Universal Pain Management
Patient Information Form

Patient Last Name_____First Name_____Middle Initial___
Mailing Address_____#_____City_____State_____Zip_____
Home Address_____#_____City_____State_____Zip_____
Home Phone Number_____Work Phone Number_____
Pager/Cell Phone Number _____ Alternative Phone Number _____
Email Address _____
Birth Date_____Social Security Number_____Sex: M / F Marital Status:_____

Reason for Visit: _____
_____
_____

Were you injured at work?: ☐ Yes ☐ No (If Yes, complete Form 1A)
Were you injured in an automobile accident? ☐ Yes ☐ No
Is this visit related to a Personal injury? ☐ Yes ☐ No

Employment Status: [ ] Full Time [ ] Part Time [ ] Unemployed [ ] Retired [ ] Disabled
Employer:_____

Primary Insurance Information:
Insurance Company Name_____
Address_____Phone Number_____
Group/Policy Number_____Identification Number_____
Guarantor Name_____ Relationship to insured: Self Spouse Child Other
Guarantor's Birth Date_____Guarantor's Social Security Number_____Sex: M / F

Secondary Insurance Information:
Insurance Company Name_____
Address_____Phone Number_____
Group/Policy Number_____Identification Number_____
Guarantor Name_____ Relationship to insured: Self Spouse Child Other
Guarantor's Birth Date_____Guarantor's Social Security Number_____Sex: M / F

Universal Pain Management Provider you are seeing today_____
Referring Physician (if any)_____ Phone Number_____
Primary Care Physician_____ Phone Number_____
Referring Patient (if any)_____

Person to be contacted in case of emergency_____
Phone Number_____Relationship_____

In signing this form you agree that all of the above is true and correct as of date signed. You also understand that we bill your insurance as a courtesy to our patients. If your insurance does not pay your claims for whatever reason, you understand that you are ultimately responsible for your bill. This does not apply to injury cases.

