PREMIER MEDICAL

PHONE (210) 616-9400 FAX (210) 616-9402

Dmitriy Buyanov, M.D.
Larina Gutenberg, D.O.
Alexander Timchenko, M.D.
Michael Mcleod, M.D.
Aamir Siddiqi, M.D.

Information on New Consultation Appointments

We are pleased that you have been referred to our office. As part of the initial appointment, we will need you to fill out paperwork that pertains to your medical history; insurance coverage and contact information. We request that you have this filled out by the time you check in to our office to make this process easier for you. This paperwork can be down loaded from our web site. Otherwise, arriving **45 minutes** before your appointment time should allow enough time to fill out paperwork and check in. We request that you bring all your medications, including over the counter medications, picture ID, and insurance cards. If your address in the ID is not correct, we will need a recent utility bill with the correct address.

At your initial appointment, our purpose is to do a complete evaluation, to include a clinical review of x-rays reports/films that have been taken recently that relate to your pain concerns. Without this information, we cannot perform a comprehensive evaluation or review options for your care. If medical records are not provided by you or your referring doctor a second appointment may be required after the medical records have been received to complete the medical evaluation. We may also need to order current radiological examinations, lab work, etc. If needed to complete our evaluation. Please note it is not our protocol to prescribe medication during the evaluation process. If medication is part of your treatment plan, then it will be discussed with protocols on how these medications are managed through our office.

Once a complete evaluation is done, we will discuss treatment options. If you wish to proceed with our plan of care and we accept you as a patient, then the patient/provider relationship will begin. Be assured that the evaluation is kept in the strictest confidence. We understand that you have the option to not pursue a relationship as a patient. We also reserve the right to accept you as a patient once we determine that we can be of assistance.

We hope this information is helpful and we look forward to working with you.

