Douglas Dobecki, M.D.
5395 Ruffin Rd, Unit 202
San Diego, CA, 92123
T (858) 576-1011
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Welcome to San Diego Pain Institute!

Address:
5395 Ruffin Road
Unit 202
San Diego, CA. 92123

Telephone: (858) 576-1011 Fax: (858) 576-1025

Consultation Scheduled: _____

***Please complete this packet and bring with you to your appointment along with your insurance card/s and a photo ID. If you do not have your completed packet with you for your appointment, then check in 1 hour early. Thank you.**

New Patient Coordinator
Tel: (858) 576-1011
Fax: (858) 576-1025

Today's Date:_____/____/_____ **Please fill out the following information to help us bill your claims correctly.**

Patient's Legal Name:_____Date of Birth:_____SSN#:_____

Address:_____City:_____State:_____Zip:_____

Home Phone #:_____Cell Phone #:_____Work Phone #: _____

E-Mail Address:_____Marital Status: _____

Emergency Contact:_____Phone #:_____Relationship to you: _____

Primary Care Provider:_____Referring Provider: _____

Are you currently working/retired, etc.? _____

With what race, do you identify? ❑ Hispanic or Latino ❑ Non-Hispanic or Latino ❑ Decline to Answer

With what ethnicity, do you identify? ❑ American Indian/Alaskan Native ❑ African American/Black ❑ Asian

❑ Native Hawaiian/Pacific Islander ❑ White ❑ Decline to Answer ❑ Other: _____

What is your preferred language? ❑ English ❑ Spanish ❑ Other: _____

If we are treating you under your <u>private insurance,</u> please complete the following:

<u>PRIMARY INSURANCE:</u> _____ID #:_____Group #: _____

Primary Subscriber — Name: _____Date of Birth: _____

Subscriber's SSN#:_____Relationship to you? _____

<u>SECONDARY INSURANCE:</u> _____ID #:_____Group #: _____

Primary Subscriber — Name: _____Date of Birth: _____

Subscriber's SSN#:_____Relationship to you? _____

If we are treating you under a <u>personal injury lien</u> from your attorney, please complete the following:

Attorney: _____ Phone #: _____ Fax #: _____

Date of Injury: _____ Type of Injury: _____

Have you or do you currently have a worker's compensation claim? ❑ Yes ❑ No

AUTHORIZATION: I hereby authorize payment directly to San Diego Pain Institute, Inc for medical services rendered and to release any information acquired in the course of my examination or treatment to my insurance company and/or referring entity. I also acknowledge and understand that I am solely responsible for keeping my account current and accurate at all times with San Diego Pain Institute, which includes demographics, insurance information and balances due. Failure to notify San Diego Pain Institute of updates to my account may result in me being financially responsible for all services rendered.

Patient's / Guardian's Signature:_____Date: _____

San Diego Pain Institute

Douglas Dobecki, M.D.