_____ _____
Patient or Patient Representative Signature Date

_____ _____
Witness Date

Universal Pain Management
Workers Compensation Information

Patient: _____ Date: _____

Referral Source: _____ Phone # _____

Address: _____ Fax #_____

Primary Treating Physician For Workers' Comp:_____
Address: _____

Phone #_____ Fax #_____

Claim # _____ Date of Injury: _____

Workers' Compensation Company:_____
*Address:*_____
Phone # _____ Fax # _____

Employer at Time of Injury: _____
Address: _____
Phone # _____ Fax# _____

Claims Adjustor: _____

Address: **_____**

Phone # _____ Fax #_____

Medical Case Manager: **_____**
Address: _____

Phone # _____ Fax #_____

Utilization Review Department: **_____**
Address: _____

Phone # _____ Fax #_____

Patient's Attorney: _____

Address: _____

Phone # _____ Fax #_____

Defense Attorney: _____

Address: _____

Phone # _____ Fax #_____

Universal Pain Management

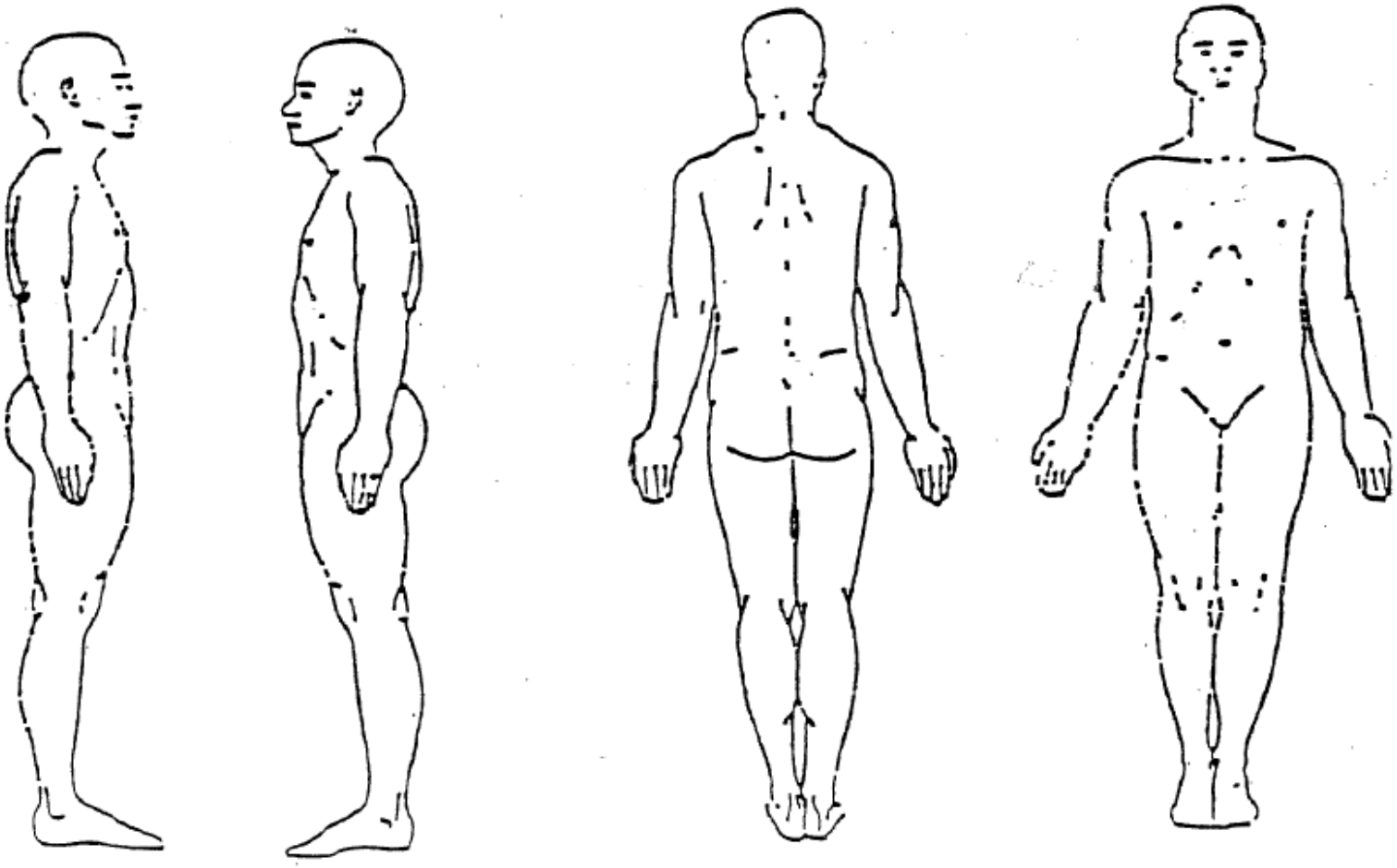
Name:_____Date:_____

Use the following scales to indicate how severe your pain is:

PAIN NO PAIN UNBEARABLE

A.	**When at its LEAST:**	**0**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
B.	**When at its WORST:**	**0**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
C.	**At PRESENT:**	**0**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Please indicate location(s) of your pain below:



Universal Pain Management
Initial Evaluation

How long have you had this pain? _____

Please circle the words that describe your pain:

ACHING	**SHOOTING**	**DULL**	**CONSTANT**
BURNING	**TINGLING**	**TIGHT**	**RADIATING**
CRAMPING	**HOT**	**HEAVY**	**ANNOYING**
NUMB	**COLD**	**INTENSE**	**SEVERE**
STINGING	**SORE**	**TRANSIENT**	**EXCRUIATING**

Please use a check mark to indicate if any of the following increases, decreases or causes no change in your pain?

	Increases Pain	Decreases Pain	No Change
Liquor	_____	_____	_____
Coffee	_____	_____	_____
Eating	_____	_____	_____
Heat	_____	_____	_____
Cold	_____	_____	_____
Dampness	_____	_____	_____
Weather Changes	_____	_____	_____
Physical Activity	_____	_____	_____
Massage	_____	_____	_____
Movement	_____	_____	_____
Sleep, Rest	_____	_____	_____
Lying Down	_____	_____	_____
Sitting	_____	_____	_____
Walking	_____	_____	_____
Sexual Intercourse	_____	_____	_____
Standing	_____	_____	_____
Distraction (TV etc.)	_____	_____	_____
Urination	_____	_____	_____
Bowel Movement	_____	_____	_____
Tension or Stress	_____	_____	_____
Bright Lights	_____	_____	_____
Loud Noises	_____	_____	_____
Fatigue	_____	_____	_____
Sneezing or Coughing	_____	_____	_____

UNIVERSAL PAIN MANAGEMENT
INITIAL EVALUATION

Have you had any operations for treatment of this problem?

TYPE OF OPERATION	DATE	RESULT

Please list all medications you are currently taking.

MEDICATION	DOSAGE	REASON TAKEN	HOW OFTEN	DOCTOR

Please list medications you have tried for this problem but are no longer taking.

MEDICATION	DOSAGE	BENEFIT: YES OR NO	WHY STOPPED

UNIVERSAL PAIN MANAGEMENT
INITIAL EVALUATION

Please check any of the following treatments you have had for this pain problem. Include the approximate dates and the results.