Sincerely,

Management
PREMIER MEDICAL

_____ _____

Patient signature Date

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PATIENT INFORMATION

REFERRED BY: _____ E-MAIL ADDRESS: _____

LAST NAME (PASADO): _____ FIRST NAME (PRIMERO): _____ MI: _____

ADDRESS (DIRECCION): _____

CITY (CIUDAD): _____ STATE (ESTADO): _____ ZIP: _____

PHONE #_____AGE____ DATE OF BIRTH _____/____/_____ SEX ___M ___F
SOC. SEC # _____ /____ /_____

MARITAL STATUS ☐S ☐M ☐D ☐W SPOUSE'S NAME _____

EMPLOYER INFROMATION

OCCUPATION: _____

EMPLOYER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

BUSINESS PHONE#: _____ FAX #: _____

INSURANCE INFORMATION

TYPE OF INSURANCE ☐PRIVATE HEALTH ☐MEDICARE ☐NONE

INSURED'S NAME: _____ DATE OF BIRTH: ___/___/_____ SS#: ____/___/_____

PATIENT'S RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER _____

NAME OF INSURANCE CO: _____ POLICY #: _____

SECONDARY INSURANCE

INSURED'S NAME: _____ DATE OF BIRTH: ___/___/_____ SS#: ____/___/_____

PATIENT'S RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER _____

NAME OF INSURANCE CO: _____ POLICY #: _____

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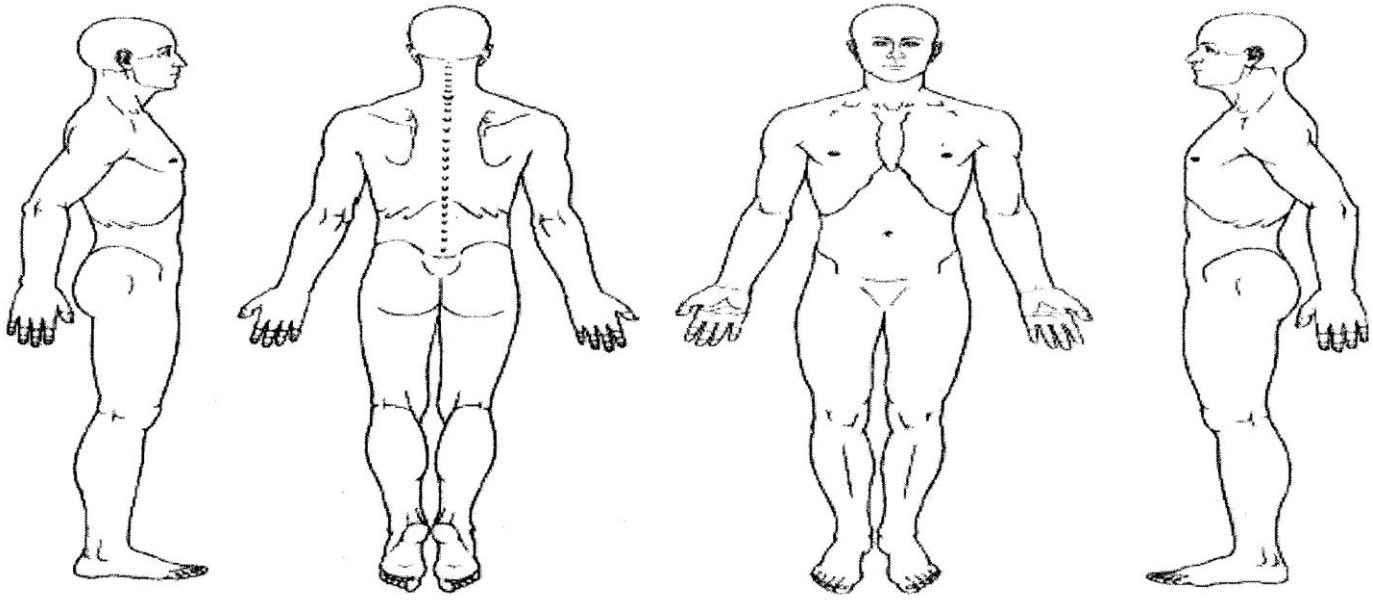
CONFIDENTIAL NEW PATIENT QUESTIONNAIRE

MARK ON THE PICTURE WHERE YOU ARE HAVING PAIN. ALSO MARK (**X**) FOR NUMBNESS, (**T**) FOR TINGLING, (**B**) FOR BURNING.



Is your pain mostly in your: ☐neck ☐ arm ☐about the same **OR** ☐back ☐leg ☐ about the same

How bad are your symptoms at their:

	None										Unbearable
Today:	0	1	2	3	4	5	6	7	8	9	10
Best:	0	1	2	3	4	5	6	7	8	9	10
Worst:	0	1	2	3	4	5	6	7	8	9	10

Duration of pain:

☐< 1 week ☐1-4 weeks ☐1-3-months
☐3-6 months ☐6-12 months ☐>1 year

How and when did the pain begin? _____ (month/year)

☐Work Accident ☐Following surgery
☐Home Accident ☐Other accident or injury
☐Auto Accident ☐Unknown
☐Other _____

How has your pain intensity changed since it began

☐Continuously ☐Constantly (76%-100% of the day) ☐Frequently (51-75% of the day)
☐Occasionally (26-50% of the day) ☐Intermittently (0-25% of the day)
☐less than daily ☐Weekly ☐Monthly

Select one or more items below to describe the nature of your pain:

☐ Throbbing ☐Shooting ☐Sharp ☐ Cramping ☐ Hot/Burning
☐ Aching ☐Stabbing ☐ Tingling ☐Numbing ☐ Dull ache

How do the following factors affect your pain?

	Better	Worse	No effect		Better	Worse	No effect
Heat	☐	☐	☐	Climate	☐	☐	☐
Cold	☐	☐	☐	Fatigue	☐	☐	☐
Lying down	☐	☐	☐	Coughing	☐	☐	☐
Sitting	☐	☐	☐	Massage	☐	☐	☐
Walking	☐	☐	☐	Alcohol	☐	☐	☐
Sneezing	☐	☐	☐	Lifting	☐	☐	☐
Sleeping on back	☐	☐	☐	Sleeping on stomach	☐	☐	☐
Sex	☐	☐	☐				

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CONFIDENTIAL NEW PATIENT QUESTIONNAIRE (cont.)