Victoria Falasco, PA-C

New Patient Questionnaire

Patient Information

Appointment Date :____/____/_____

Name:_____DOB:_____Gender:_____

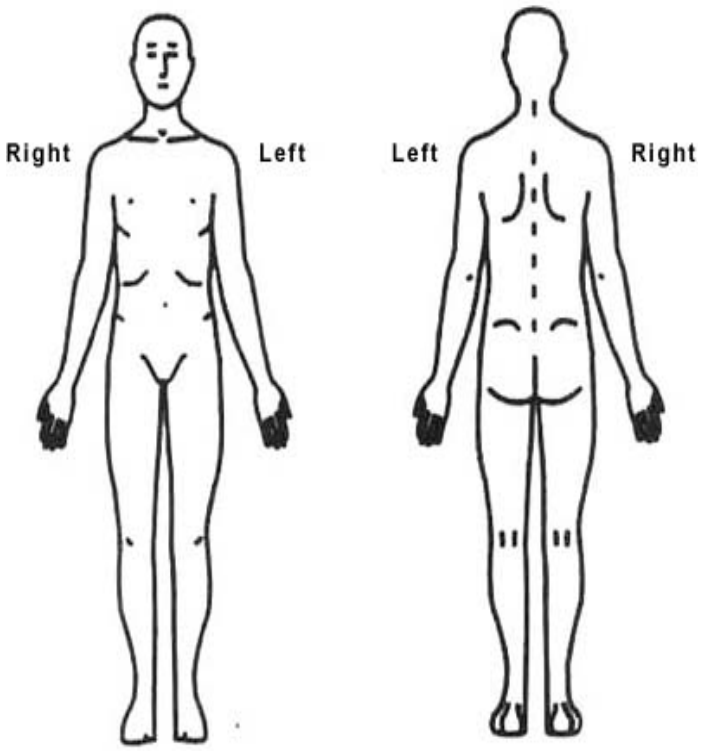
Reason for visit: _____

Are you Pregnant or planning to become pregnant? (Please Circle One) YES NO

Any implanted devices? (Pacemaker, Hearing Aid, etc.) NO YES _____

Current Pain Details

Please indicate all areas of your pain using the following symbols to fill in the diagram below:



N = Numbness
\+ = Sharp
* = Burning
Δ = Aching
// = Pins & Needles
✓ = Shooting
O = Other

Answer the following by circling number
From 0 (no pain) to 10 (worst pain imaginable)
What's is your **Current** pain score (0-10):
0 1 2 3 4 5 6 7 8 9 10
What's is your **Average** pain score (0-10):
0 1 2 3 4 5 6 7 8 9 10

Where is your worst pain located?

_____

Does your pain radiate? ❑ Yes ❑ No
If so, where? _____

CURRENT PAIN DETAILS (CONTINUED)

During the average day, rate your level of pain/discomfort:

What is your ***Current*** pain score (0-10):	0	1	2	3	4	5	6	7	8	9	10
What is your ***Average*** pain score (0-10):	0	1	2	3	4	5	6	7	8	9	10
What is your ***Highest*** pain score (0-10):	0	1	2	3	4	5	6	7	8	9	10
What is your ***Lowest*** pain score (0-10):	0	1	2	3	4	5	6	7	8	9	10

Have you developed any of the following? (Please check all that apply):

❑ Numbness	❑ Suicidal Thoughts	❑ Chills	❑ Vomiting
❑ Weakness	❑ Homicidal Thoughts	❑ Fevers	❑ Nausea
❑ Bowel Incontinence	❑ Difficult Walking	❑ Poor Sleep	❑ Current Infection
❑ Bladder Incontinence	❑ Balance Problems	❑ Fatigue	❑ Paresthesia

❑ I have not recently developed any of the above problems

Please indicate the type of pain/discomfort you are having (Please check all that apply):

❑ Sharp	❑ Pins & Needles	❑ Burning	❑ Dull
❑ Pressure	❑ Aching	❑ Shooting	❑ Pulsing
❑ Nagging	❑ Pinching	❑ Tingling	❑ Throbbing
❑ Numbing	❑ Tender	❑ Hot	❑ Cramping
❑ Crushing	❑ Squeezing	❑ Cutting	❑ Stinging
❑ Itching	❑ Splitting	❑ Shock-like	❑ Exhausting
❑ Heavy	❑ Stabbing	❑ Tiring	

PAIN SYMPTOM CHARACTERISTICS

What makes your pain better or worse? (Please circle one for each activity)

Bending Backward	Better	Worse	No Change
Bending Forward	Better	Worse	No Change
Twisting	Better	Worse	No Change
Prolonged Standing	Better	Worse	No Change
Prolonged Sitting	Better	Worse	No Change
Walking	Better	Worse	No Change
Lying Flat On Your Back	Better	Worse	No Change
Lying On Your Stomach	Better	Worse	No Change
Changes In Weather	Better	Worse	No Change
Climbing Stairs	Better	Worse	No Change
Coughing/Sneezing	Better	Worse	No Change
Lifting Objects	Better	Worse	No Change
Rising from a Sitting Position	Better	Worse	No Change

Patient Name: _____

PAIN SYMPTOM CHARACTERISTICS (CONTINUED):

ONSET: When did your pain begin? (Date): _____

TIMING: Did your pain begin gradually or suddenly? ❑ GRADUALLY ❑ SUDDENLY

Is your pain constant or intermittent? ❑ CONSTANT ❑ INTERMITTENT
When is your pain the worst? ❑ MORNING ❑ DAYTIME ❑ EVENING

