

**Pain Institute of Central California, Inc.**  
**Arturo Palencia, M.D. \* Afaq Kazi, M.D. \* Carmen Fischer, M.D.**  
Phone: (661)665-7880 Fax: (661)665-7811

Dear. Patient,

We would like to take this opportunity to welcome you to our office. Please fill out your paperwork completely and in blue or black ink. If you have any additional information that you would like the doctor to see, please bring it with you, let us know and we will copy and attach it to your completed paper work. If you have any questions regarding the paper work, please give us a call and we will do our best to answer them for you.

We understand that most patients tend to reach a comfort level with one provider and we will accommodate that whenever possible, however, there will be times that their schedules are full or they are out of the office and we will offer an appointment with your doctor or a different provider in our office as soon as there is an opening. We look forward to seeing you at your upcoming appointment.

Thank you,

Veronica  
New patient coordinator



PLEASE BRING ALL YOUR MEDICATION WITH YOU  
TO YOUR APPOINTMENT.

THERE WILL BE A \$25 CHARGE TO PATIENTS WHO  
DO NOT SHOW UP TO THEIR APPOINTMENT OR  
DO NOT CALL 24 HOURS IN ADVANCE TO  
RESCHEDULE.

PATIENTS WILL BE RESCHEDULED IF THEIR  
PAPERWORK IS NOT COMPLETED BEFORE THEIR  
APPOINTMENT TIME OR DO NOT HAVE THEIR CO-  
PAYMENT.



## PATIENT'S BILL OF RIGHTS AND RESPONSIBILITY

The observance of the following guidelines will provide more effective patient care and greater satisfaction for the patient, the physician and the individuals that make the office organization. It is in recognition of these factors that these rights are affirmed.

The patient has the right to considerate and respectful care.

The patient has the responsibility to provide the physician with the most accurate and complete information regarding their medical/surgical history. The patient has the right to obtain from the physician complete current information concerning his/her diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. The patient must inform the physician if at anytime they do not understand the diagnosis or treatment plan.

The patient has the right to receive from his/her physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternative, the patient has the right to know the name of the person responsible for the procedures and/or treatment.

The patient has the responsibility to follow the plan of care of express concerns with compliance. The patient has the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of his/her action.

The patient has the right to every consideration of his/her privacy concerning his/her medical care program. Care discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. Those not directly involved in his/her care must have the permission of the patient to be present.

The patient has the right to expect that all communications and records pertaining to his/her care should be treated confidential.

The patient has the right to have their pain assessed, managed and treated as effectively as possible.

The patient has the right to expect that within its capacity, this ambulatory facility must provide evaluation service and/or referral as indicated by the urgency of the case. When medically permissible, a patient may be transferred to another facility only after he/she has received complete information and explanation concerning the need for and alternatives to such a transfer.

The patient has the right to obtain information as to any relationship of this facility to the other health care and educational institutions in so far as his/her care is concerned. The patient has

the right to obtain information as to the existence of any professional relationships among individuals, by names, which are treating him/her.

The patient has the right to expect reasonable continuity of care. The patient has the right to expect that this facility will provide a mechanism whereby he/she is informed by his/her physician of the patient's continuing health care requirements following discharge.

The patient has the right to know the mechanism for grievance as well as suggestions.

The patient has the right to change their choice of physician.

The patient has the right to dispute information in their medical record.

The patient has the right to examine and receive explanation of his/her bill.

The patient has the right to know what facility rules and regulations apply to his/her conduct as a patient.

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Date: \_\_\_\_\_ New Patient: Yes\_\_\_ No\_\_\_  
Patient Name: \_\_\_\_\_ Sex\_\_\_\_\_ Age\_\_\_\_\_

Date of Birth: \_\_\_\_\_

Marital status: Single\_\_\_ Married\_\_\_ Divorced\_\_\_ Widowed\_\_\_ Separated\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Nearest Relative not living with you: \_\_\_\_\_

Phone #: \_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_

Phone #: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Other Physicians: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Is the problem work-related? Yes\_\_\_ No\_\_\_ If yes, date of injury: \_\_\_\_\_

Place of employment when injured: \_\_\_\_\_

Current Medical Diagnosis: \_\_\_\_\_

What form of payment will you use? Cash\_\_\_ Insurance\_\_\_ Medicare\_\_\_ Medi-cal\_\_\_

Primary Insurance: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Insured's DOB: \_\_\_\_\_ SS #: \_\_\_\_\_ Employer: \_\_\_\_\_

Primary Insurance Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Adjuster: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Insured's DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ Employer: \_\_\_\_\_

2<sup>nd</sup> Insurance Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Adjuster: \_\_\_\_\_

**PAIN INSTITUTE OF CENTRAL CALIFORNIA, INC.**  
**Initial Evaluation**

**PAIN MANAGEMENT QUESTIONNAIRE**

Please complete this form before your first appointment at **Pain Institute of Central California, Inc.** Your careful answers will help us to understand your pain problem and design the best treatment program for you. You may feel concerned about what happens to the information you provide, as much of it is personal. Our records are strictly confidential. No outsider is permitted to see your medical record without your written permission unless we are required to do so by law (e.g., Workmans' Compensation Claims).