TREATMENT	YES	PAIN RELIEF: YES	NO	DATE DONE
NERVE BLOCKS	____	_____		_____
EPIDURAL STEROIDS	____	_____		_____
TENS UNIT	____	_____		_____
PHYSICAL THERAPY	____	_____		_____
TRACTION	____	_____		_____
ACUPUNCTURE	____	_____		_____
CHIROPRACTOR	____	_____		_____
PAIN CLINIC	____	_____		_____
PSYCHOLOGIST	____	_____		_____
HYPNOSIS, BIO-FEEDBACK	____	_____		_____
OTHER	____	_____		_____
_____	____	_____		_____
_____	____	_____		_____

Are you allergic to any medicines or foods? Please describe. Reaction?

_____

_____

Do you now, or have you ever had any other medical problems? (check each)

DIABETES	____	EPILEPSY	___
HIGH BLOOD PRESSURE	____	SHINGLES	___
HEART DISEASE	____	BOWEL PROBLEMS	___
VASCULAR PROBLEMS	____	ARTHRITIS	___
ASTHMA	___	OTHER	_____
EMPHYSEMA	___	OTHER	_____
KIDNEY PROBLEMS	___	OTHER	_____
AIDS OR HIV	___	OTHER	_____
LIVER DISEASE	___	OTHER	_____
STROKE	___	OTHER	_____

UNIVERSAL PAIN MANAGEMENT
INITIAL EVALUATION

Do you use tobacco? _____ If yes, how much? _____

Do you drink alcohol? _____ If yes, how much? _____

Do you have a medical marijuana card? Yes _____ No _____

Have you ever had a problem with abusing drugs or alcohol? _____
If yes, please describe.

Has anyone in your family had any serious illnesses? Please describe.

Are you currently taking any anticoagulants or blood thinners, such as Coumadin or Warfarin?

How do you spend your time during the day?

Have you ever been convicted for abuse, possession, or sale of narcotics? If yes, please explain below.

Are you currently on disability? If yes, which type of disability?

Is it possible you could be pregnant?

UNIVERSAL PAIN MANAGEMENT
INITIAL EVALUATION

REVIEW OF SYSTEMS

Please circle any of the symptoms, disease or problems you have had recently.

RASH
FEVER
CHILLS
SWEATS
DIZZINESS
BLURRY VISION
CHANGE IN HEARING
SWOLLEN GLANDS
SORE THROAT
COUGH
SHORTNESS OF BREATH
CHEST PAIN
PALPITATIONS
NAUSEA
VOMITING
DIARRHEA
BLOOD IN STOOL
BLOOD IN URINE
COUGHING UP BLOOD
PAIN ON URINATION
LOSS OF BOWEL CONTROL
LOSS OF BLADDER CONTROL
WEAKNESS
NUMBNESS
UNUSUAL LOSS OR GAIN OF WEIGHT
EASY BRUISING OR BLEEDING
TUBERCULOSIS
CANCER
STROKE
BRONCHITIS
HIV OR AIDS
SEIZURES
KIDNEY PROBLEMS

Have you traveled out of the country recently? If yes, where?

_____

Have you been exposed to any known toxins?

_____

Is there any additional information you think we should have?

_____

_____

_____

UNIVERSAL PAIN MANAGEMENT
INITIAL EVALUATION

Please indicate any diagnostic tests you have had, and the approximate date and location where they were performed.

	YES	DATE	LOCATION	BODY PART
X-RAYS	____	_____	_____	_____
EMG	____	_____	_____	_____
CAT SCAN	____	_____	_____	_____
MYELOGRAM	____	_____	_____	_____
DISCOGRAM	____	_____	_____	_____
MRI	____	_____	_____	_____
OTHER	____	_____	_____	_____

Marital Status: Married/Single/Widowed/Separated/Divorced

Education Level: _____

Have you ever had a work-related injury? Yes _____ No _____
If yes, what was the date of the injury: _____

Have you had an auto accident resulting in injury? Yes _____ No _____
If yes, what was the date of the accident: _____

UNIVERSAL PAIN MANAGEMENT
Pain Disability Index

The rating series below are designed to measure the degrees to which several aspects of your life are presently disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain on your life, not just when the pain is at its worst.

For each category, please *circle the number* which describes the level of disability you typically experience. A score of "0" means no disability at all, and a score of "10" means that all the activities in which you would normally be involved in have been totally disrupted or prevented by your pain.

1. Family/home responsibilities. Activities related to the home or family, including chores and duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school.)