CONTEXT: What caused your current pain episode? _____

EXERCISE/WORK

Are you able to perform your daily activities? ❑ YES ❑ NO

Do you exercise? ❑ YES ❑ NO If yes, what do you do? _____

How often do you exercise? (please check one): ❑ DAILY ❑ 2-3 DAYS WEEK ❑ WEEKLY ❑ MONTHLY

Are you on or seeking disability? ❑ YES ❑ NO

Are you currently working? ❑ YES ❑ NO Occupation: _____

OTHER THERAPIES TRIED

Which of the following therapies have you tried and did it make your pain better, worse or was there no change? (Please circle one for each therapy)

Therapies Tried:	Length of Time	Never Tried	Better	Worse	No Change
Physical Therapy		Never Tried	Better	Worse	No Change
TENS		Never Tried	Better	Worse	No Change
Acupuncture		Never Tried	Better	Worse	No Change
Biofeedback		Never Tried	Better	Worse	No Change
Brace Support		Never Tried	Better	Worse	No Change
Traction		Never Tried	Better	Worse	No Change
Psychological Therapy		Never Tried	Better	Worse	No Change
Injections	N/A	Never Tried	Better	Worse	No Change
Surgery	N/A	Never Tried	Better	Worse	No Change
Massage Therapy		Never Tried	Better	Worse	No Change
Chiropractor		Never Tried	Better	Worse	No Change
Ice		Never Tried	Better	Worse	No Change
Heat		Never Tried	Better	Worse	No Change
Daily Exercise		Never Tried	Better	Worse	No Change
Other:		Never Tried	Better	Worse	No Change

MEDICATIONS TRIED

Which of the following medications have you tried for your pain? (Please check all that apply):

❑ Opioids (Vicodin, Percocet, etc.)
❑ Anticonvulsants
❑ Anti-Inflammatory
❑ Benzodiazepines
❑ Muscle Relaxants
❑ Oral Steroids
❑ Constipation Medications
❑ Topical Creams
❑ Sleep Aids
❑ Anti-Depressants
❑ Anti-Rheumatics
❑ Migraine Medications
❑ Gout Medications
❑ Dopamine Stimulants
❑ Cymbalta/Savella
❑ Neurontin/Lyrica
❑ NSAIDs (Motrin, Aleve, etc.)
❑Other: _____

Patient Name:_____

INTERVENTIONAL PAIN TREATMENTS TRIED

Which of the following interventional pain treatments have you tried for your pain? (Please check all that apply):

❑ Facet Injections ❑ Nerve Blocks ❑ Intrathecal Therapy (Pump)

❑ Epidural Steroid Injections ❑ Radiofrequency Ablation ❑ Trigger Point Injections

❑ Medial Branch Blocks ❑ Spinal Cord Stimulator ❑ Vertebroplasty or Kyphoplasty

❑ Other _____

❑ I have not had **any** interventional procedures performed for my current pain problem

OTHER DOCTORS CONSULTED

Which of the following doctors have you consulted for pain relief?:

❑ Acupuncturist ❑ Anesthesiologist ❑ Chiropractor ❑ Dentist

❑ Endocrinologist ❑ ENT Physician ❑ General Physician ❑ Hypnotist

❑ Internist ❑ Neurologist ❑ Ophthalmologist ❑ Orthopedic Surgeon

❑ Neurosurgeon ❑ Pain Physician ❑ Physical Therapist ❑ Plastic Surgeon

❑ Podiatrist ❑ Psychiatrist ❑ Psychologist ❑ Rheumatologist

❑ Other _____

LITIGATION

Is there any pending litigation? ❑ YES ❑ NO

Is your pain related to a worker's compensation case? ❑ YES ❑ NO

Are you involved in a personal injury case? ❑ YES ❑ NO

DIAGNOSTIC TESTS AND IMAGING

Which of the following have you had done? If so, when?:

❑ MRI ❑ YES ❑ NO Date: _____/_____/_____

❑ Discogram ❑ YES ❑ NO Date: _____/_____/_____

❑ X-Ray ❑ YES ❑ NO Date: _____/_____/_____

❑ EMG/NC ❑ YES ❑ NO Date: _____/_____/_____

❑ Blood work related to current pain complaint ❑ YES ❑ NO Date: _____/_____/_____

❑ Other: _____

❑ I have NOT had any diagnostic test performed for my current pain condition

Patient Name: _____

CURRENT MEDICATIONS

Please list all CURRENT MEDICATIONS – Prescription & Over-the-counter: (Please Print Clearly)

Drug	Dose	Frequency

ALLERGIES

Are you allergic to LATEX?: ❑ YES ❑ NO

Do you have any CONTRAST allergies? ❑ YES ❑ NO

Other Allergies	Reaction

Patient Name:_____

PAST MEDICAL HISTORY

Have you had any of the following diseases or conditions? (Please circle all that apply):

(1) General

Cancer
Diabetes
Headaches
High Cholesterol
Hypertension
Kidney Dysfunction
Liver Dysfunction
Migraines

(2) Head/Eyes/Ears/Nose/Throat

Cataracts
Head Injury
Hyperthyroidism
Hypothyroidism
Stroke

(3) Gastrourinary

Dialysis
Kidney Stones
Urinary Incontinence
UTIs/Bladder Infections

(4) Cardiovascular

Anemia
Heart Attack
Angina
Vascular Disease
Peripheral Vascular Disease
Phlebitis
Coronary Artery Disease

(5) Gastrointestinal

GI Bleeding
Constipation
Bowel Incontinence
Irritable Bowel Syndrome
Crohn's/Ulcerative Colitis
GERD/Heartburn
Diarrhea
Ulcer History

(6) Respiratory

Asthma
Bronchitis
Fibromyalgia
Reflex Sympathetic Dystrophy/CRPS
Vertebral Compression Fracture
COPD
Emphysema

(7) Musculoskeletal

Amputation
Bursitis Tendonitis
Carpal Tunnel Syndrome
Chronic Joint Pain
Chronic Low Back Pain
Chronic Neck Pain
Elbow Pain
Rheumatoid Arthritis
Joint Injury
Lateral Epicondylitis
Medial Epicondylitis
Osteoarthritis
Osteopenia
Osteoporosis
Phantom Limb Pain

(8) Neuropsychological

Alcohol Abuse
Alzheimer Disease
Anxiety
Bipolar Disorder
Depression
Drug Abuse
Epilepsy
Multiple Sclerosis
Paralysis
Peripheral Neuropathy
Seizures
Schizophrenia

(9) Infectious Disease

Hepatitis (A), (B), (C)
HIV/AIDS
MRSA History
Pneumonia
Tuberculosis
Current Infection

Other

Please Describe:

_____
_____
_____

Patient Name: _____

PAST SURGICAL HISTORY

Please list all surgeries and dates:

Surgery	**Date(s)**

FAMILY HISTORY

❑ Chronic Pain	❑ Diabetes	❑ Kidney Problems	❑ Seizure History
❑ Arthritis	❑ Hypertension	❑ Liver Problems	❑ Alcohol Abuse
❑ Rheumatoid Arthritis	❑ Heart Disease	❑ Headaches	❑ Drug Abuse
❑ Cancer	❑ Lung Disease	❑ Stroke	❑ Depression

SOCIAL HISTORY

Do you drink alcohol? ❑ OFTEN ❑ SOCIALLY ❑ NEVER

Do you smoke/use tobacco? ❑ Current Everyday ❑ Current Someday ❑ Never ❑ Former

Do you use illegal drugs or have you used illegal drugs? ❑ Yes Current ❑ Yes Former ❑ Never

Have you ever abused or misused prescription medications? ❑ YES ❑ NO

REVIEW OF SYSTEMS

Do you have or have you had any of the following diseases or conditions?: (Please circle all that apply)

GENITOURINARY

Urinating Frequently
Urinating Urgency
Painful Urination
Kidney Stones
Blood in Urine
Kidney Disease
Flank Pain