Which of the following activities are affected by your pain?
☐Mood ☐Activities of daily living ☐Social interactions ☐Household chores ☐Sexual Activity
☐Work ☐Falling asleep ☐Staying asleep ☐Leisure ☐Ability to enjoy life

Do you have any: ☐Urinary incontinence ☐Stool incontinence ☐Sexual function disturbance
Check the treatments you have had for pain, please provide treatment dates:
☐Acupuncture: _____ ☐Physical Therapy: _____ ☐Biofeedback: _____
☐Exercise: _____ ☐Psychotherapy: _____ ☐TENS unit: _____
☐Facet Blocks: _____ ☐Epidurals: _____ ☐Nerve Blocks: _____
☐Trigger Points: _____ ☐Massage:_____ ☐Hypnosis: _____
☐Chiropractor: _____ ☐Brace: _____ ☐Surgery: _____

PAST MEDICAL HISTORY **REVIEW OF SYSTEMS**

Constitutional
☐Obesity ☐Weight loss ☐ Weight gain ☐Chills ☐Fever ☐Fatigue
☐ Loss of appetite ☐ Night Sweats
Musculoskeletal
☐Arthritis ☐Fibromyalgia ☐ Muscle Spasms ☐Numbness ☐Weakness
Neurological
☐Headache ☐Seizures ☐ Migraines ☐ Stroke ☐Confusion ☐Dizziness ☐Light Sensitivity
☐ Sense of smell ☐ Chewing ☐ Swallowing ☐ Loss of balance ☐ Change in voice/speech
☐ Memory Loss ☐ Change in facial appearance
Psychiatric
☐Depression ☐Substance abuse ☐Anxiety ☐Suicidal thoughts ☐ Fatigue
☐Anxiety ☐Bipolar ☐Schizophrenia ☐Difficulty Sleeping ☐ Mood Swings
Cardiovascular
☐Angina ☐Heart Attack ☐Heart Stent ☐Chest Pain ☐Palpitations
☐Pacemaker ☐High Blood Pressure (Hypertension)
Respiratory
☐Asthma ☐Emphysema ☐Chronic Bronchitis ☐Cough ☐Shortness of Breath ☐Bloody Cough
Gastrointestinal
☐Reflux ☐Hepatitis ☐Ulcers ☐Diarrhea ☐Constipation ☐Abdominal Pain
☐Incontinence ☐ Irritable Bowel Syndrome ☐Heartburn ☐Bloating ☐Nausea
☐Cirrhosis ☐Diverticulitis ☐Colon Cancer ☐Vomiting ☐Bloody Stools ☐Painful Bowel Movement
Genitourinary
☐Impotence ☐Kidney Stones ☐Incontinence ☐Decreased Libido ☐Urinary frequency ☐Bloody Urine
☐Urinary Tract Infection ☐Cancer ☐Prostate Problems ☐Urinary Hesitancy
Integumentary
☐Herpes Zoster/Shingles ☐Skin Cancer ☐Rash/Hives ☐ Itchy Skin ☐Swelling
Endocrine, Hematologic, Allergy/Immunologic, HEENT
☐Diabetes ☐Hypothyroidism ☐Hyperthyroidism ☐Easy Bruising ☐Ringing in Ears ☐Lymphoma
☐HIV ☐Hyperlipidemia (Elevated Cholesterol) ☐Visual Changes ☐Leukemia ☐Multiple Myeloma
☐Cancer:_____
Rheumatologic
☐Lupus ☐Sjogren's ☐Scleroderma ☐Painful joints ☐Blurry Vision
☐Polymyalgia Rheumatic ☐Rheumatoid Arthritis ☐ Multiple Sclerosis ☐ Other:_____
Do you have ALLERGIES to any medications? ☐YES ☐NO if YES please list:_____
Do you Smoke? ☐YES ☐NO How many packs per day?_____ How many years?_____

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Do you Drink Alcohol? ☐YES ☐NO How much per day?_____ How many years?_____
Do you use Illicit drugs? ☐YES ☐NO How much per day?_____ How many years?_____

CONFIDENTIAL NEW PATIENT QUESTIONNAIRE (cont.)