Referring Physician

Primary Care Physician (if not the same)

\_\_\_\_\_

\_\_\_\_\_

Patient Information

\_\_\_\_\_  
Last Name                      First Name

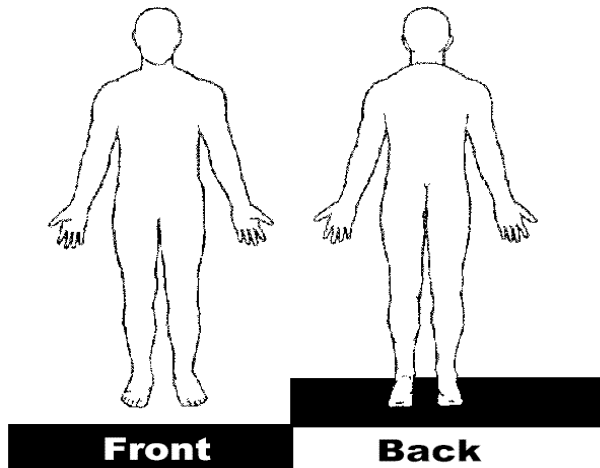
Age: \_\_\_\_\_ Sex:    M \_\_\_\_\_ F \_\_\_\_\_

**About Your Pain**

What is the main problem for which you are seeking treatment at Pain Institute of Central California, Inc.?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PAIN LOCATION**



**Please mark the location(s) of your pain on the diagrams above with an "X"**  
**If whole areas are painful, please shade in the painful area(s).**

**Pain Institute of Central Ca., Inc**  
**Initial Evaluation**

**Onset of Pain and Duration**

Briefly describe when and how your pain problem began.

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**Timing of Pain**

How often do you have your pain? (Please check one)

- Constantly (100% of the time)
- Frequently (75% of the time)
- Intermittently (50% of the time)
- Occasionally (25% of the time)

**Pain Quality**

How would you describe the pain? (Choose as many adjectives as are applicable)

- burning                       sharp                       cutting                       throbbing     cramping
- numbness                       dull, aching                       pressure                       pins & needles
- shooting                       electric-like                       other \_\_\_\_\_

**Pain Intensity**

Circle your current pain intensity with “0” representing no pain and “10” the most severe pain imaginable.

0    1    2    3    4    5    6    7    8    9    10

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Circle your average pain score over the last 7 days.

0    1    2    3    4    5    6    7    8    9    10

---

Circle your best pain score over the last 7 days.

0    1    2    3    4    5    6    7    8    9    10

---

Circle your worst pain score over the last 7 days.

0    1    2    3    4    5    6    7    8    9    10

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**Pain Institute of Central Ca., Inc**  
**Initial Evaluation**

**Relieving and Aggravating Factors**

How do the following affect your pain? (Please check one for each item)

	Decrease	Increase	No Change
Lying down	_____	_____	_____
Standing	_____	_____	_____
Sitting	_____	_____	_____
Walking	_____	_____	_____
Exercise (if applicable)	_____	_____	_____
Medications	_____	_____	_____
Relaxation	_____	_____	_____
Thinking about something else	_____	_____	_____
Coughing/Sneezing	_____	_____	_____
Urination	_____	_____	_____
Bowel Movements	_____	_____	_____

**Functional Limitations**

Place a check mark next to the activities that you avoid because of pain.

- \_\_\_\_\_ Going to work
- \_\_\_\_\_ Performing household chores
- \_\_\_\_\_ Doing yard work or shopping
- \_\_\_\_\_ Socializing with friends
- \_\_\_\_\_ Participating in recreation
- \_\_\_\_\_ Having sexual relations
- \_\_\_\_\_ Physical exercise
- \_\_\_\_\_ Driving
- \_\_\_\_\_ Caring for self

How many feet, blocks or miles can you walk before having to stop because of pain?

\_\_\_\_\_ feet    \_\_\_\_\_ blocks(s)    \_\_\_\_\_ mile(s)

How many minutes or hours can you sit before having to get up and move about because of pain?

\_\_\_\_\_ minutes    \_\_\_\_\_ hours

How many minutes or hours can you stand before you have to sit down because of pain?

\_\_\_\_\_ minutes    \_\_\_\_\_ hours

How often during the day do you lie down because of pain?

\_\_\_\_\_ Never    \_\_\_\_\_ seldom    \_\_\_\_\_ sometimes    \_\_\_\_\_ often    \_\_\_\_\_ constantly

**Pain Institute of Central Ca., Inc**  
**Initial Evaluation**

**Medications**

Please list your current medications with dosages

Name of medication	Dose	How often per day
--------------------	------	-------------------

_____		
_____		
_____		
_____		
_____		
_____		
_____		
_____		
_____		
_____		

Please list any previous pain medications that you stopped taking and the reason for stopping

Name of medication	Dose	How often per day
--------------------	------	-------------------

_____		
_____		
_____		
_____		
_____		
_____		
_____		
_____		

**Allergies**

Are you allergic to any iodine dye contrast agents? Yes \_\_\_ No \_\_\_ (if yes, please explain)

Also, please indicate the names of any medication(s) that you are allergic to (and what happened to you when you took it/them)

