1100 Paseo Camarillo
Camarillo, CA 93010
T: 805-484-8558

Dear Valued Patient,

Thank you for choosing the Spanish Hills Interventional Pain Specialists (SHIPS). As Interventional Pain Specialists, we believe that each patient's pain is unique and should be treated as such. SHIPS physicians utilize a variety of treatment modalities, such as: Physical Therapy, Injection Therapies, Pain Pumps, Pain Stimulators, and Oral Medications.

In order to best serve our patients, SHIPS requires that all new patients complete the "New Patient Packet" (NPP) so that we may adequately evaluate and generate treatment plans. The NPP must be completed in its entirety for SHIPS physicians to begin treatment. New patients will also be required to complete a functional questionnaire. This questionnaire may be administered multiple times throughout the course of treatment, as it allows SHIPS physicians to monitor patient progress. The NPP and questionnaire must be completed prior to the initial consultation; patients will be considered late if paperwork is not completed prior to scheduled appointment time and may need to be rescheduled.

Late/Missed Appointment Policies

SHIPS patients are required to arrive on time for all appointments. Patients who arrive late for visits cannot expect or demand to be seen. Late patients may be placed on a waiting list to be seen if an appointment allocation becomes available. All patients who arrive on time will be seen prior to late patients. Patients who arrive 15 minutes or later will be rescheduled to the next available appointment time. Patients on medication should take extra care to arrive on time; no prescriptions will be written without a physician appointment.

Should you need to cancel or reschedule your appointment, SHIPS requires a minimum of 24 hours notice. Patients are expected to keep their scheduled appointments; a $25 no-show fee will be charged for missed appointments without advance notice. No-show fees are due at the date of the next appointment, and patients will not be able to see the physician without making payment. Insurance companies do not cover fees for missed appointments.

Patient Information Updates

Patients are required to provide SHIPS with any updates or changes to patient information. These updates include, but are not limited to, insurance policy, address, phone number, and medication lists. SHIPS regularly contacts patients by phone and cannot provide adequate service (including appointment reminders) without up-to-date contact information.

Billing Information and Policies

SHIPS payments are dependent on services rendered and insurance coverage. Co-payments are dependent solely on insurance coverage ("Specialist" fee). New cash patients are required to pay a $300 consultation fee, $50 urine screen fee. All follow up visits are $100 fee, and $50 fee for each urine screen. Urinalysis fees must be paid when prompted; urine screens are mandatory in SHIPS medication management. Please be prepared to pay the entire amount at each visit.

I hereby authorize SHIPS to release my medical information to necessary insurance companies for the sole purpose of obtaining payment for care. I hereby assume financial responsibility for all charges incurred for services rendered not covered by my insurance company. I understand that I will be required to pay co-payments, amounts applied to deductibles, and balances of bills not paid in accordance with benefits of my insurance. If I am unable to make payment in full within in 30 days of treatment, I agree to call the billing company, HBBS, at 805-786-4878 to make payment arrangements.

I certify that the information I have reported regarding my insurance coverage is correct and current. I authorize SHIPS to verify insurance coverage and benefits allowed in accordance with my insurance company.

I hereby authorize payment for all medical insurance benefits which are payable under the terms of my insurance policy to be paid directly to Spanish Hills Interventional Specialists or designates for services rendered.

Random Urine Drug Screening (UDS)
SHIPS new patients, and existing patients who are being prescribed medications are required to submit to random urine screening as per the narcotics agreement when prompted by their physician. SHIPS may elect to not release prescriptions without obtaining a current urine sample. Patients with questions or concerns may address their physician during their scheduled appointment. All samples will be tested in the office, and may be sent to a secondary lab for confirmation screening.

Medical Records
SHIPS requires that patient records be obtained before the initial consultation. It is the responsibility of the patient to ensure that all pertinent medical records are obtained from existing/past physicians. Furthermore, it is the responsibility of the patient to verify that medical records pertinent to their treatment at SHIPS are sent in a timely manner to our office. This is required throughout the entire course of treatment.

