Review of Systems (please circle all that apply):

Weight Loss	Weight Gain	Fever	Chills	Rash
Itching	Blurred Vision	Headache	Neck Pain	Cough
Shortness of Breath	Chest Pain	Pain on Urination	Pelvic Pain	Nausea
Vomiting	Constipation	Blood in Stools	Dark Tarry Stools	Tender Muscles
Weakness Arms/Hands	Dizziness	Loss of Balance	Depression	Anxiety
Poor Sleep		Other:		

22. List all previous surgeries and give approximate dates: ____

____

23. List all your current medications and dosages: ____

____

____

24. List all other medications tried previously for pain: ____

____

25. List all medications to which you are allergic: ____
26. Are you presently working? ☐ Yes ☐ No
27. Are you receiving disability benefits? ☐ Yes ☐ No
28. Workers' Compensation Benefits? ☐ Yes ☐ No
29. Are you currently involved in any legal action or proceeding? ☐ Yes ☐ No

Additional Comments:

____

____

____

PLEASE DO NOT WRITE BELOW THIS LINE

History:

____

____

____

____

VS: HT: ______ WT: ______ BP:_______ P: ________ Temp: _______ R: _______

KIUMARS ARFAI, M.D.
MEDICAL CORPORATION

NOTICE OF PRIVACY PRACTICES
PROTECTED HEALTH INFORMATION

All patient information including but not limited to written, typed, faxed or electronic correspondence, billing, demographic, and all medical records and charts will be physically and electronically protected in order to maintain patient privacy and confidentiality and to protect unauthorized access to that information.

ALL physicians and staff members will implement the following policies and procedures:

1. All patient information will be maintained in the medical record chart and the chart will be kept in a lockable file cabinet with lockable doors with limited key access.

2. Medical charts, notes, billing information, schedules and any other form of patient information will not be left within view of or accessible by unauthorized persons.

3. All physician and staff confidential conversations regarding patients are to take place, to the maximum extent possible, only in areas that cannot be overheard by unauthorized persons.

4. Computer data integrity will be maintained with firewall and virus protection software, regular backups of information and by limited access with password protection by only authorized personnel.

5. Patient medical information, photographs or images will not be released without the written consent of the patient or legal guardians.

6. Patient information may be released without prior consent for purposes such as: treatment, to report abuse, neglect, domestic violence, public health risks, to obtain payment for treatment, communication with family members if necessary or to report reactions to medications or products.

7. Patients have the right to inspect and receive a copy of their medical records and to request an amendment to their records. Although the health care provider has the right to deny inclusion of an amendment, the patient has the right to file a "Statement of Disagreement" which will then become part of the patient's record.

Patients at this medical office are provided with this NOTICE OF PRIVACY PRACTICES and will be asked to sign an acknowledgement that will become part of the patient's medical records.

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" NOTICE OF PRIVACY PRACTICES" ACKNOWLEDGEMENT FORM

I acknowledge that I have access to a copy of the HIPAA approved "Notice of Privacy Practices."

I further acknowledge that the office "Notice of Privacy Practices" is available on the office website at www.KiumarsArfaiMD.com and at the front desk upon request.

______________________________ ______________________
Patient Signature Date

____
Print Name

____
Signature of Patient Representative
(Required if patient is a minor or an adult unable to sign this form)

AWARENESS SHEET

POTENTIAL OPIATE SIDE EFFECTS/RISKS

You MUST be aware that opiates/narcotics have the potential for significant side effects which include:

1. **Persistent constipation**. This is likely to occur. Taking medications to prevent this problem are recommended and will be available through your prescribing doctor. Please avoid the intake of bulk-forming medications such as Metamucil.

2. **Nausea and vomiting**. If this complaint becomes consistent and appears on a regular basis, notify your doctor.

3. **Excessive drowsiness and sedation**. It is VERY IMPORTANT for you and your family to pay attention to this potential side effect. It may seriously affect your CAPACITY TO DRIVE or to operate dangerous machinery. AT THE FIRST sign of significant sedation, please stop driving or operating dangerous equipment, and performing potentially hazardous activities (swimming alone, etc.). There are medications to treat this side effect, but they need to be discussed with your prescribing doctor before taking them.

4. Other potential side effects include pruritus (itching), decreased sexual performance, mood changes and insomnia.

5. Be aware that ALL opiates/ narcotics have the potential to create **physical dependence and/or addiction**. Physical dependence means that once started on these medications your body may "get used" to them and if stopped abruptly they may provoke a withdrawal syndrome which is NOT life-threatening but can be quite uncomfortable (flu-like symptoms, abdominal cramps, diarrhea, anxiety, etc.) and may last for a few days. Addiction means the psychological "craving" for these drugs. Addiction is rare in individuals who are taking pain medication for medical reasons. It is more common in individuals who have a preexisting problem of addiction to drugs or alcohol. If you have a history of addiction you must inform your physician immediately.

6. Please take your medications the way they are prescribed. DO NOT change the schedule, break tablets in half or take extra doses, unless this is part of a preestablished plan. Failure to take your medication as prescribed may lead to **respiratory depression, cardiac arrest, and death**.