_____
_____
_____
_____

**Pain Institute of Central Ca., Inc**  
**Initial Evaluation**

**Pain Treatments**

Please check all of the treatments you have tried for your pain and then complete the appropriate column at the right to the best of your ability

<b>Treatment</b>	<b>Date (approx)</b>	<b>Excellent Relief</b>	<b>Moderate Relief</b>	<b>No Relief</b>
Medications	_____	_____	_____	_____
Hospital bed rest	_____	_____	_____	_____
Traction	_____	_____	_____	_____
Surgery	_____	_____	_____	_____
Hypnosis	_____	_____	_____	_____
Acupuncture	_____	_____	_____	_____
Nerve block/injections	_____	_____	_____	_____
TENS	_____	_____	_____	_____
Physical Therapy	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Heat Treatment	_____	_____	_____	_____
Biofeedback	_____	_____	_____	_____
Psychotherapy	_____	_____	_____	_____
Chiropractic	_____	_____	_____	_____
Other	_____	_____	_____	_____

**Previous Diagnostic Studies**

Please indicate approximate date and results, if known:

**MRI** \_\_\_\_\_

**CT** \_\_\_\_\_

**X-RAYS** \_\_\_\_\_

**EMG** \_\_\_\_\_

**OTHER** \_\_\_\_\_

**Pain Institute of Central Ca., Inc**  
**Initial Evaluation**

**ROS (Review of Systems/Symptoms)**

Please circle any of the following signs or symptoms that you feel are applicable to you now

<u>Fever or chills</u>	<u>yes</u>
<u>Unplanned weight loss</u>	<u>yes</u>
<u>Double or blurred vision</u>	<u>yes</u>
<u>Hearing loss</u>	<u>yes</u>
<u>Difficulty swallowing</u>	<u>yes</u>
<u>Bleeding gums</u>	<u>yes</u>
<u>Low platelet count</u>	<u>yes</u>
<u>Heat or cold intolerance (circle which one)</u>	<u>yes</u>
<u>Thyroid problems</u>	<u>yes</u>
<u>Skin rash</u>	<u>yes</u>
<u>Shortness of breath</u>	<u>yes</u>
<u>Wheezing</u>	<u>yes</u>
<u>Palpitations</u>	<u>yes</u>
<u>Chest pain</u>	<u>yes</u>
<u>Constipation</u>	<u>yes</u>
<u>Abdominal pain</u>	<u>yes</u>
<u>Nausea/vomiting</u>	<u>yes</u>
<u>Diarrhea</u>	<u>yes</u>
<u>Sexual dysfunction</u>	<u>yes</u>
<u>Urinary retention (difficulty urinating)</u>	<u>yes</u>
<u>Back pain</u>	<u>yes</u>
<u>Joint pain (knee, elbow, etc.)</u>	<u>yes</u>
<u>Muscle pain</u>	<u>yes</u>
<u>Loss of consciousness or blackouts</u>	<u>yes</u>
<u>Memory loss</u>	<u>yes</u>
<u>Muscle weakness</u>	<u>yes</u>
<u>Seizures</u>	<u>yes</u>
<u>Trouble walking</u>	<u>yes</u>
<u>Dizziness</u>	<u>yes</u>
<u>Drowsiness or excessive fatigue</u>	<u>yes</u>
<u>Difficulty falling or remaining asleep</u>	<u>yes</u>
<u>Loss of interest in hobbies or activities</u>	<u>yes</u>
<u>Feelings of guilt</u>	<u>yes</u>
<u>Feeling depressed</u>	<u>yes</u>

**Other Pain Problems**

Do you have other pain problems not already mentioned? What are they?

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**Pain Institute of Central Ca., Inc**  
**Initial Evaluation**

**Past Medical History**

Have you had any of the following health problems? (please check all that apply)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Kidney disease    |
| <input type="checkbox"/> Angina              | <input type="checkbox"/> Stroke                 | <input type="checkbox"/> Liver disease     |
| <input type="checkbox"/> Heart attack        | <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Arthritis         |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> seizures/epilepsy      | <input type="checkbox"/> Bleeding problems |
| <input type="checkbox"/> Chronic cough       | <input type="checkbox"/> Psychological problems | <input type="checkbox"/> other _____       |

Please explain any medical conditions check above

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**All Surgeries**

Approximate date and type of operation

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**Psychological History**

Education

Your highest educational level achieved

- Graduate or professional training (obtained degree)
- College graduate (obtained degree)
- Partial college training
- High school graduate
- GED or trade-technical school graduate
- Partial high school (10<sup>th</sup> grade through partial 12<sup>th</sup>)
- Partial junior high school (7<sup>th</sup> grade through 9<sup>th</sup> grade)
- Elementary school (6<sup>th</sup> grade or less)

**Legal Issues**

Please indicate any of the following claims you have filed related to your pain problem

- Workman's Compensation
- Personal injury/liability (unrelated to work)



**Pain Institute of Central Ca., Inc  
Initial Evaluation**

**Family Life**

Living arrangements:

“I currently am”:

- Living alone
- Living with friends
- Living with children
- Living with spouse/partner
- Living with spouse/partner and children