For copies of medical records at SHIPS, there is a $15 flat fee plus $0.25 per page. Patients may assess what they would like to have copied. Payment must be made upon record pick-up. Records processing may take up to 14 days; it is the patient's responsibility to request the records at the appropriate time.

Prior Authorization Requests/Disability Forms/Other Forms:
All paperwork requests for medication prior authorizations, disability forms etc., may be completed for a $50 fee. Paperwork or online processing will be completed within 7 days of receipt of said form. Fees must be paid prior to form being filled out, or online forms submitted.

I, _____, agree to the above outlined policies and requirements of the Spanish Hills Interventional Pain Specialists practice. I understand that my continued treatment is dependent on compliance with all office policies and physician orders.

_____ _____

Patient Signature **Date**

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give consent for **the physicians** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

(The Notice of Privacy Practices provided by **the physicians** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **The physicians** reserve the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **the physicians**.

With this consent, **the physicians** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test, results, among others.

With this consent, **the physicians** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **the physicians** may email to my home any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request **the physicians** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **the physicians** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **the physicians** may decline to provide treatment to me.

Please complete the following information:

Primary Phone: _____ **Cell Phone: _____**

E-Mail Address: _____

Please indicate any people that you give us permission to leave your health information with.

Name: _____ **Relation: _____**

Name: _____ **Relation: _____**

Name: _____ **Relation: _____**

*Note: We cannot guarantee that cell phone calls are confidential due to the nature of this type of communication.

_____ _____

Patient or Legally Authorized Individual Signature **Date**

_____

Relationship to Patient if Signed by Anyone Other Than Patient

Notice to Consumers Regulation

Medical doctors (M.D.) are licensed and regulated by the Medical Board of California.
(800) 633-2322 www.mbc.ca.gov

I understand that the physician is licensed and regulated by the board.

_____ _____

Patient or Legally Authorized Individual Signature **Date**

_____

Relationship to Patient if Signed by Anyone Other Than Patient

Patient Information

Thank you for choosing SHIPS! In order to serve you properly, we need the following information. Please print and use pen. All information will be confidential.

Date_____ Patient Name_____ Patient #_____

SS # / SIN: _____ Gender: Male / Female Date of Birth: _____

Home Phone_____ Cell Phone_____ Email_____

Address_____ City_____ State_____ Zip_____

Circle appropriate status: Minor Single Married Divorced Widowed Separated

Patient's or parent/guardian's employer:_____ Work phone:_____

Business address: _____ City:_____ State:_____ Zip:_____

Spouse or parent/guardian's name_____ Employer_____ Work Phone_____

If patient is a student, name of school/college:_____ City:_____ State:_____

Whom may we thank for referring you?_____

Person to contact in case of emergency:_____ Relationship_____ Phone_____

Responsible Party

Name of person responsible for this account:_____ Relationship to Patient_____

Address_____ Home Phone_____

Email_____ Cell Phone_____

Driver license #_____ Birthdate_____ Financial Institution_____

Employer_____ Work Phone_____

Is this person currently a patient at our office? Yes No

Insurance Information

Name of insured_____ Relationship to patient_____

Birthdate_____ SS#/SIN_____ Date Employed_____

Name of Employer_____ Work Phone_____

Address of Employer_____ City_____ State_____ Zip_____

Insurance Company_____ Group #_____ Union or Local #_____

Ins. Co. Address_____ City_____ State_____ Zip_____

How much is your deductible?_____ How much have you used?_____ Max. annual benefit?_____

Do you have any additional insurance? (Yes/No) If yes, complete the following section:

Name of insured_____Relationship to patient_____

Birthdate_____SS#/SIN_____Date Employed_____

Name of Employer_____Work Phone_____

Address of Employer_____City_____State_____Zip_____

Insurance Company_____Group #_____Union or Local #_____

Ins. Co. Address_____City_____State_____Zip_____

How much is your deductible?_____How much have you used?_____Max. annual benefit?_____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X_____ _____