________________________________ ____________________

Patient Signature Date

________________________________ ____________________ ______________

Print Name Date Birth Date

<u>OFFICE POLICY</u>

PAYMENT IS DUE WHEN SERVICE IS RENDERED: We will bill most insurance companies for you as a courtesy, provided we have all the necessary information. It is your responsibility to verify with your insurance carrier as to whether you are covered for the medical services provided to you, e.g. physician consults, epidurals, facet blocks, IDET. Any deductibles, co-payments, or balances not paid by the insurance company are your financial responsibility. This applies to all insurances including Medicare.

CO-PAYMENTS AND DEDUCTIBLES ARE DUE WHEN SERVICES ARE RENDERED: Insured patients are responsible for all charges not paid by the insurance company within 45 days after the date of service. Payment arrangements can be made on an individual basis AT OUR DISCRESTION. We reserve the right to withdraw the extension of credit.

CANCELLATION POLICY: Patients who fail to cancel an appointment within 24 hours of the appointment time will be subject to a $50.00 fee billed directly to the patient.

RETURNED CHECKS POLICY: <u>PLEASE BE ADVISED THERE IS A SERVICE FEE OF $25.00 ON ALL RETURNED CHECKS.</u>

PATIENT AGREEMENT AND ASSIGNMENT OF INSURANCE BENEFITS: 1 agree to pay reasonable attorney's fees and costs should legal proceedings be necessary to collect any portion of the bill or to enforce this agreement. also agree to permit my Physician to consult with any other Physician should he/she believe it necessary and I agree to pay for said consult. If any surgical procedures are to be performed, I authorize my Physician to engage the services of another Physician and I. agree to pay for said services. I hereby authorize my Physician to release any information acquired in the course of my examination and treatment. I further authorize payment of insurance benefits to be paid directly to my Physician.

AGREEMENT TO DISCLOSE INFORMATION: 1 hereby state that my ailment, injury(ies), etc., are not due to any type of personal injury, motor vehicle accident, etc., for which I am seeking damages. I agree that if at any time after receiving treatment as a direct result of any type of motor vehicle accident or personal injury, I will disclose this information to Mission Hills Pain Management and sign the appropriate lien(s) in favor of Mission Hills Pain Management, Kiumars Arfai, M.D. and staff. I understand that the disclosure of insurance and other information is necessary in order that the services I receive are paid in full. The non-disclosure of the information to Mission Hills Pain Management pertaining to my legal case for said injury might make me personally responsible for all charges incurred at Mission Hills Pain Management.

CONSENT TO TREATMENT. I understand that the treatment to be received by me at Mission Hills Pain Management will be administered only upon full and complete disclosure of benefits, potential risks, and complications of said treatments, and that my informed consent to the treatment to be received by me will be obtained prior to my receiving said treatment. The medical doctors working at Mission Hills Pain Management are not employed by Mission Hills Pain Management. Each of the physicians working at Mission Hills Pain Management uses his or her independent medical judgment when providing you with medical care. 'I'he physician seeing you and not Mission Hills Pain Management is responsible for the medical care you receive at Mission Hills Pain Management.

I declare under penalty of perjury under the laws of the State of California that I have read the foregoing, that I understand it, and that by executing this document on this _______day ___________ of 20____ , in the City of _________________, I accept and agree to its contents.

Patient's Signature:____ Date of Birth:_________________________

Print Name:____Date: _____________________________________

Parent/Guardian:____Date:___________________________________

MEDICATION MANAGEMENT AGREEMENT

This Agreement between__________________, ("Patient") and ("Doctor") is for the purpose of establishing an agreement between Doctor and Patient on clear conditions for the prescription and use of pain controlling medications prescribed by the Doctor for the Patient. Doctor and Patient agree that this Agreement is an essential factor in maintaining the trust and confidence necessary in a doctor/ patient relationship.

The Patient agrees to and accepts the following conditions for the management of pain medication prescribed by the Doctor for the Patient:

I understand that a reduction in the intensity of my pain and an improvement in my quality of life are the goals of this program.

I realize that all medications have potential side effects.

I realize that it is my responsibility to keep myself and others from harm, including the safety of my driving. If there is any question of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform the activity.

I will not attempt to get pain medication from any other health care provider. If my primary care physician is willing to prescribe my medications, the Doctor will make arrangements to transfer my care to my primary care physician.

I will safeguard my medication from loss or theft and agree that the consequence of my failure to do so is that I will be without my prescribed medication for a period of time.

I understand that it is my responsibility to schedule and keep a follow-up appointment with my doctor for all medication refills. Medications will not be refilled over the phone or on a walk-in basis. Refills will not be made if you run out early.

Refills will not be made on an emergency basis.

I agree that I will submit to a blood or urine test if requested by my Doctor to determine my compliance with my regimen of pain control medication.

I agree that I will use my medication at a rate no greater than the prescribed rate and that use of my medication at a greater rate will result in my being without medication for a period of time.

Doctor and Patient agree that this Agreement is essential to the Doctor's ability to treat the Patient's pain effectively and that failure of the Patient to abide by the terms of this Agreement may result in the withdrawal of all prescribed medication by the Doctor and the termination of the Doctor/ Patient relationship.

This agreement is entered into on this _______________ day of ______________, 20____.

________________________________ ______________________________________

Patient Signature Kiumars Arfai, M.D.

________________________________ ______________________________________

Print Name Witness

____

Birth Date