Innovative Pain Solutions - Rajan Kalia, M.D

HISTORY

Pain Related Information. Please answer all questions.

1. Describe the event(s) surrounding the onset of your pain. (Like date of injury, whether pain is same or getting worse?)

   _____

   _____

   _____

   _____

   _____

   _____

2. Duration of Pain: Years _____ Months _____

3. How many emergency room visits have you had in the last year for pain? _____

4. Circle the number between 0 and 10 which represents the intensity of your *average* daily pain

5. Circle the number between 0 and 10 which represents the intensity of your <u>*worst* daily pain</u>.

6. Circle all the things that make your pain ***<u>Worse</u>:***

   Sitting standing rest heat cold walking exercise touch other: _____

7. Circle all the things that make your pain ***<u>Better</u>:***

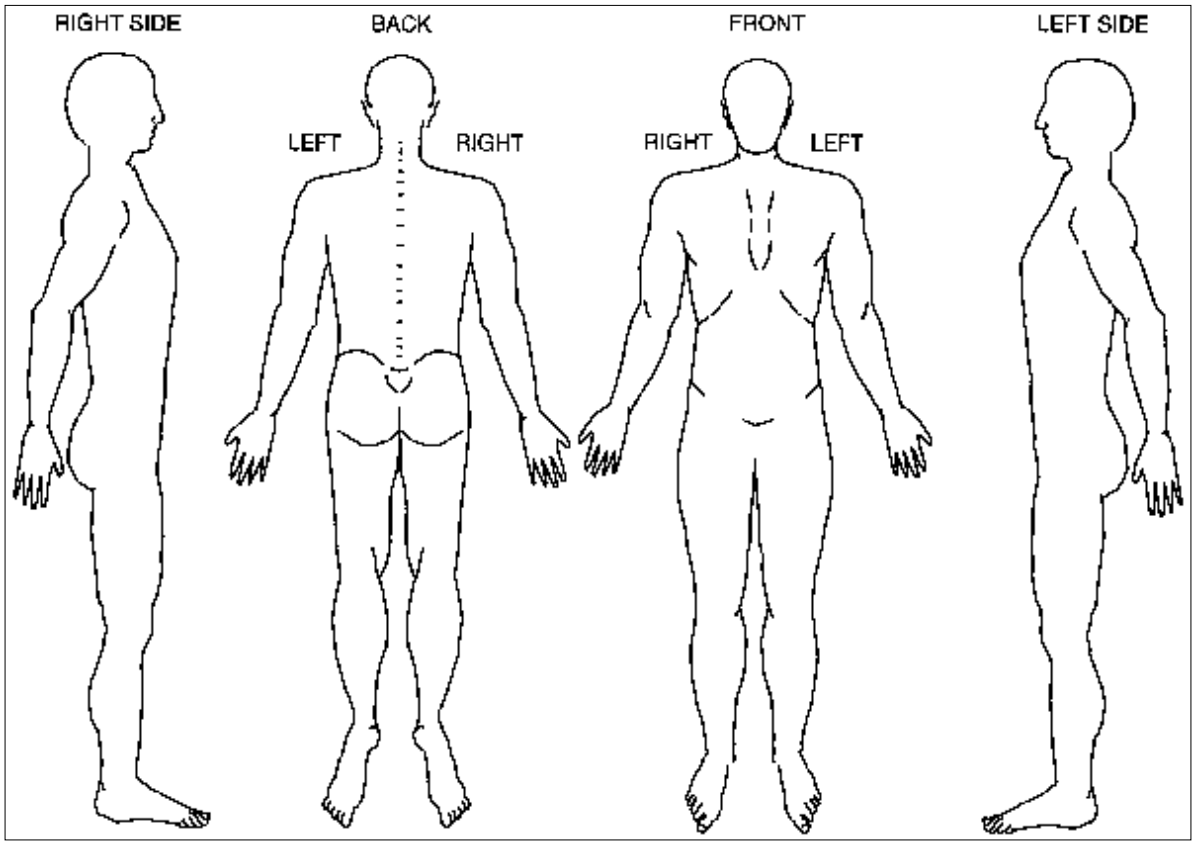
   Sitting standing rest heat cold walking exercise touch other: _____

8. **Describe the nature of your pain** (e.g. sharp, shooting, dull, aching, etc.):

   _____

9. **Describe associated symptoms** (e.g. nausea, palpitations, etc.):

   _____



10. Using these pictures, **shade the parts** of your body that are **affected by pain**. You can use different colors to represent different types of pain. Use an "X" to indicate specific trigger or tender joints.