   0 1 2 3 4 5 6 7 8 9 10

   No Disability Total Disability

2. Recreation. Hobbies, sports, and similar leisure time activities

   0 1 2 3 4 5 6 7 8 9 10

   No Disability Total Disability

3. Social Activity. Participation with friends and acquaintances *other than family members* including theater, dining out, and other social functions.

   0 1 2 3 4 5 6 7 8 9 10

   No Disability Total Disability

4. Occupation. Activities that are a part of or are directly related to one's including non-paying jobs such as that of a homemaker or volunteer work.

   0 1 2 3 4 5 6 7 8 9 10

   No Disability Total Disability

5. Sexual activity. This category refers to the frequency and quality of one's sex life.

   0 1 2 3 4 5 6 7 8 9 10

   No Disability Total Disability

6. Self Care. Activities of personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.).

   0 1 2 3 4 5 6 7 8 9 10

   No Disability Total Disability

7. Life support activities. Basic life support behaviors such as eating, sleeping, and breathing.

   0 1 2 3 4 5 6 7 8 9 10

   Life Disability Total Disability

Print Name: _____ Date: _____

Signature: _____

UNIVERSAL PAIN MANAGEMENT MEDICAL CENTER
SHORT FORM MCGILL PAIN QUESTIONNAIRE

For each word that applies to your pain, rate the intensity of that particular quality of pain.

DESCRIPTION	(0) None	(1) Mild	(2) Moderate	(3) Severe
1. Throbbing	___	___	____	____
2. Shooting	___	___	____	____
3. Stabbing	___	___	____	____
4. Sharp	___	___	____	____
5. Cramping	___	___	____	____
6. Gnawing	___	___	____	____
7. Hot, Burning	___	___	____	____
8. Aching	___	___	____	____
9. Heavy	___	___	____	____
10. Splitting	___	___	____	____
11. Tiring-Exhausting	___	___	____	____
12. Sickening	___	___	____	____
13. Fearful	___	___	____	____
14. Punishing-Cruel	___	___	____	____

Rate the intensity of your pain overall:

0	**No Pain**	_____
1	**Mild**	_____
2	**Discomfort**	_____
3	**Distressing**	_____
4	**Horrible**	_____
5	**Excruciating**	_____

On the following line indicate the intensity of your pain overall:

No Pain _____Worse possible pain

_____

Print Name

_____ _____

Signature **Date**

UNIVERSAL PAIN MANAGEMENT

NAME: **DATE:**

AGE: **SEX:** **OCCUPATION:**

Please describe how you have felt during the PAST WEEK by placing a check (✔) in the appropriate box. Do not think too long before answering.

	NOT AT ALL	A LITTLE/ SLIGHTLY	A GREAT DEAL/ QUITE A BIT	EXTREMELY/ COULD NOT HAVE BEEN WORSE
1. Feeling hot all over				
2. Sweating all over				
3. Dizziness				
4. Blurring of vision				
5. Feeling Faint				
6. Nausea				
7. Pain in Stomach				
8. Churning in Stomach				
9. Mouth becoming dry				
10. Neck muscles aching				
11. Legs feeling weak				
12. Muscles twitching & jumping				
13. Tense feelings across forehead				

SUBTOTAL:_____

On the following, put a check (✔) in the box according to how it relates to you and your feelings during the PAST WEEK or so.

	NONE OR A LITTLE OF THE TIME	SOME OF THE TIME	GOOD PART OF THE TIME	MOST OR ALL OF THE TIME
1. I feel down-hearted, blue & sad				
2. Morning is when I feel the best				
3. I have crying spells or feel like it				
4. I have trouble sleeping through the night.				
5. I eat as much as I used to.				
6. I enjoy looking at, talking to and being with attractive women/men				
7. I notice that I am losing weight.				
8. I have trouble with constipation.				
9. My heart beat faster than usual.				
10. I get tired for no reason.				
11. My mind is as clear as it used to be.				
12. I find it easy to do the things I used to.				
13. I am restless and can't keep still.				
14. I feel hopeful about the future.				
15. I am more irritable than usual.				
16. I find it easy to make decisions.				
17. I feel that I am useful and needed.				
18. My life is pretty full.				
19. I feel that others would be better off if I were dead.				
20. I still enjoy the things I used to do.				

SUBTOTAL:_____

TOTAL:_____

DISPOSITION:_____

Name: _____

Oswestry Low Back Pain Disability Questionnaire

Instructions

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem.