PAST SURGICAL HISTORY (mark and list surgeries that you have, please provide approximate date):

☐Appendectomy: _____	☐Tonsillectomy/Adenoids: _____	☐Gallbladder surgery: _____
☐Coronary Bypass:_____	☐Hernia Repair: _____	☐Hemorrhoid: _____
☐Tubal Ligation: _____	☐Mastectomy: _____	☐Breast Biopsy: _____
☐Prostate:_____	☐Vasectomy: _____	☐Hysterectomy and ovaries:_____
☐Knee Replacement: _____	☐Hip Replacement: _____	☐Knee Surgery: _____
☐Shoulder Surgery: _____	☐Cataracts:_____	☐Colon: _____
☐Back Surgery: _____	☐Neck Surgery: _____	☐Other: _____

WOMEN: ARE YOU PREGNANT? ☐YES ☐NO ☐NOT SURE PATIENT'S INITIALS: _____

FAMILY HISTORY

	DIABETES	HEART	ANXIETY	KIDNEY	CANCER	DEPRESSION	BACK	OTHER CONDITIONS
MOTHER	☐	☐	☐	☐	☐	☐	☐	☐_____
FATHER	☐	☐	☐	☐	☐	☐	☐	☐_____
BROTHER (S)	☐	☐	☐	☐	☐	☐	☐	☐_____
SISTER (S)	☐	☐	☐	☐	☐	☐	☐	☐_____

List All Medications You Are Currently Taking:

Medication	Dose	Medication	Dose
1.		**9.**	
2.		**10.**	
3.		**11.**	
4.		**12.**	
5.		**13.**	
6.		**14.**	
7.		**15.**	
8.		**16.**	

Past pain medications tried:

I ACKNOWLEDGE THAT I HAVE COMPLETED THIS QUESTIONAIRE ACCURATELLY AND TO THE BEST OF MY KNOWLEDGE.

_____ _____

PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

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CONFIDENTIAL NEW PATIENT QUESTIONNAIRE (cont.)

ASSIGNMENT OF BENEFITS/RIGHT FOR DIRECT PAYMENT TO DOCTOR

PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE ASSIGNMENT FOR DIRECT PAYMENT TO DOCTOR

I hereby instruct and direct the _____ Insurance Company to pay by check made out and mailed directly to: Premier Pain Consultants, for professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered.
THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.
This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay any balance of said professional service charges over and above this insurance payment in full, except in instances where No-Fault or Workers' Compensation insurance fee schedules apply.

I also understand and agree that I am ultimately responsible for all fees including reasonable collection costs. This assignment of benefits does not release me from my obligation to pay professional fees.

A PHOTO COPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.
I authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

_____ _____

Signature of patient, parent or guardian: Date

MEDICARE ASSIGNMENT OF BENEFITS/RIGHTS FOR DIRECT PAYMENT TO DOCTOR

I request that payment of authorized Medicare benefits be made on my behalf to PREMIER PAIN CONSULTANTS, PLLC for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Signature of patient, parent or guardian: Date

APPOINTMENT POLICY

In an effort to provide efficient treatment to all of our patients, it is the policy of this company that if you are unable to make your scheduled appointment, you must call to cancel/reschedule the appointment no later than 24 hours before the scheduled time. If you fail to cancel/reschedule your appointment or fail to show up to the appointment, you will be charged a "NO SHOW" fee of $25 per occurrence. For most instances plans and Worker's Compensation carriers "NO SHOW" charges are non-covered service. You will be solely responsible for payment of this charge. Repeated "NO SHOW" and cancellations of your schedule appointments may result in you being DISCHARGED from care at the Premier Pain Consultants, PA. If you have any question about this form, please talk to our staff before signing.