SURGERIES: - LIST ALL SURGERIES:

_____

_____

_____

_____

_____

PATIENT MEDICAL HISTORY: (Please circle the applicable)

High blood pressure:	Heart Disease:	Stroke:
Diabetes:	Kidney Disease:	Liver Disease:
Asthma:	Cancer:	Arthritis:

Other:_____

FAMILY's MEDICAL HISTORY: Please list any major illnesses in your family, and tell us which relatives had them. Include cancer, stroke, high blood pressure, diabetes, chronic pain, and others.

High blood pressure:	Heart Disease:	Stroke:
Diabetes:	Kidney Disease:	Liver Disease:
Asthma:	Cancer:	Arthritis:
Other:_____		

ALLERGIES: List all allergies and reaction

_____

_____

Are you allergic to iodine or contrast dye (for IVP, myelogram, etc.)? YES NO

MEDICATIONS: Please list any medications you are currently taking, with their doses and number of times taken per day. Please include "over the counter" drugs and herbal supplements. You can use the back of this sheet if necessary. **If you have a list – please provide a copy.**

Drug	Dose	How Long	Who Prescribes?

Are you taking any Blood Thinners? (Please check the applicable)
Aspirin (ASA): Coumadin: Plavix: Agrenox: Other:_____

Pain treatments in the past: (Please circle)
Injections Physical therapy Surgery Medication Other:_____

WORK:

Do you work? Yes No If yes, what do you do? _____ Hours per day_____

If no, how long have you been out of work? _____ *What was your occupation*?_____

Have you ever been in the military? Yes No

Are you able to do household chores? Yes No (explain)

_____

INCOME:

Do you have medical insurance? Yes No

Type _____

Are you on *Disability*? Yes No

Are you involved with *Worker's Compensation*? Yes No

Is there any *litigation* pending against an employer or individual involved in an accident or injury? Yes No

Are you *applying* for disability or worker's compensation? If so, which one?

_____

DAILY ACTIVITIES:

What exercises do you participate in? _____

EDUCATION: Have you ever completed? (Circle)

High School Junior College College Graduate School Post-graduate School Trade School

SOCIAL:

Circle the number between 0 and 10 which represents your involvement in social activities

(No involvement) 0 1 2 3 4 5 6 7 8 9 10 (Actively Involved)

Do you smoke? YES NO If yes, how many packs a day? _____ How many years? _____

Do you use alcohol? YES NO About how often? _____

Was there ever a time in your life when you may have had an alcohol problem? YES NO

Did you or do you use *street drugs*? YES NO If yes, which ones? _____

PCP Heroin Marijuana Cocaine Other: _____

Have you ever been *addicted* to prescription drugs? YES NO

Have you ever been in a **treatment program** for *alcohol* or *drug abuse*? YES NO

If 'Yes', please explain: _____

_____

_____

Please assist us in the proper handling of your claims for services provided by Dr.Kalia.
Please complete all fields. Thank You.

Patient Name: _____ Male □ Female □

Circle your present marital status: Single Married Separated Divorce Widowed

Patient Street Address: _____

City_____ State _____ Zip_____ Email: _____

Home Phone: ( )_____ Work Phone: ( )_____ Cell Phone: ( )_____

Patient Date of Birth: _____/_____/_____ Patient Social Security: _____-_____-_____

Emergency Contact: _____ Emergency phone: ( ) _____

Primary Doctor Name:_____

Charges should be billed to: Health Insurance: □ Workers Comp: □ Car Insurance: □

Insurance Name: _____ Phone: ( ) _____

Policy/Claim No:_____ Policy Holder:_____

Group Number: _____ Date of Injury/Accident: _____

Claim office address: _____

_____

Attorney Name and Telephone: _____

If work related injury, place of business at time of injury: _____

_____

If motor vehicle accident, please provide healthcare coverage to submit for any deductibles.

_____

_____

Please provide a copy of your health insurance card, front and back.

Authorization for release of information:

I hereby authorize Dr.Kalia to furnish the above named insurance company all information, which the insurance company may request concerning my present illness or injury.

Signed: _____ Date: _____/_____/_____

Authorization to pay benefits:

I herby authorize the above named insurance company to issue payment directly to Dr.Kalia for the services rendered.