Section 1 –Pain Intensity

- ☐ I have no pain at the moment (0)
- ☐ the pain it very mild at the moment (1)
- ☐ The pain is moderate at the moment (2)
- ☐ The pain is fairly severe at the moment (3)
- ☐ The pain is very severe at the moment (4)
- ☐ The pain is worst imaginable at the moment (5)

Section 2 –Personal care (washing, dressing etc)

- ☐ I can look after myself normally without causing extra pain (0)
- ☐ I can look after myself normally but it causes extra pain (1)
- ☐ I can look after myself and I am slow and careful (2)
- ☐ I need some help but manage most of my personal care (3)
- ☐ I need help every day in most aspect of self-care (4)
- ☐ I do not get dressed, I wash with difficulty and stay in bed (5)

Section 3-Lifting

- ☐ I can lift heavy weights without extra pain (0)
- ☐ I can lift heavy weights but it gives extra pain (1)
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed eg. on a table (2)
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned. (3)
- ☐ I can lift very light weights (4)
- ☐ I cannot lift or carry anything at all (5)

- ☐ **Section 4-Walking***
- ☐ Pain does not prevent me from walking any distance. (0)
- ☐ Pain prevents me from walking more than 1 mile (1)
- ☐ Pain prevents me from walking more than 1/4 mile (2)
- ☐ Pain does not prevent me from walking more than 100 yards (3)
- ☐ I can only walk using a stick or crutches (4)
- ☐ I am in bed most of the time and have to crawl to the toilet (5)

Section 5 –Sitting

- ☐ I can sit in any chair as long as I like (0)
- ☐ I can only sit in my favorite chair as long as I like (1)
- ☐ Pain prevents me sitting more than 1 hour (2)
- ☐ Pain prevents me sitting more than 30 minutes (3)
- ☐ Pain prevents me sitting more than 10 minutes (4)
- ☐ Pain prevents me sitting at all (5)

Section 6 –Standing

- ☐ I can stand as long as I want without extra pain (0)
- ☐ I can stand as long as I want but it gives me extra pain (1)
- ☐ Pain prevents me from standing more than 1 hour (2)
- ☐ Pain prevents me from standing more than 30 minutes (3)
- ☐ Pain prevents me from standing more than 10 minutes (4)
- ☐ Pain prevents me from standing at all (5)

Section 7 – Sleeping

- ☐ My sleep is never disturbed by pain (0)
- ☐ My sleep is occasionally disturbed by pain (1)
- ☐ Because of pain I have less than 6 hours of sleep (2)
- ☐ Because of pain I have less than 4 hours of sleep (3)
- ☐ Because of pain I have less than 2 hours of sleep (4)
- ☐ Pain prevents me from sleeping at all (5)

Section 8 –Sex Life (if applicable)

- ☐ My sex life is normal and causes no extra pain (0)
- ☐ My sex life is nearly normal and causes some pain extra (1)
- ☐ My sex life is normal but is very painful (2)
- ☐ My sex life is severely restricted by pain (3)
- ☐ My sex life is nearly absent because of pain (4)
- ☐ Pain prevents any sex life (5)

Section 9 –Social Life

- ☐ My social life is normal and gives me no extra pain. (0)
- ☐ My social life is normal increases the degree if pain. (1)
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests eg. Sport (2)
- ☐ Pain has restricted my social life and I do not go out as often. (3)
- ☐ Pain has restricted my social life to my home. (4)

  I have no social life because of my pain. (5)

Section 10 -Traveling

- ☐ I can travel anywhere without pain. (0)
- ☐ I can travel anywhere but it gives me extra pain. (1)
- ☐ Pain is bad but I manage journeys over two hours. (2)
- ☐ Pain restricts me to journeys of less than one hour (3)
- ☐ Pain restricts me to short necessary journeys under 30 minutes. (4)
- ☐ Pain restricts me from traveling except to receive treatment. (5)

Universal Pain Management

A Comprehensive Approach to Pain and Rehabilitation

Patient's Name: _____

DOB: _____

READ CAREFULLY BEFORE SIGNING:

MEDICAL CONSENT: The patient is under the care of the attending physicians. The patient or patient's representative consent to any medical treatments or procedures, including invasive procedures (upon special consent), x-ray examinations, taking of medical photographs and laboratory procedures.

FINANCIAL AGREEMENT: The undersigned agrees, whether he/she signs as agent or as the patient, that in consideration of services to be rendered to the patient, he/she hereby individually obligates himself to pay the account of Universal Pain Management and all treating physicians in accordance with the regular posted rates and the terms of Universal Pain Management.

ASSIGNMENT OF BENEFITS: I do hereby assign irrevocably to Universal Pain Management, to the full extent permitted by law, all rights and benefits payable under any insurance policies providing coverage for medical services costs in an amount not to exceed the charges I incur to my Universal Pain Management account for services during the period of my treatment. I fully understand that I am primarily responsible to Universal Pain Management/physicians for the charges in addition to those charges not paid for under the assignment, and in the event the money is due or the benefits are not paid within sixty (60) days from the date of billing for payment. I will promptly make arrangements to pay the outstanding accounts in full.