_____ _____

Signature of patient, parent or guardian: Date

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PAYMENT AUTHORIZATION

PLEASE READ CAREFULLY AND THOROUGHLY, IF YOU HAVE ANY QUESTIONS
PLEASE ASK BEFORE SIGNING

Name of Patient: _____ Date of Birth: _____

I hereby authorize medical/surgical treatment care and /or services by Premier Pain Consultants, PLLC, to the above named patient.

I, the undersigned, fully understand that I am primarily and financially responsible for the fees incurred by the above named patient. I further understand that the payment to said doctor is not contingent on any settlement, judgment or verdict by which the above patient may eventually recover for sad medical/surgical fees. The undersigned individually obligates him/her to pay the account of the medical services in accordance with the regular rates and terms of the physician practice.
I hereby, assign, transfer, and convey payment and authorize said payment to be made directly to Premier Pain Consultants, PA, for any hospital benefits, sick benefits, injury benefits, due because of liability of a third party, or proceeds of all claims resulting from the liability of a third party, payable by any party, organization, etcetera, to or for discharge or completion of all outstanding obligation related to these medical services. I further agree that this assignment **WILL NOT BE WITHDRAWN OR VOIDED** at any time until this account for this medical service is paid in full.

I understand that providing this information does not guarantee payment of any health care claim by my insurance carrier and such information is subject to change even retroactively, at any time.

I hear by authorize photocopies of this form to be valid as the original.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize Premier Pain Consultants, PLLC, to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I certify that I have read and fully understand the above.

_____ _____
Signature of patient, parent or guardian: SSN

Witness: _____ Date: _____

IF A PATIENT IS A MINOR (LESS THAN 18 YEARS OF AGE). A PARENT OR GUARDIAN MUST SIGN.

IT'S THE POLICY OF THIS OFFICE THAT PAYMENT IS DUE AT THE TIME OF SERVICE

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OFFICE PROTOCOL AGREEMENT

The following protocols are necessary to provide appropriate care to all our patients. Please review, initial each entry and sign below indicating that you understand these office protocols and agree to abide be them. Lack of signature does not invalidate these protocols.

I understand that refills are given at the time of the office visit. Refills are not done over the phone. _____(Initial)

I understand with controlled substance therapy (narcotics), it is expected that I may need to undergo random urine drug testing as part of my treatment plan. _____(Initial)

I understand that I am an active participant in my health care and agree to abide by the treatment plan given and reviewed with me at each visit. I understand that any changes in condition may need an office visit for reassessment. For acute changes in my condition, I may need to access care through the emergency room. _____(Initial)

I understand that this practice utilizes mid level practitioners such as Physicians'' Assistant and Nurse Practitioner. They provide care in terms of assessing new patients: assessing patients on routine follow-ups; assessing any changes in conditions; education of patient on condition, meds and treatment options. _____(Initial)

I understand that my access to care via telephone or on site will require my behavior to be in a manner that is not abusive to staff. I agree to refrain for behavior that reflects yelling, cursing, name-calling or multiple calls in same day. I understand that this behavior may terminate my relationship with this practice. _____(Initial)

I agree to cancel my established appointments in advance to benefit other patients that are in need of earlier appointments. I understand that not showing up for an appointment without calling in advance, may be a factor in the continuation or discontinuation of my care with this group. _____(Initial)

I understand that I am to arrive 15 minutes before my appointment time to check in for follow up appointments and 45 minutes before a new patient appointment. _____(Initial)

Patients Name: _____
(print name)

Patients Signature: _____

Date: _____

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LONG-TERM CONTROLLED SUBSTANCE THERAPY AGREEMENT

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefits. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Our policy regarding narcotic use for CHRONIC NONMALIGNANT (non-cancerous) pain is **strict and non-negotiable,** and is based on medical research and clinical experience. Narcotics should be used **ONLY** as a last resort and **ONLY** as an adjuvant to other therapies. The physician will provide physical resources to improve your function, as well as medical therapies and injections. Our goal is to minimize narcotic use. The rules regarding narcotic use are outlined below. These rules were developed with the patient's welfare in mind. If these rules are unacceptable or at odds with your medical goals, we will honor your request to be referred to another pain management physician.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the physician to consider the initial and/or continued prescription of controlled substance to treat your chronic pain. It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit.