Signature of patient or parent/guardian if minor Date

NEW PATIENT QUESTIONNAIRE

Patient's Name: _____

Today's Date: _____Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Primary Care Physician:_____ Phone:_____

Referring physician: _____Phone:_____

Other physicians consulted:_____ Phone: _____

When did your pain start? _____

How did your pain start? ☐ Auto Accident ☐ After Surgery ☐ Fall (not at work) ☐ Work Related ☐ Other

Describe the problem:

_____

_____

_____

What does your pain ***feel like***? *(Check all that apply)*

☐ Constant ☐ Intermittent ☐ Sharp ☐ Dull/Aching ☐ Throbbing ☐ Gnawing ☐ Heavy Tender
☐ Stabbing ☐ Burning ☐ Electrical/Shooting ☐ Cramping ☐ Weakness ☐ Splitting/ Tiring
☐ Exhausting ☐ Sickening ☐ Fearful ☐ Punishing

Other, please describe: _____

Does the pain RADIATE anywhere? (Eg. left arm, leg, chest wall etc.)_____

What ***increases*** your pain? *(Check all that apply)*

☐ work ☐ walking ☐ lying down ☐ sitting ☐ coughing ☐ exercise ☐ standing ☐ sneezing

Other, please describe: _____

What ***decreases*** your pain? *(check all that apply)*

☐ not working ☐ walking ☐ heat ☐ medication ☐ exercising ☐ sitting ☐ lying down ☐ stretching
☐ TENS ☐ physical therapy ☐ standing ☐ resting ☐ cold ☐ injections

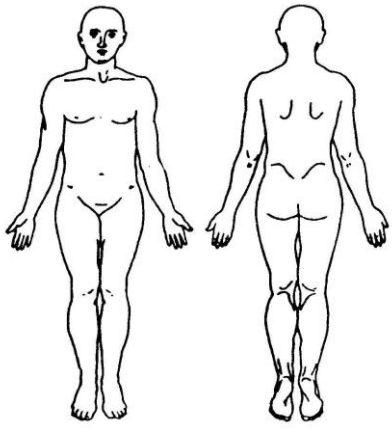
Other, please describe: _____

Do you have any numbness/tingling? ☐ Yes ☐ No
Do you have any weakness? ☐ Yes ☐ No
Does it keep you from falling asleep at night? ☐ Yes ☐ No
Do you have any changes in your bowel /bladder? ☐ Yes ☐ No
How often do you use the emergency room for pain control? _____

In the last 2-3 weeks, how often has your pain occurred?

☐ constant ☐ intermittent ☐ less than 8 hours a day ☐ 8-16 hours a day

PLEASE SHADE IN THE AREAS OF YOUR PAIN ON THE FIGURES BELOW.



Please indicate on a scale of 0-10 what level your pain is, 0 = no pain,
10 = unbearable pain

PRESENT PAIN
0 1 2 3 4 5 6 7 8 9 10
USUAL PAIN
0 1 2 3 4 5 6 7 8 9 10
LEAST SEVERE PAIN
0 1 2 3 4 5 6 7 8 9 10
WORST PAIN
0 1 2 3 4 5 6 7 8 9 10

NEW PATIENT QUESTIONNAIRE

Briefly List:

Treatments tried: _____

Injections tried: _____

Medications tried: _____

Physical therapy tried: _____

Have you had any previous?

□ CT scans -when _____ facility name _____
□ MRI-when _____ facility name _____
□ EMG -when _____ facility name _____
□ Bone scans -when _____ facility name_____

PLEASE HAVE THE REPORTS OF THESE STUDIES AVAILABLE WHEN YOU ARE SEEN

Past and Present Medical Problems:

High Blood Pressure	□ **YES** □ **NO**	Epilepsy	□ **YES** □ **NO**	Arthritis	□ **YES** □ **NO**
Chest Pain	□ **YES** □ **NO**	Emphysema	□ **YES** □ **NO**	Headaches	□ **YES** □ **NO**
Heart Attack	□ **YES** □ **NO**	Asthma	□ **YES** □ **NO**	Shingles	□ **YES** □ **NO**
Congestive Heart Failure	□ **YES** □ **NO**	Stomach Ulcers	□ **YES** □ **NO**	Lyme	□ **YES** □ **NO**
Diabetes	□ **YES** □ **NO**	Hepatitis	□ **YES** □ **NO**	Hypothyroid	□ **YES** □ **NO**
Stroke	□ **YES** □ **NO**	Cancer	□ **YES** □ **NO**	Other Issues:	□ **YES** □ **NO**

Please list **all surgeries** you have had:

DATE	SURGERY	PHYSICIAN

Do you use anticoagulants/blood thinners? □ Yes □ No - *(circle which one)*

Heparin: Coumadin Plavix Lovenox Xarelto Other: _____

Allergies:_____

Social History:

Do you smoke? □ Yes □ No _____ packs per day. If stopped, when? _____

Do you consume alcohol? □ Yes □ No Type: _____How much? _____

Have you ever felt you should cut down on your drinking? □ Yes □ No

Have people annoyed you by criticizing your drinking? □ Yes □ No

Have you ever felt bad or guilty about your drinking? □ Yes □ No

Do you consume caffeinated beverages? □ Yes □ No How many per day?_____

Do you take prescription pain medication? □ Yes □ No

If yes, do you take more than the prescribed amount □ Yes □ No

Do you use recreational drug(s)? □ Yes □ No

If yes, which drug(s)? _____For how long?_____

Are you, or have you ever been in recovery? □ Yes □ No If **YES** For how long?_____

Are you married? □ Yes □ No □ divorced □ widowed Do you live alone? □ Yes □ No

Are you a caregiver to anyone? □ Yes □ No

Is there someone at home who can help you with activities of daily living? □ Yes □ No

Occupational History:

Are you working? □ Yes □ No

Occupation and description of job:_____

NEW PATIENT QUESTIONNAIRE

If not working:

Date last worked: _____

Is your pain keeping you from working? □ Yes □ No

Do you feel you are able to return to work? □ Yes □ No

Who released you from work? _____

When are you scheduled to return?_____

Are you on Worker's Comp? □ Yes □ No Date started:_____

Are you on Disability? □ Yes □ No Date started:_____

What type of Disability do you have? □ short term □ long term □ social security □ other

What is the medical diagnosis for this disability? _____

Family History

Did/Does anyone in your family have chronic pain? □ Yes □ No_____

Did/Does anyone in your family have alcoholism/addiction history? □ Yes □ No_____

Do you have any blood relatives/children/siblings with significant medical problems? □ Yes □ No

Explain:_____

Behavioral Health

How has the pain affected your personality? Check all that apply:

□ no effect □ slightly upset □ moderately upset □ severely upset □ irritable □ anxious □ moody
□ withdrawn □ unmotivated

What stress has the pain caused you at home / work? _____

_____

_____

Are you depressed now? □ Yes □ No

Do you have thoughts of suicide? □ Yes □ No

Do you want to see a behavioral health specialist to help you deal with the pain? □ Yes □ No

Have you ever seen a counselor, psychologist, or psychiatrist? □ Yes □ No

Please include their name, date last seen, and office number._____

_____

What type of behavioral health treatment have you tried?

□ ECT □ Counseling □ Medication □ Group Therapy □ Biofeedback □ Other_____

Check any Health issues that apply to you.