Signed: _____ Date: _____/_____/_____

Innovative Pain Solutions - Rajan Kalia, M.D

Kissimmee Office
801 W Oak Street, Suite # 203,
Kissimmee, FL- 34741.

St.Cloud Office
3102 17th Street, Suite A,
St.Cloud, FL-34769.

Tel: (407) 284-1993 Fax: (407) 362-7136

Financial Policy

This is an agreement between Innovative Pain Solutions, as creditor, and the Patient/Debtor named on this form.

By executing this agreement, you are agreeing to pay for all services that are received. Payment is expected at the time services are rendered. We accept cash, personal check, money orders cashier's check, Visa and Master Card. We collect copay, coinsurance and any deductible at the time services are rendered.

Insurance: Insurance is a contract between you and your insurance company. We will file insurance claims only for plans with whom we have a contract with. We participate in some managed care plans. In order to file your claims, we require a legible copy of the front & back of the insurance card, photo ID, social security number and verification of benefits by your insurance company prior to visits. It is the responsibility of the insured/patient to supply current and accurate information for claims submissions. All copay, coinsurance, and deductibles are due at the time services are rendered.

If you are covered by a plan that we are not participating providers for, payment is expected when services are rendered. We will provide you with an itemized receipt for you to file your insurance. Your insurance company will be responsible for reimbursing you for any coverage you may have.

Collection fee: A fee totaling 30% of the balance due will be added to your account if we have to send your account to a collection agency. You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We may have the option to report your account to any credit reporting agency such as a credit bureau.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Returned checks: There is a fee currently of $25.00 for any checks returned by the bank. Payment made on a returned check must be made in cash or by a money order.

Copying of records: You will need to request in writing, and pay a reasonable copying fee ($1/page for the first 25 pages and 25 cents for every page thereafter) if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Effective date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

My signature below certifies that I have read (or the form has been read to me) and I understand the contents on this form.

Patient's name: _____ Date: ____/____/_____

Responsible party (if not the patient): _____

OPIOD RISK TOOL (ORT)

The ORT was developed to assess an individual patient's risk of nonmedical use of prescribed opioids. By determining risk level (i.e., low, moderate, or high) with this validated tool, the physician can provide appropriate levels of monitoring and improve clinical outcomes.

	Female	Male
1. Family history of substance abuse		
Alcohol	☐ 1	☐ 3
Illegal Drugs	☐ 2	☐ 3
Prescription drugs	☐ 4	☐ 4
2. Personal history of substance abuse		
Alcohol	☐ 3	☐ 3
Illegal Drugs	☐ 4	☐ 4
Prescription drugs	☐ 5	☐ 5
3. Age (mark box if between 16 - 45 years)	☐ 1	☐ 1
4. History of preadolescent sexual abuse	☐ 3	☐ 0
5. Psychological disease		
ADO, OCD, bipolar, schizophrenia	☐ 2	☐ 2
Depression	☐ 1	☐ 1
Scoring totals:	_____	_____

#1 pertains to patient's parents and/or siblings.

Questions #2 thru #5 pertain to Patient.

Authorization for Release of Confidential Information

I, _____ hereby authorize _____
To release medical, psychiatric, drug and/or alcohol abuse or HIV testing and AIDS information in my medical records to:

Innovative Pain Solutions
801 W Oak St,
Suite # 203,
Kissimmee, FL-34741.
Tel: (407) 284-1993 Fax: (407) 362-7136

For the purpose of medical care,
I understand that the specific reports shall include ___ office visits ___ radiology reports ___Meds List
___other : _____.

I understand that this consent is revocable upon written notice to _____, except to the extent that action by _____ has been taken in reliance of this authorization and that this authorization and that this authorization shall remain in force for a reasonable time order to effect the purpose which it is given.

Alcohol abuse information, if present has been disclosed from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR Part 2) prohibit making any further of it without the specific written consent of the undersigned, or as otherwise permitted by such regulations. HIV testing and/or AIDS related diagnosis is prohibited from further disclosure by State Regulations without consent from the patient.

_____

Patient Signature in full | Date of Authorization

_____

Date of Birth | Parent, Legal Guardian or Authorized Representative

_____

Social Security Number | Witness

*****Patient may delete any of the categories above by marking through**

Office use only

_____

Specific records Released

_____

Date of Release | Released by

NARCOTIC AGREEMENT

We are committed to doing all we can to treat your chronic pain condition. In some cases, controlled substances are used as a therapeutic option in the management of chronic pain, which is strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and the physician by establishing guidelines, within the laws, for proper and controlled substance use. The words "we" and "our" refer to the facility and the words "I," "you," "me," or "my" refer to you, the patient.