**Family History**

- Do you have members of your family who have had migraine headaches?  Yes  No
  - Do you have members of your family who have had back pain?  Yes  No
  - Do you have members of your family who have committed suicide?  Yes  No
  - Do you have members of your family who have had psychiatric illness?  Yes  No
- 

**I hereby authorize the release of the reports of my evaluations and treatments, including psychological, from PAIN INSTITUTE OF CENTRAL CA, INC. to my physicians and to the other relevant person(s) listed below:**

Signature \_\_\_\_\_

Date \_\_\_\_\_

Printed Name \_\_\_\_\_

Physicians, Providers, Attorney, Case Manager, Other	Address	Phone/Fax



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### **Consent for Chronic Opioid Therapy**

The Doctors of Pain Institute of Central California are prescribing opioid medicine, sometimes called narcotic analgesics, to me for a diagnosis of: \_\_\_\_\_

\_\_\_\_\_  
-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 possibility that the medicine will not provide complete pain relief.

-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 may be slowed. Such activities include, but are not limited to: using heavy equipment, operating motor vehicles, working or being responsible for another individual who is unable to care for him or herself.

-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 that physical dependence means if my pain medicine use is suddenly stopped, I will experience a withdrawal syndrome. This means I may have any or all of the following symptoms: 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 and may be life threatening.

-I am aware that it is my responsibility to call in my medication(s) or call my physician if I stop my medication.

-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 gynecologist 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 had it read to me. 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 medications.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

Witness to above \_\_\_\_\_

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**OPIOID AGREEMENT- PART 1**

When opioids are prescribed, communications must be clear, because the DEA monitors prescriptions closely.

1. Narcotics or opioids are often used to treat chronic intractable pain but do not “cure” the underlying condition(s) that cause pain and they may cause other problems.
2. The main goal of opioid therapy is to help improve your physical and vocational functioning.
3. Before a prescription for opioids is written, it is in your best interest to have a primary care physician (PCP) who agrees with the proposed therapy and signs part 2 **OR** part 3 of this opioid agreement.
4. By signing part 2, your PCP agrees to take over opioid prescribing only after it is proven to be an appropriate, safe and effective therapy for managing your chronic pain problem. This will only be necessary if you stop coming to Pain Institute of Central California, Inc.
5. By signing part 3, your PCP does NOT agree to prescribe your pain medications but agrees with the other stipulations and agrees that we are to be the ONLY physicians prescribing your opioids.

**THE REQUIREMENTS:**

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Because of the controversy and concern surrounding opioid usage, we must require that you:

1. **HAVE ONLY ONE PHYSICIAN PRESCRIBING THESE OPIOIDS.** Having more than one prescriber will constitute grounds for dismissal from the clinic. This may be either my PCP or my pain physician.
2. Use only one pharmacy for medications: This pharmacy is \_\_\_\_\_.
3. **Take your medications only as prescribed.**
4. Document your progress.
5. Maintain a primary care physician. This Dr. is \_\_\_\_\_.
6. Have your primary care physician’s signature on file at Pain Institute of Central California, Inc. prior to receiving a prescription for opioids.
7. Know that lost or stolen medications or prescriptions will not be replaced.
8. Know that forged or abused prescriptions constitute grounds for dismissal.
9. Know that treatment discussions can only occur within your appointments.
10. Telephone the office **only for urgent medical problems** ( not for routine prescription refills).
11. Allow random drug screens to be taken.
12. Allow us to discuss your case with your caregivers.

**UNDERSTANDINGS:**

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Prior to receiving a prescription for opioids, I must secure an agreement from my PCP that he or she is willing to take over opioid prescribing:

- only if it is proven to be an appropriate, safe and effective therapy.
- After my prescription dose has become stabilized.
- And if I stop coming to Pain Institute of Central California inc. for treatment.

If I do not follow the above-listed requirements, I may be discharged from the pain clinic. The standard procedure is to be given a tapering 15 day dosage and a reference list of other community pain physicians.

I have received and will read the opioid therapy brochure that I will keep for future reference and questions.

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Patient signature and date

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Pain Physician signature and date

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**OPIOID AGREEMENT – PART II**

Dear Primary Care Physician:

Your Patient, \_\_\_\_\_, has been seen at the Pain Institute of Central California, Inc. and appears to be an appropriate candidate for opioid therapy. Prior to initiating opioid therapy, we need your agreement with the proposed therapy and request your support in being willing to provide your patient with opioid or secure prescriptions if necessary in the future should he/she stop coming to our pain clinic. Your patient has been apprised of the concerns and difficulties surrounding opioid prescriptions, and the final step is to secure your agreement. If you have any questions or concerns about the pain clinic please do not hesitate to call our office.

- Narcotics or opioids are often used to treat chronic intractable pain but do not “cure” the underlying condition(s) that cause pain and they may cause other problems.
- The main goal of opioid therapy is to help improve your physical and vocational functioning.
- Before a prescription for opioids is written, it is in your best interest to have a primary care physician (PCP) who agrees with the proposed therapy and signs part 2 of this opioid agreement thereby agreeing to take over opioid prescribing only after it is proven to be an appropriate, safe and effective therapy for managing you chronic pain problem.
- This is a courtesy agreement between you and your PCP and is not a legally binding contract but will provide you with a “safety net” should you ever stop coming to Pain Institute of Central California, Inc. for treatment.