SKIN

Dryness
Itching
Rash
Ulcers
Shingles
Seasonal Allergies
Hay Fever

RESPIRATORY

Shortness of Breath
Cough
Wheezing
Pulmonary Embolism

ENDOCRINE

Cold Intolerance
Hot Intolerance
Hot Flashes

GASTROINTESTINAL

Abdominal Pain
Liver Disease
Diarrhea
Constipation
Hernia
Acid Reflux/Heartburn
Blood in Stool
Irritable Bowel Syndrome
Ulcer Disease
Nausea/Vomiting

MUSCULOSKELETAL

Back Pain
Neck Pain
Joint Pain
Joint Swelling
Muscle Spasms
Joint Stiffness
Skin Temperature Changes
Skin Color Changes
Increase Sensitivity to Touch
Edema

NEUROLOGICAL

Carpal Tunnel Syndrome
Headaches
Loss of Balance/Coordination
Weakness
Numbness
Tremors
Seizures
Dizziness
Stroke
Migraines
Dementia
Hydrocephalus

CONSTITUTIONAL

Fevers
Tremors
Chills
Excessive Sweating
Night Sweats
Insomnia
Loss of Appetite
Fatigue
Unexplained weight loss or gain

CARDIOVASCULAR

Bleeding Disorder
Shortness of Breath
High Blood Pressure
Irregular Heartbeat
Fainting
Pacemaker
Swelling in Feet
Heart Failure
Blood Clots
Murmur
Angina

Head/Eyes/Ears/Nose/Throat

Blurred Vision
Ringing in Ears
Vertigo
Hearing Loss
Dry Mouth
Sinusitis
Abnormal Smells
Dental Issues
Nosebleeds
Earaches
Sore Throat
Sinus Problems
Difficulty Swallowing
Glasses
Excessive Tearing
Cataracts
Glaucoma

PSYCHIATRIC

Depression
Anxiety
Stress
Difficulty with Thinking
Poor Sleep

REPRODUCTIVE

Inability to Have Sex Due to Pain
Decreased Sex Drive

Name:_____ Date:_____

Please mark any medications that you have tried PREVIOUSLY or are CURRENTLY taking.

Antidepressants
Asendin (amoxaprine)
Celexa (citalopram)
Cymbalta (duloxetine)
Desyrel (trazedone)
Effexor (venlafaxine)
Elavil (amltriptyline)
Lexapro (escitalopram)
Luvox (fluvoxamine)
Norpramin (desipramine)
Pamelor (nortriptyline)
Paxil (paroxetine)
Pristiq (desvenlafaxine)
Prozac (fluoxetine)
Remeron (mirtazipine)
Savella (milnacipran)
Seroquel (quetiapine)
Serzone (nefazodone)
Sinequan (doxepin)
Tofranil (imipramine)
Vlibryd (vilazodone)
Vivactil (protriptyline)
Wellbutrin (bupropion)
Zoloft (sertraline)
Zyrexa (olanzapine)

Anxiolytics
Buspar (buspirone)
Equanil (meprobamate)
Trancopal (chlormezanone)
Vistaril (hydroxyzine)

Benzodiazepines
Ativan (lorazepam)
Clorazepate (tranxene)
Klonopin (clonazepam)
Librium (chlordiazepoxide)
Restoril (temazepam)
Serax (oxazepam)
Valium (diazepam)
Xanax (alprazolam)

Hypnotics
Ambien (zolpidem)
Intermezzo
Lunesta
Rozerem
Sonata (zaleplon)

Topical
Capsaicin
Flector Patch (Diclofenac)
Lidoderm Patch
Pennsaid (diclofenac)
Voltaren gel (diclofenac)
Ztlido (lidocaine)

Anti-arrhythmic
Mexitil (mexiletine)

Anticonvulsants
Depakote (valproic acid)
Dilantin (phenytoin)
Gabitril (tiagabine)
Gralise (gabapentin)
Lamictal (lamotrigine)
Lyrica (pregabalin)
Neurontin (gabapentin)
Tegretol (carbamazepine)
Topamax (topiramate)
Trileptal (oxcarbazepine)
Zonegran (zonisamide)
Horizant (gabapentin enacarbil)