1. All controlled substances must come from the physician whose signature appears below or, during his/her absence, by the covering physician, unless specific authorization is obtained for an exception. I understand that I must tell the physician whose signature appears below or, during his/her absence, the covering physician, all drugs that I am taking, have purchased, or have obtained, even over-the-counter medications. Failure to do so may result in drug interactions or overdoses that could result in harm to me, including death. I will not seek prescriptions for controlled substances from any other physician, healthcare provider, or dentist. I understand it is unlawful to be prescribed the same controlled medication by more than one physician at a time without each physician's knowledge. I also understand that it is unlawful to obtain or to attempt or obtain a prescription for a controlled substance by knowingly misrepresenting facts to a physician, or his/her staff, or knowingly withholding facts from a physician or his/her staff (including failure to inform the physician or his/her staff of all controlled substances that I have been prescribed).

2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:

Pharmacy Name: _____ **Phone :** (_____)_____

3. You may not share, sell, or otherwise permit others, including spouse or family members, to have access to any controlled substances that you have been prescribed.

4. Unannounced urine or serum toxicology specimens may be requested from you, and your cooperation is required. Presence of unauthorized substances in urine or serum toxicology screens may result in your discharge from this facility.

5. I will not consume excessive amounts of alcohol in conjunction with controlled substances. I will not use, purchase, or otherwise obtain any other legal drugs except as specifically authorized by the physician whose signature appears below or, during his/her absence by the covering physician, as set forth in Section 1 above. I will not use, purchase or otherwise obtain any illegal drugs, including marijuana, cocaine, etc. I understand that driving while under the influence of any substance, including a prescribed controlled substance, or any combination of substances (e.g., alcohol and prescription drugs) which impairs my driving ability, may result in DUI charges.

6. Medications or written prescriptions may not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen it will not be replaced unless explicit proof is provided with direct evidence from authorities. A report narrating what you told authorities is not enough.

7. Early refills will not be given. Renewals are based upon keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.

8. In the event you are arrested or incarcerated related to legal or illegal drugs (including alcohol), refills on controlled substances will not be given.

9. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribed by this physician and other physicians at the facility and that law enforcement officials may be contacted.

10. I affirm that I have full right and power to sign and be bound by this agreement, and that I have read it and understand and accept all of its terms. A copy of this document has been given to me.

_____ _____

Patient's Full Name Patient's Signature Date

_____

Physician's Signature Date

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCUSSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician. our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. to pay your health care bills. to support the operation of the physicians practice. and any other use required by law.

Treatment: We will use and disclose your protected health information to provide. coordinate. or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example. we would disclose your protected health information. as necessary. to a home health agency that provides care to you. For example. your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used. as needed. to obtain payment for your health care services. For example. obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose. as-needed. your protected health information in order to support the business activities of your physician's practice. These activities include. but are not limited to. quality assessment activities. employee review activities. training of medical students. licensing. and conducting or arranging for other business activities. For example. we may disclose your protected health information to medical students that see patients at our office . In addition. we may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information as necessary to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law. Public health issues as required by law. Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners. Funeral Directors. and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law. we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent. Authorization or Opportunity to Object unless required by law.

You may revoke this authorization. at any time. in writing. except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law. however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. **You have the right to obtain a paper copy of this notice from us.** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature: _____ Date:_____

Innovative Pain Solutions - Rajan Kalia, M.D

Authorization to Release Healthcare Information

Patient Name: _____

Date of Birth: ____/_____/_____

I _____ hereby authorize Innovative Pain Solutions to disclose my healthcare information to the following people:

Name	Relationship to patient	Phone number
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ ____/_____/_____

Patient Signature Date

Cancellation /Missed Appointment Policy

New Patients/Established Patients:

24 hour notice is required to cancel an appointment. Less than 24 hour notice or missed appointments are subject to a $25 no show charge.

All Patients:

3 or more cancelled or missed appointments will result in dismissal from the practice.

If you are more than 15 minutes late to your appointment, your appointment will be canceled and you will be rescheduled.

We do understand there are times when 24 hour notice is not possible. Emergency cancellations or missed appointments will be evaluated on an individual basis.

_____ ____/_____/_____

Patient Signature **Date**