Constitutional: □ weight loss □ excess fatigue □ chills □ fever □ night sweats □ loss of appetite

Eyes: □ glasses/contacts □ vision changes □ eye pain □ tearing

ENT/mouth: □ earache □ ringing in the ears □ hearing loss □ infections □ sore throat □ post nasal drip
□ bleeding gums

Cardiovascular: □ chest pain □ angina □ palpitations □ short of breath with activity □ heart murmur

Pulmonary: □ cough □ productive cough □ wheezing □ short of breath at rest □ asthma □ TB

Gastrointestinal: □ heartburn □ peptic ulcers □ nausea □ vomiting □ diarrhea □ constipation
□ bloating □ laxative use □ jaundice □ loss of bowel control

Urological: □ frequent urination □ urinary tract infection □ painful urination □ urinary retention
□ urinary dribbling □ loss of urinary control

Musculoskeletal: □ joint pain □ joint swelling □ joint stiffness □ muscle pain □ muscle stiffness

NEW PATIENT QUESTIONNAIRE

Endocrine: □ hot flashes □ hair loss □ always hot □ always cold □ always thirsty
Skin: □ itching □ rash □ infection
Blood: □ easy bruising □ easy bleeding □ anemia □ swollen lymph nodes
Immune compromise: □ AIDS □ steroid use □ frequent infections □ chemotherapy
Neurological: □ numbness □ tingling □ tremor □ fainting □ headaches □ weakness □ dizziness
Psychological: □ anxiety □ depression □ insomnia □ nightmares

For men only: do you have problems with erections? □ yes □ no
For women only: could you be pregnant now? □ yes □ no Date of last menstrual period _____

MEDICATION RECONCILIATION FORM

Name:				Allergic To:/Describe Reaction:		
Date of Birth:				Pharmacy Phone#:		
Information Source: □ Patient/Family □ Rx Bottles □ List of Medication □ MD/ MD Office □ Pharmacy						
Date Started	Medication	Dose	Route (Oral, IM?)	How Often	Reason for Taking	D/C Date

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○

 The SOAPP®-R was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

PainEDU.org
IMPROVING PAIN TREATMENT THROUGH EDUCATION

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

Please include any additional information you wish about the above answers.
Thank you.

PainEDU.org
IMPROVING PAIN TREATMENT THROUGH EDUCATION

Pain Disability Questionnaire

Patient Name:_____Date:_____

Instructions: These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and mark the ONE number on EACH scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?

   Work Normally — Unable to work at all

   0 1 2 3 4 5 6 7 8 9 10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?

   Take care of myself completely — Need help with all my personal care

   0 1 2 3 4 5 6 7 8 9 10

3. Does your pain interfere with your traveling?

   Travel anywhere I like — Only travel to see doctors

   0 1 2 3 4 5 6 7 8 9 10

4. Does your pain affect your ability to sit or stand?

   No problems — Cannot sit/stand at all

   0 1 2 3 4 5 6 7 8 9 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?

   No problems — Cannot do at all

   0 1 2 3 4 5 6 7 8 9 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop or squat?

No problems Cannot do at all

0 1 2 3 4 5 6 7 8 9 10

7. Does your pain affect your ability to walk or run?

No problems Cannot walk/run at all

0 1 2 3 4 5 6 7 8 9 10

8. Has your income declined since your pain began?

No decline Lost all income

0 1 2 3 4 5 6 7 8 9 10

9. Do you have to take pain medication everyday to control your pain?

No medication needed On pain medication throughout the day

0 1 2 3 4 5 6 7 8 9 10

10. Does your pain force you to see doctors much more often than before your pain began?

Never see doctors See doctors weekly

0 1 2 3 4 5 6 7 8 9 10

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?

No problem Never see them

0 1 2 3 4 5 6 7 8 9 10

12. Does your pain interfere with recreational activities and hobbies that are important to you?

No interference Total interference

0 1 2 3 4 5 6 7 8 9 10

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?

Never need help Need help all the time

0 1 2 3 4 5 6 7 8 9 10

14. Do you now feel depressed, tense, or anxious than before your pain began?

No depression/tension Severe depression/tension

0 1 2 3 4 5 6 7 8 9 10

15. Are there emotional problems caused by your pain that interfere with your family, social and or work activities?

No problems Severe problems

0 1 2 3 4 5 6 7 8 9 10

OFFICE USE ONLY

Functional: 1___ +2 ___ +3____ +4____ +5____+6 ____+7____+12____+13____ = _____

Psychosocial 8____ +9____ +10___+11___+14___+15____=_____

TOTAL=_____/150