A photocopy of this assignment is to be considered as valid as an original and revocable by me only in writing. I hereby authorize said assignees to release all information to secure payment.

AUTHORIZATION TO RELEASE MEDICAL RECORDS: I do hereby give my permission and consent to release any and all medical records to Universal Pain Management, upon request, and requested records be sent to Universal Pain Management within seven (7) days.

Signature	Witness
Signature of Patient's Representative	Relationship to Patient
Financial Guarantor	Name of Insurance Subscriber

PATIENT RIGHTS AND RESPONSIBILITIES
&
NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received information regarding Universal Pain Management's Patient Rights and Responsibilities & Notice of Privacy Practices:

_____ _____

Patient/Parent/Legal Guardian **Date**

_____

Relationship to Patient

Complete this section if patient does not sign above.

Documentation of Good Faith and Effort

The patient identified below was provided with information regarding UPM's Patient Rights and Responsibilities & Notice of Privacy Practices. A good faith effort has been made to obtain a written acknowledgement of the patient's receipt of the above-mentioned documents; however, acknowledgement was not obtained because:

☐ Patient refused to sign.
☐ Patient was unable to sign because: _____
☐ There was a medical emergency. UPM will attempt to obtain acknowledgement as soon as practical.
☐ Other reason: _____

Employee Signature: _____ Date: _____

819 Auto Center Drive, Palmdale, CA 93551 – Phone (661) 267-6876 Fax (661) 538-9483
28212 Kelly Johnson Pkwy, #155, Valencia, CA 91355 – Phone (661) 367-9788 Fax (661) 367-9789
16179 Siskiyou Rd, Apple Valley, CA 92307 – Phone (760) 241-0350 Fax (760) 243-0738
4835 Van Nuys Blvd, Suite 210, Sherman Oaks, CA – Phone (818) 850-ACHE (2243)
www.UniversalPain.com

UNIVERSAL PAIN MANAGEMENT
AUTHORIZATION FOR DISCLOSURE
OF PROTECTED HEALTH INFORMATION

Please complete this form in its entirety. Items not checked or blanks unfilled are assumed to be non-applicable or specifically not authorized for release. This release is not valid if it does not contain the patient's original signature and date signed or if it has expired as described below. A copy of this signed form will be provided to the patient.

I hereby authorize (name of provider/address):

_____

_____

_____

I hereby authorize any and all Pharmacies to release my prescription history.

To disclose the following information from the health records of:

Name: _____
Last First MI Previous Name

Birthdate: _____ Social Security #: _____

Telephone: (H)_____(Cell)_____ (W) _____

Address: _____
Street City State Zip

This information is to be disclosed to:

☐ 819 Auto Center Drive, Palmdale, CA 93551 – Phone (661) 267-6876 Fax (661) 538-9483

☐ 28212 Kelly Johnson Pkwy, #155, Valencia, CA 91355 – Phone (661) 367-9788 Fax (661) 367-9789

☐ 16179 Siskiyou Road, Apple Valley, CA 92307 – Phone (760) 241-0350 Fax (760) 243-0738

☐ 4835 Van Nuys Blvd, Suite 210, Sherman Oaks, CA – Phone (818) 850-ACHE (2243) Fax (661) 367-9789

Covering the periods of healthcare (Date(s) of service):

From (date)_____ to (date)_____**Present**_____

For the purpose of:_____
(Not required if the disclosure is requested by the patient)

The following information may be released:

_____

☐ **All information may be released**

UNIVERSAL PAIN MANAGEMENT MEDICAL CORPORATION
AUTHORIZATION FOR DISCLOSURE
OF PROTECTED HEALTH INFORMATION

I understand that this will include information relating to **(check and initial, if applicable):**

☐ Acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection.
☐ Behavioral health service/psychiatric care.
☐ Treatment for alcohol and/or drug abuse.

If compensation will be received: I understand that _____ will receive compensation for its use/disclosure of the information release pursuant to this authorization.
Patient's initials: _____

Affirmation of Release:

I give _____See Front_____or the named agency permission to release only the information I have selected on this form to the individual(s) or agency (ies) I have named and only for the purposes I have checked. I understand that this release is valid up to one year from the date I sign it and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing. As a patient I have the right to access my treatment records during hospitalization and after discharge. Copies of the records may be obtained with reasonable notice and payment of copying cost. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan or health care clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be redisclosed and no longer protected by the regulations.