NSAIDs
Salicylic Acid:
Aspirin
Disalcid (salsalate)
Dolobid (diflusinal)
Trillsate (choline mag)
Propionic Acid:
Aleve (naproxen)
Ansaid (flurbiprofen)
DayPro (oxaprozin)
Motrin (ibuprophen)
Orudis (ketoprofen)
Acetic Acid:
Arthrotec
Clinoril (sulindac)
Indocin (indomethacin)
Lodine (etodolac)
Relafen (nabumetone)
Tolectin (tolmetin)
Toradol (ketorolac)
Voltaren (diclofenac)
Fenamates:
Meclofenamate
Oxicams:
Feldene (piroxicam)
Mobic (meloxicam)
COX-2 inhibitor:
Bextra (valdecoxib)
Celebrex (celecoxib)
Naprelan (naproxen)
Vioxx (rofecoxib)
Zipsor (diclofenac)

Antispasmodics
Baclofen (lioresel)
Flexeril (cyclobenzaprine)
Norflex (orphenadrine)
Robaxin (methocarbamol)
Skelaxin (metaxalone)
Soma (carisoprodol)
Zanaflex (tizanidine)
Lorzone (chlorzoxazone)

Sympatholytics
Cardura (doxazosin)
Catapres (clonidine)
Dibenzyline (phenoxybenzamine)
Hytrin (terazosin)
Minipres (prazosin)

Analgesics
Ultram/Ultracet/Ultram ER (tramadol)
Propoxyphene compounds:
Darvocet, Darvon
Propacet, Wygesic
Codeine compounds:
Tylenol with codeine
Phenaphen with codeine
Margesic
Aspirin with codeine
Fioricet with codeine
Fiorinal with codeine
Hydrocodone compounds:
Vicodin, Lortab, Lorcet, Bancap, Ceta-plus, Co-gesic, Duocet, Dolacet, Hydorcet, Hydrogesic, Hy-phen, Margesic H, Anexsia, Panacet, Stagesic, T-gesic, Zydone, Azdone, Panasal, Vicoprophen, Xodol, Hysingla, Zohydro
Oxycodone compounds:
Percocet, Roxicet, Tylox, Percodan Roxiprin, Roxilox, Oxycontin, OxylR
Oxymorphone products:
Opana, Opana ER
Morphine compounds:
MS Contin, Oramorph SR Kadian, Roxinol, Morphine sulfate, MSIR, Avinza
Fentanyl products:
Duragesic, Transdermal Fentanyl Actiq, Fentora, Subsys, Abstral, Lazanda, Fentanyl patch
Dilaudid (hydromorphone)
Exalgo (hydromorphone)
Methadone
Stadol (Butorphanol)
Demoral (meperidine)
Talwin (pentazocine)
Suboxone (buprenorphine)
Subutex (buprenorphine sublingual)
Butrans (buprenorphine transdermal)
Nucynta (tapentadol)
Belbuca (buprenorphine buccal film)

Migraine
Imitrex, Relpax, Maxalt, Axert, Zomig, Frova Migranol, Midrin, Fiorinal, Fioricet, DHE, Amerge (naratriptan), Treximet, Cambia

San Diego
Pain Institute

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____acknowledge that I have been given access to read the Notice of Privacy Practices of San Diego Pain Institute and all affiliated providers. I also have been made aware that I can receive a copy of the Notice of Privacy Practices upon my request. This notice describes how San Diego Pain Institute and all affiliated providers may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Our Notice of Privacy Practices is subject to change. If we change our Notice, you may obtain a copy of the revised notice by contacting any staff person involved in your care at (858) 576-1011.

_____ _____
Signature of Patient or Responsible Party Date

_____
Printed Name

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW SAN DIEGO PAIN INSTITUTE MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

San Diego Pain Institute is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, either created by San Diego Pain Institute or received by San Diego Pain Institute from other healthcare providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this Notice. San Diego Pain Institute will abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of your protected health information.

San Diego Pain Institute reserves the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current Notice from our office at any time by contacting our office at (858) 576-1011.

Uses and Disclosures of Your Protected Health Information Not Requiring Your Consent

San Diego Pain Institute may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and healthcare operations. There are certain restrictions on uses and disclosures of treatment records. which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results.
HIPAA electronic medical records privacy rules allow healthcare providers to use or disclose patient health information, such as diagnostic images, laboratory tests, diagnoses, and other medical information for treatment purposes without the patient's authorization.