1. All controlled substances must come from the physician who is assigned to your care or, during his or her absence, by the covering provider, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment.) You are not to receive prescriptions for narcotic or sedative drugs from any other provider.
2. The prescribing provider has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.
3. 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:
   _____ Phone: _____
4. Unannounced urine or serum toxicology screens will be requested, and your cooperation is <u>required.</u> Presence of unauthorized substances may prompt termination of your opioid treatment and referral for assessment for addictive disorder.
5. Long-acting narcotics will be administered for chronic pain problems. Our goal is the discontinuation of short acting narcotics and narcotic mixtures (i.e. Percocet, Lortab, Vicodin, etc.).
6. "Rescue Doses" of short acting narcotics will not be routinely prescribed.
7. Refills will occur on a monthly basis and ONLY after a visit and physical examination. **NO REFILLS WILL BE MADE OVER THE TELEPHONE. NO REFILLS WILL BE GIVEN AFTER HOURS, ON WEEKENDS, OR HOLIDAYS. <u>Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.</u>**
8. If refill requests are made after hours, you will be instructed by the answering service to go to an emergency room of your choice.
9. Your are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.

_____ _____

Patient's Name (Printed) Patient's Signature

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10. Prescriptions may be issued early if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they not to be filled prior to the appropriate date. Early refills will not be given.
11. Any evidence of prescriptions, forged prescriptions, substance abuses. Or aberrant behavior (including verbal abuse to my office staff) will result in termination of patient-physician relationship.
12. Medications will not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc., so protect your medications. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made.
13. Prescriptions are to be used **ONLY** written. Use of increased amount of medication, without consultation with a physician, will not be allowed.
14. You may not share, sell, or otherwise permit others to have access to these medications.
15. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.
16. Original containers of medications should be brought in to each office visit.
17. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.
18. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.
19. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.
20. The risks are potential benefits of these therapies are explained elsewhere (and you acknowledge that you have received such explanation).
21. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.
22. Termination terms will include a written letter to you and fulfillment of your medical needs, including narcotic prescription, for one month after the date of termination. You will be presented with the option, in lieu of termination, to receive an evaluation for drug dependency and, if appropriate, be referred for detoxification.

Your pain is **YOUR** responsibility. Making appointments for medication refills is **YOUR** responsibility. Premier Pain Consultants, P.A., will provide medical support in you quest to minimize your pain. You must make new efforts to improve SLEEP HABITS, NUTRITION, BODY WEIGHT, CONDITIONING, and PSYCHOLOGICAL STATE. Narcotics are not the answer to chronic pain, but can be used effectively to improve your pain.

You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

I, _____, have read and accept the conditions of this contract.

_____ _____

Signature of patient, parent or guardian: SSN

Witness: _____ Date: _____

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NOTICE OF PRIVACY/COMMUNICATION AUTHORIZATION FORM

Patient Name: _____ Date of Birth: _____

By signing below I acknowledge that I have been given the opportunity to read and/or take a copy of the Premier Pain Consultants, PLLC Privacy Practices Policy.

When it comes to your medical treatment we strive to communicate with you in a timely and professional manner. As a patient there are certain occasions when you will want our staff to be able to communicate directly with family members, friends, or any other individuals that might be involved in your care.

In order to protect the privacy of your personal health information, please indicate below the names of those individuals with whom we can discuss your protected health information with:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

By signing below I hereby authorize Premier Pain Consultants, PLLC to disclose any billing, medical or other relevant information to the individuals indicated above in the following manner by **initialing below**:

_____ Speak To Me Only

_____ May Leave Me Detailed Voicemails

Printed Name: _____ Date: _____

Patient Signature: _____ Date: _____