**Requirements:**

1. **HAVE ONLY ONE PHYSICIAN PRESCRIBING THESE OPIOIDS.**
2. Use only one pharmacy for medications.
3. Take your medications as prescribed.
4. Document your progress.
5. Maintain a primary care physician
6. Have your primary care physician signature on file at Pain Institute of Central California, Inc. prior to the initiation of opioid therapy.
7. Know that lost or stolen medications or prescriptions will not be replaced.
8. Know that treatment discussions can only occur within your appointments.
9. Telephone the pain clinic only for urgent medical problems.
10. Allow random drug screens to be taken.
11. Allow us to discuss your case with your caregivers.

**Understandings:**

1. Prior to receiving a prescription for opioids, I must secure an agreement from my Primary Care Physician that he/she is willing to take over opioid prescribing:
  - a. only if it is proven to be an appropriate, safe and effective therapy,
  - b. after my prescription dose has become stabilized,
  - c. and if I stop coming to Pain Institute of Central California, Inc.
2. If I do not follow the above –listed requirements, I may be discharged from the pain clinic. The standard procedure is to be given a tapering 15 day dosage and a reference list of other community pain physicians.

I have received and will read the opioid therapy brochure that I will keep for future reference and questions.

\_\_\_\_\_  
Patient signature and date

\_\_\_\_\_  
Primary Care Physician signature and date

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**OPIOID AGREEMENT – PART III**

Dear Primary Care Physician:

Your Patient, \_\_\_\_\_, has been seen at the Pain Institute of Central California, Inc. and appears to be an appropriate candidate for opioid therapy. Prior to initiating opioid therapy, we need your agreement with the proposed therapy. Your patient has been apprised of the concerns and difficulties surrounding opioid prescriptions. If you have any questions or concerns about this regimen, or any other questions about the pain clinic, please do not hesitate to call our office.

- Narcotics or opioids are often used to treat chronic intractable pain but do not “cure” the underlying condition(s) that cause pain and they may cause other problems.
- The main goal of opioid therapy is to help improve your physical and vocational functioning.
- Before a prescription for opioids is written, it is in your best interest to have a primary care physician (PCP) who agrees with the proposed therapy and signs part 3 of this opioid agreement.
- This is a courtesy agreement between you and your PCP and is not a legally binding contract but will provide you with a “safety net” should you ever stop coming to Pain Institute of Central California, Inc. for treatment.

**Requirements:**

1. **HAVE ONLY ONE PHYSICIAN PRESCRIBING THESE OPIOIDS.**
2. Use only one pharmacy for medications.
3. Take your medications as prescribed.
4. Document your progress.
5. Maintain a primary care physician
6. Have your primary care physician signature on file at Pain Institute of Central California, Inc. prior to the initiation of opioid therapy.
7. Know that lost or stolen medications or prescriptions will not be replaced.
8. Know that treatment discussions can only occur within your appointments.
9. Telephone the pain clinic only for urgent medical problems.
10. Allow random drug screens to be taken.
11. Allow us to discuss your case with your caregivers.

**Understandings:**

1. My Primary Care Physician is **NOT** willing to take over opioid prescribing.
2. I agree to receive opioid medications **ONLY** from my pain physician
3. If I do not follow the above –listed requirements, I may be discharged from the pain clinic. The standard procedure is to be given a tapering 15 day dosage and a reference list of other community pain physicians.

I have received and will read the opioid therapy brochure that I will keep for future reference and questions.

\_\_\_\_\_  
Patient signature and date

\_\_\_\_\_  
Primary Care Physician signature and date

**Pain Institute of Central California, Inc.**  
**Arturo Palencia, M.D. \* Afaq Kazi, M.D.**  
Office: (661)665-7880 Fax: (661)665-7811

**RELEASE OF PATIENT MEDICAL INFORMATION**

Pain Institute of Central CA., Inc. generally communicates directly with our patients about their medical condition and treatment. However, you can tell us not to do this. Please **initial** the one that applies to you:

1. Communicate directly with me and the people I designate below. \_\_\_\_\_
2. Do not communicate with me. Only communicate with the people designated below. \_\_\_\_\_

I give the physicians and staff of Pain Institute of Central Ca., Inc. permission to discuss my treatment, diagnostic tests, and medical condition with the following family members and friends. I understand that if I wish individuals added or deleted from this list, that I must notify Pain Institute of Central Ca., Inc. in writing.

With \_\_\_\_\_  
Who Is \_\_\_\_\_  
Relationship \_\_\_\_\_ Phone# \_\_\_\_\_

And/or \_\_\_\_\_  
Who Is \_\_\_\_\_  
Relationship \_\_\_\_\_ Phone# \_\_\_\_\_

And/or \_\_\_\_\_  
Who Is \_\_\_\_\_  
Relationship \_\_\_\_\_ Phone# \_\_\_\_\_

And/or \_\_\_\_\_  
Who Is \_\_\_\_\_  
Relationship \_\_\_\_\_ Phone# \_\_\_\_\_

**This is an indefinite consent form unless otherwise specified.**

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date Signed

**Pain Institute of Central California, Inc.**  
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**Notification of Patient Responsibility for Non-Covered Services**

Patient Name \_\_\_\_\_

At Pain Institute of Central Ca., Inc., we want to provide you and your referring Physician with the highest level of treatment. However, there are times when your insurance carrier and/or third-party payer (including Medicare and Medi-Cal) will deny some services because they are not covered under your health insurance contract or they were not authorized by your health plan or HMO.