_____ _____
Signature of the Patient/Guardian/Legal Representative **Date Signed**

_____ _____
Signature of Witness/Relationship to Patient **Date Signed**

Expiration date:_____
One year from date signed

Universal Pain Management
PATIENT CARE TREATMENT AGREEMENT

Patient Name: _____ **DOB:** _____

This policy is enacted to ensure the safe and proper use of any controlled substances.

Please Initial:

____1. Patient will provide a complete and accurate history including past medical records, past pain treatments and hospitalizations, drug and alcohol use and drug abuse and addiction history.

____2. Patient agrees and gives permission for family members, significant others, roommates, healthcare professionals, and law enforcement officials to provide information for the purpose of obtaining information relevant to evaluating the efficacy, non-efficacy, side effects or appropriateness of the medication prescribed.

____3. Patients must be seen regularly in the clinic and may be asked for a urine sample for drug screening without notice, at any visit and at any time. **FAILURE TO PROVIDE A URINE SAMPLE ON REQUEST, MAY CONSTITUTE GROUNDS FOR DISCHARGE FROM THIS CLINIC.**

____4. Patients must receive prescriptions for controlled substances from providers in this practice only. The prescriptions are to be filled at only one pharmacy.
The pharmacy name and phone number is: _____

_____

____5. Patient will inform provider of all noticed drug side effects and any concerns about the medication.

____6. Patient will **NOT** take prescribed medication in **ANY** manner, **OTHER THAN** as directed, without first contacting the provider, as this may constitute reason for terminating the prescribing relationship. Furthermore, abuse of prescriptions will prompt notification of all pertinent area providers and law enforcement authorities.

____7. Lost or stolen drugs or prescriptions will not be accepted as a reason for refill prior to the appropriate time period. This office **AND** local law enforcement agencies must be notified of such loss or theft.

____8. This mode of **TREATMENT MAY BE STOPPED IF** *any* **ONE** of the following occurs:

- Patient hoards, gives, sells or misuses these controlled drugs or **any other** illegal drug.
- Patient develops rapid tolerance or loss of effectiveness from this treatment.
- Patient develops side effects that are significant in the view of the provider.
- Patient's functional activities decrease.
- Patient obtains any form of opiates or narcotics from sources other than the providers in this office.

PATIENT CARE TREATMENT AGREEMENT

Please Initial:

____9.Pregnancy may warrant discontinuance of opiate therapy at the discretion of the treating provider.

___10. If narcotic abuse occurs, the drug may be stopped/tapered immediately and the patient may be referred to a detoxification program.

___11. Patient will not operate machinery or drive when feeling drowsy or when patient can expect to feel drowsy from medication, or at other times considered necessary at the discretion of the treating provider.

___12. Patient understands that the providers of Universal Pain Management will be reasonable but firm in interpreting all of the above policy statements.

REGARDING DRIVING OR USE OF HAZARDOUS MACHINERY: Pain medicine can decrease your alertness and thereby make certain activities such as driving more dangerous. You should take great care to avoid injury to yourself or others while taking these medicines. As each person responds differently to these medicines, it is impossible for your provider to know what is a "safe dose" for you to take while driving. Some patients will be able to drive safely once they become accustomed to their medicines, but others will not. As with the use of alcohol, you must exercise careful personal judgment to determine in which activities you may safely participate while taking your medicines. In some cases, it will become apparent to the provider that driving is not safe. In these cases, the provider will advise you against driving. If necessary, your provider will notify the Dept. of Motor Vehicles that driving privileges should be restricted.

THEREFORE, by my signature below, I affirm that I have read (or have had read to me) this Patient Care Treatment Agreement, understand it, and have had all questions answered satisfactorily, and thus, I (the patient) **CONSENT TO THE USE OF OPIATES/NARCOTICS UNDER THE TERMS AS OUTLINED IN THIS AGREEMENT.**

Patient Signature: _____

Date: _____

Witness Signature: _____

Date: _____

A consent form adapted from the American Academy of Pain Medicine

Dr. _____ is prescribing opioid medicine, sometimes called narcotic analgesics, to me for a diagnosis of chronic pain:

This decision was made because my condition is serious or other treatments have not helped my pain.

I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and likelihood that the medicine will not provide complete pain relief.

I am aware about the possible risks and benefits of other types of treatments that do not involve the use of opioids. The other possible treatments include non-opioid analgesics, interventional therapies and alternative medicine therapies.

I will tell my doctor about all other medicines and treatments that I am receiving.

I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include, but are not limited to: using heavy equipment or a motor vehicle, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself.