Please be advised that it is your responsibility to know the terms of your health plan contract (including covered and non-covered services). In addition, the patient is also responsible for utilizing a network provider in the event you are affiliated with an HMO and making certain that prior authorization was obtained prior to your visit. By signing below, you agree to be financially responsible for all services we provide that were not covered or authorized by your health plan.

Please be advised that under the Medicare program, there are certain supplies and injections that are not covered. By signing below, you agree to be financially responsible for any item(s) that are not covered under the Medicare program.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Company Representative

\_\_\_\_\_  
Date

**Pain Institute of Central California, Inc.**  
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**HIPPA Privacy Rule Individual Consent Agreement**

**Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment or Healthcare Operations (ξ164.506(a))**

I \_\_\_\_\_ understand that as part of my health care, **Pain Institute of Central Ca., Inc.** originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the health professionals who may contribute to my health care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided;
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I have been provided with and understand that **Pain Institute of Central Ca., Inc's Notice of Privacy Practices** provides a more complete description of the uses and disclosures of information.

I understand that:

- I have the right to review **Pain Institute of Central Ca., Inc's. Notice of Privacy Practices** prior to signing this consent;
- That **Pain Institute of Central Ca., Inc.** reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations and that **Pain Institute of Central Ca., Inc.** is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that **Pain Institute of Central Ca., Inc.** has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

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Accepted       Denied

Signature of Individual or Legal Representative Witness: \_\_\_\_\_

Printed Name of Individual or Legal Representative Witness: \_\_\_\_\_

Date: \_\_\_\_\_

**HIPPA Privacy Rule Individual Authorization Agreement**  
**Authorization for the disclosure of protected health information**  
**[§164.508(a)]**

I \_\_\_\_\_ understand that as part of my health care, **Pain Institute of Central Ca., Inc.** originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the health professionals who may contribute to my health care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided;
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I have been provided with and understand that **Pain Institute of Central Ca., Inc's Notice of Privacy Practices** provides a more complete description of the information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another party. I have the right to review **Pain Institute of Central Ca., Inc's Notice of Privacy Practices** prior to signing this authorization. I authorize the disclosure of my Protected Health Information, other than for treatment, payment or health care operations, as specified below for the purposes and to the parties designated by me.

PHI Authorized:

All PHI necessary for purposes of my continued treatment

Purpose Authorized:

For my continued treatment

Parties to whom my PHI is authorized to be released:

Those covered entities that **Pain Institute of Central Ca., Inc.** considers necessary for my treatment purposes.

I understand that:

- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations by other covered entities;
- I may revoke this consent in writing at any time, except to the extent that Pain Institute of Central Ca., Inc. has already taken action in reliance thereon.

Signature of Individual or Legal Representative Witness: \_\_\_\_\_

Printed Name of Individual or Legal Representative Witness: \_\_\_\_\_

Date: \_\_\_\_\_

**HIPPA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgement  
Form**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE [§164.520(C)]

I \_\_\_\_\_ understand that as part of my health care, **Pain Institute of Central Ca., Inc.** originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that **Pain Institute of Central Ca., Inc's Notice of Privacy Practices** provides a complete description of the uses and disclosures of my health information.

I understand that:

- I have the right to review **Pain Institute of Central Ca., Inc's Notice of Privacy Practices** prior to signing this acknowledgement;
- That **Pain Institute of Central Ca., Inc.** reserves the right to change their **Notice of Privacy Practices** and prior to implementation of this will mail a copy of any revised notice to the address I've provided of requested.

Signature of Individual or Legal Representative Witness: \_\_\_\_\_

Printed Name of Individual or Legal Representative Witness: \_\_\_\_\_

Date: \_\_\_\_\_





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### **EXPLANATION OF CHARGES**

Pain Institute of Central California, Inc. provides services through two separate entities- A Pain Medicine Clinic and a Surgery Center. Each has its own schedule of fees, which are Billed separately. The Physician's professional fee and related charges are billed by the Pain Medicine Clinic. The cost associated with the use of the operating room is billed through the Surgery Center.

**BILLING STATEMENTS:** For your convenience we will bill your insurance company, however, insurance policies rarely pay the full cost of providing a service. Before receiving a service, verify the amount your insurance will pay. You will be billed any amounts not collected from your insurance, including deductibles and co-insurance. Payment is due when your statement is received. **The statement for the Pain Medicine Clinic is white in color and the Surgery Center's is yellow.**

**MISSED APPOINTMENTS:** Missed appointments are not tolerated. Failure to reschedule an appointment will result in a \$25 charge, payable in cash or check prior to your next appointment. We will discontinue services to patient's that repeatedly miss scheduled appointments.