I am aware that certain other medicines such as nalbuphine (Nubain), pentazocine (Talwin), buprenorphine (Buprenex), and butorphanol (Stadol), may reverse the action of the medicine I am using for pain control. Taking any of these other medicines while I am taking my pain medicines can cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of these medicines and to tell any other doctors that I am taking an opioid as my pain medicine and cannot take any of the medicines listed above.

I am aware that addiction is defined as the use of a medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug and a decreased quality of life. I am aware that the chance of becoming addicted to my pain medicine is very low. I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge.

I understand that physical dependence is a normal, expected result of using these medicines for a long time. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine use is markedly decreased, stopped or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening.

I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain; however, it has been seen and may occur to me. If it occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment.

(Males only) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

(Females only) If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medicines; the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

I have read this form or have it read to me. I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give my consent for the treatment of my pain with opioid pain medicines.

_____ _____

Print Patient Name Date

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

Universal Pain Management
A Comprehensive Approach to Pain and Rehabilitation

URINE DRUG SCREEN POLICY

The Guidelines for Prescribing Controlled Substances published by the Medical Board of California requires that urine drug screens be administered periodically to patients on chronic opioid therapy. As a result, we cannot prescribe opioid analgesics to our patients without obtaining regular, random urine drug screens. The frequency of testing is determined by an individualized assessment of risk for opioid abuse. This is based on our clinical assessment as well as the dose prescribed. If a patient's insurance does not pay for urine drug screens, the patient will be charged accordingly. (Excludes workers compensation insurance)

By my signature below, I affirm that I have read (or have had read to me) the Urine Drug Screen policy, understand it, and have had all questions answered satisfactorily, and thus, I (the patient) ***CONSENT TO THE USE OF OPIATES/NARCOTICS UNDER THE TERMS AS OUTLINED IN THIS POLICY.***

Patient Name: _____

Patient Signature: _____

Date: _____

819 Auto Center Drive, Palmdale, CA 93551 – Phone (661) 267-6876 Fax (661) 538-9483
28212 Kelly Johnson Pkwy, #155, Valencia, CA 91355 – Phone (661) 367-9788 Fax (661) 367-9789
16179 Siskiyou Rd, Apple Valley, CA 92307 – Phone (760) 241-0350 Fax (760) 243-0738
4835 Van Nuys Blvd, Suite 210, Sherman Oaks, CA – Phone (818) 850-ACHE (2243)
www.UniversalPain.com

Universal Pain Management
A Comprehensive Approach to Pain and Rehabilitation

Notice to Our Valued Patients

Missed Appointment Policy

In order for us to serve you better, it is important for you to give us at least 24 hours' notice if you will not be able to make your appointment. You will be charged if cancelation does not occur within 24 hours (weekday) of your appointment. As a courtesy, you will receive a reminder call, but it is your responsibility to know your appointment date and time and cancel with notice.

Missed Appointment Fee

Office Visit -	$50.00
Procedure -	$150.00

By signing below, I understand that if I miss my appointment and run out of medication, I will not receive a refill or bridge of medications until I am seen. I further understand that I will be referred to another pain management practice for continuous violations of this policy.

_____
Print Patient's Name

_____ _____
Patient or Guardian's Signature Date

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Universal Pain Management

(661) 267-6878 x 174

Automatic Payment Authorization Form

"This does not apply to Workers Compensation Insurance."

As a convenience to you, please schedule your payment to be automatically deducted from your bank account, or charged to your credit card. Just complete and sign this form to get started!

Automatic Payments Will Make Your Life Easier:

- **It's convenient** saving you time and postage
- Your payment is always on time (even if you're out of town), **eliminating late charges or any finance charges**

Here's How Recurring Payments Work:

This will occur ONLY on any charges you owe. You authorize scheduled charges to your checking/savings account or credit card. You will ONLY be charged the amount agreed upon. A receipt for each payment will be sent to you and the charge will appear on your bank statement as an "ACH Debit." You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

Please complete the information below:

I _____ authorize Universal Pain Management to charge my credit card
(full name) or checking / Savings Account.

Deductible and/or Co-insurance or any other services provided by Universal Pain Management.

Payment in Full _____ or $_____ on the _____ of each Week, Biweekly, Monthly
(Please circle one)

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Checking/ Savings Account

☐ Checking ☐ Savings

Name on Acct _____

Bank Name _____

Account Number _____

Bank Routing # _____

Bank City/State _____

Credit Card

☐ Visa ☐ MasterCard

☐ Amex ☐ Discover

Cardholder Name _____

Account Number _____

Exp. Date _____

CVV Number _____

SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Universal Pain Management in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that Universal Pain Management may at its discretion attempt to process the charge again within 30 days, and agree to an additional $25.00 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.