**CASH PATIENTS:** Cash paying patients receive a significant discount. Payments are due on the day services are provided. All cash paying patients must make payment arrangements with Pam (661)325-8498 prior to visit.

**MEDICARE PATIENTS:** Medicare requires beneficiaries to pay both a deductible and 20% co-insurance on all medicare allowable charges. Allowable charges are less than billed charges. Your secondary (Medi-Gap) insurance may pay some or all of these amounts.

**MEDI-CAL:** At this time we do not accept new Medi-Cal patients.

**WORKERS' COMPENSATION:** Your industrial carrier is responsible for paying all approved medical expenses. Prior authorization of all services is required.

**HMO AND OTHER MANAGED CARE PLANS:** Prior authorization of services is usually required. We accept contract amounts fro some, but not all of these plans. You will be responsible for co-insurance, deductibles and all non covered services. Co-payments are due the day a service is provided.

**INDEMNITY INSURANCE:** (e.g. Blue Cross): Prior authorization is generally not required. Patients are responsible for deductibles, co-insurance and amounts not paid by their insurance. Co-payments are due on the day a service is provided.

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**OFFICE FINANCIAL POLICY FOR MEDICARE PATIENTS**

**TO OUR PATIENTS:**

We are committed to your treatment being successful. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment. (Note: All patients must complete our "Patient Information Form" before seeing the doctor).

**MEDICARE PATIENTS:** We accept Medicare assignment under the Medicare program. We will bill Medicare for you as a courtesy and you will be responsible for you annual deductible and the 20% of the allowable charges Medicare will not pay. Your secondary insurance will also be billed if information is available. A service charge of 1.00% per month (12.0% APR) will be charged on any balance past due by more than 90 days.

**USUAL AND CUSTOMARY RATES:** Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area.

**MISSED APPOINTMENTS:** Unless canceled at least 24 hours in advance. Our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

**MEDICATIONS AND SPECIAL SUPPLIES:** Our office purchases medication and special supplies directly from the pharmacy and supplier. You will be charged for any dispensed medication and/or special supply provided at retail cost.

**AUTHORIZATION FOR INSURANCE BENEFITS:** I hereby authorize Pain Institute of California, Inc. to bill my insurance company directly. Furthermore, I authorize my insurance company to pay the above provider the benefit accruing to me under my medical/hospital and surgical policy for professional service rendered. I understand I am financially responsible for charges no covered by this assignment. I also authorize my insurance company and/or the above provider to release information regarding myself for the services provided.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read the above and acknowledge that I am aware of the financial policy. I also agree that failure on my part to comply with the policy will make my account eligible to be given to a collection agency.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

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**OFFICE FINANCIAL POLICY FOR MEDI-CAL PATIENTS**

**TO OUR PATIENTS:**

We are committed to your treatment being successful. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment. (Note: All patients must complete our "Patient Information Form" before seeing the doctor).

**MEDI-CAL PATIENTS:** We will bill Medi-cal for you but you are responsible for your share of cost when it applies. You will need to present your Medi-cal card so we can verify you eligibility. If we find that you are not eligible to receive Medi-cal benefits, you are held responsible for paying the service rendered by our physician. A service charge of 1.00% per month (12.0% APR) will be charged on any past due balance by more than 90 days.

**USUAL AND CUSTOMARY RATES:** Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area.

**MISSED APPOINTMENTS:** Unless canceled at least 24 hours in advance. Our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

**MEDICATIONS AND SPECIAL SUPPLIES:** Our office purchases medication and special supplies directly from the pharmacy and supplier. You will be charged for any dispensed medication and/or special supply provided at retail cost.

**AUTHORIZATION FOR INSURANCE BENEFITS:** I hereby authorize Pain Institute of California, Inc. to bill my insurance company directly. Furthermore, I authorize my insurance company to pay the above provider the benefit accruing to me under my medical/hospital and surgical policy for professional service rendered. I understand I am financially responsible for charges not covered by this assignment. I also authorize my insurance company and/or the above provider to release information regarding myself for the services provided.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read the above and acknowledge that I am aware of the financial policy. I also agree that failure on my part to comply with the policy will make my account eligible to be given to a collection agency.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

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**OFFICE FINANCIAL POLICY FOR HMO PATIENTS**

**TO OUR PATIENTS:**

We are committed to your treatment being successful. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment. (Note: All patients must complete our "Patient Information Form" before seeing the doctor).

**HMO PATIENTS:** We will bill you HMO carrier directly and you will only be responsible for you co-payment at the time service is rendered. All services must be authorized before benefits can be paid. You will be held responsible for non-authorized emergency visits if and when your HMO denies a retro-authorization on such. A service charge of 1.0% per month (12.0% APR) will be charged on any balance past due by more than 90 days.

**USUAL AND CUSTOMARY RATES:** Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area.

**MISSED APPOINTMENTS:** Unless canceled at least 24 hours in advance. Our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

**MEDICATIONS AND SPECIAL SUPPLIES:** Our office purchases medication and special supplies directly from the pharmacy and supplier. You will be charged for any dispensed medication and/or special supply provided at retail cost.

**AUTHORIZATION FOR INSURANCE BENEFITS:** I hereby authorize Pain Institute of California, Inc. to bill my insurance company directly. Furthermore, I authorize my insurance company to pay the above provider the benefit accruing to me under my medical/hospital and surgical policy for professional service rendered. I understand I am financially responsible for charges no covered by this assignment. I also authorize my insurance company and/or the above provider to release information regarding myself for the services provided.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read the above and acknowledge that I am aware of the financial policy. I also agree that failure on my part to comply with the policy will make my account eligible to be given to a collection agency.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

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**Arturo Palencia, M.D. \* Afaq Kazi, M.D.**  
Phone: (661)665-7880 Fax: (661)665-7811

**OFFICE FINANCIAL POLICY FOR CASH PATIENTS**

**TO OUR PATIENTS:**

We are committed to your treatment being successful. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment. (Note: All patients must complete our "Patient Information Form" before seeing the doctor).

**CASH PATIENTS:** If you do not have a valid insurance plan to cover the costs of our services, you will need to make full payment at the time of service and/or procedure.

**SERVICE CHARGE:** A 1% service charge per month (12.0% APR) will be charged on any balance past due by more than 90 days.

**USUAL AND CUSTOMARY RATES:** Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area.

**MISSED APPOINTMENTS:** Unless canceled at least 24 hours in advance. Our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

**MEDICATIONS AND SPECIAL SUPPLIES:** Our office purchases medication and special supplies directly from the pharmacy and supplier. You will be charged for any dispensed medication and/or special supply provided at retail cost.

**AUTHORIZATION FOR INSURANCE BENEFITS:** I hereby authorize Pain Institute of California, Inc. to bill my insurance company directly. Furthermore, I authorize my insurance company to pay the above provider the benefit accruing to me under my medical/hospital and surgical policy for professional service rendered. I understand I am financially responsible for charges not covered by this assignment. I also authorize my insurance company and/or the above provider to release information regarding myself for the services provided.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read the above and acknowledge that I am aware of the financial policy. I also agree that failure on my part to comply with the policy will make my account eligible to be given to a collection agency.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

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**OFFICE FINANCIAL POLICY FOR W-COMP PATIENTS**

**TO OUR PATIENTS:**

We are committed to your treatment being successful. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment. (Note: All patients must complete our "Patient Information Form" before seeing the doctor).

**W-COMP PATIENTS:** Your worker's compensation carrier is responsible for your medical expenses. Please provide us with complete billing information and make sure that prior authorizations have been obtained to ensure medical reimbursements.

**USUAL AND CUSTOMARY RATES:** Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area.

**MISSED APPOINTMENTS:** Unless canceled at least 24 hours in advance. Our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

**MEDICATIONS AND SPECIAL SUPPLIES:** Our office purchases medication and special supplies directly from the pharmacy and supplier. You will be charged for any dispensed medication and/or special supply provided at retail cost.

**AUTHORIZATION FOR INSURANCE BENEFITS:** I hereby authorize Pain Institute of California, Inc. to bill my insurance company directly. Furthermore, I authorize my insurance company to pay the above provider the benefit accruing to me under my medical/hospital and surgical policy for professional service rendered. I understand I am financially responsible for charges not covered by this assignment. I also authorize my insurance company and/or the above provider to release information regarding myself for the services provided.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read the above and acknowledge that I am aware of the financial policy. I also agree that failure on my part to comply with the policy will make my account eligible to be given to a collection agency.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

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**OFFICE FINANCIAL POLICY FOR PRIVATE PATIENTS**

**TO OUR PATIENTS:**

We are committed to your treatment being successful. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment. (Note: All patients must complete our "Patient Information Form" before seeing the doctor).

**PRIVATE PATIENTS:**We will bill you insurance for you as a courtesy. Please provide the necessary forms and complete billing information. We find that some of the insurance policies cover only a portion of the charges. You will be required to pay for your portion of our charges at the time of service, i.e. co-payments and deductibles. (Note: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Therefore, you are completely responsible for the cost of your treatment if and when the insurance fails to process and pay our claim within 60 days.

**SERVICE CHARGE:**A 1% service charge per month (12.0% APR) will be charged on any balance past due by more than 90 days.

**USUAL AND CUSTOMARY RATES:** Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area.

**MISSED APPOINTMENTS:** Unless canceled at least 24 hours in advance. Our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

**AUTHORIZATION FOR INSURANCE BENEFITS:** I hereby authorize Pain Institute of California, Inc. to bill my insurance company directly. Furthermore, I authorize my insurance company to pay the above provider the benefit accruing to me under my medical/hospital and surgical policy for professional service rendered. I understand I am financially responsible for charges not covered by this assignment. I also authorize my insurance company and/or the above provider to release information regarding myself for the services provided.

**BUSINESS INTEREST DISCLOSURE STATEMENT:** As required by recent CA Law of Business and Professional Code section 654.2, this notice is to inform you that I have ownership interest in where he performs some of his procedures. We maintain this interest to provide the highest quality of service at competitive prices. If you prefer to have your procedure done in another facility, please discuss with our scheduling desk to determine if this is feasible with your insurance coverage and if so, we can make arrangements for you.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read the above and acknowledge that I am aware of the financial policy. I also agree that failure on my part to comply with the policy will make my account eligible to be given to a collection agency.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_