Treatments may include:

- Consultations between healthcare providers concerning a patient:
- Providing, coordinating, and/or managing healthcare and related services by one or more healthcare providers;
- Referrals to other providers for treatment:
- Referrals to nursing homes, foster care homes, or home health agencies.

For example, San Diego Pain Institute may determine that you require the services of a specialist. In referring you to another doctor, San Diego Pain Institute may share or transfer your healthcare information to that doctor,

Payment activities may include:

- Activities undertaken by San Diego Pain Institute to obtain reimbursement for services provided to you;
- Determining your eligibility for benefits or health insurance coverage;
- Managing claims and contacting your insurance company regarding payment;
- Collections activities to obtain payment for services provided to you;
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges:
- Obtaining pre-certification and pre-authorization of services to be provided to you.

For example, San Diego Pain Institute will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis and the services provided to you.

Healthcare operations may include:

- Contacting healthcare providers and patients with information about treatment alternatives:
- Conducting quality assessment and improved activities;
- Conducting outcome evaluations and development of clinical guidelines:
- Protocol development, case management, or care coordination;
- Protocol development, case management, or care coordination;
- Conducting or arranging for medical review, legal services, and auditing functions:

For example, San Diego Pain Institute may use your diagnosis, treatment. and outcomes information to measure the quality of the services that we provide, or assess the effectiveness of your treatment when compared to patients in similar situations.

San Diego Pain Institute may contact you, by telephone. patient portal. email or mail, to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders.

We may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a parent. guardian, or legal custodian of a child: the guardian of an incompetent adult: the healthcare agent designated in an incapacitated patient's health care power of attorney, or the personal representative or spouse of a deceased patient.

There are additional situations when San Diego Pain Institute are permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following•

- As permitted or required by law.

In certain circumstances, we may be required to report individual health to legal authorities. such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse. neglect, domestic violence or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of a crime.

Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on our premises.

- For public health activities.

We may release healthcare records. with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon receipt of written request from that agency. We are required to report positive HIV test results to the state epidemiologist. We may also disclose HIV test results to other providers or persons when there has been or will be risk of exposure. We may report to the state epidemiologist the name of any person known to have been significantly exposed to a patient who tests positive for HIV. We are required by law to report suspected child abuse and neglect and suspected abuse of an unborn child but cannot disclose HIV test results in connection with the reporting or prosecution of alleged abuse or neglect. We may release healthcare records, including treatment records and HIV test results, for the purpose of reporting elder abuse or neglect. provided the subject of the abuse or neglect agrees, or if necessary to prevent from serious harm. Records may be released for the reporting of domestic violence if necessary to protect the patient or community from imminent and substantial danger.

- For health oversight activities.

We may disclose healthcare records, including treatment records, in response to a written request by any federal or state governmental agency to perform legally authorized functions, such as management audits, financial audits, program monitoring and evaluation, and facility or individual licensure or certification. HIV test results may not be released to federal or state governmental agencies, without written permission. except to the state epidemiologist for surveillance, investigation, or to control communicable diseases.

- Judicial and Administrative Proceedings.

Patient healthcare records, including treatment records and HIV test results, may be disclosed pursuant to a lawful court order. A subpoena signed by a judge is sufficient to permit disclosure of ail healthcare records except for HIV test results.

- For activities related to death.

We may disclose patient healthcare records, except for treatment records, to a coroner or medical examiner for the purpose of completing a medical certificate or investigating a death. HIV test results may be disclosed under certain circumstances.

- For research.

Under certain circumstances, and only after a special approval process. we may use and disclose your health information to help conduct research.

- To avoid a serious threat to health or safety.

We may report a patient's name and other relevant data to the Department of Transportation if it is believed the patient's vision or physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information, including treatment records and HIV test results, may be disclosed where disclosure is necessary to protect the patient or community from imminent and substantial danger.

- For workers' compensation.

We may disclose your health information to the extent such records are reasonably related to any injury for which workers compensation is claimed.

San Diego Pain Institute will not make any other uses or disclosures of your protected health information without your written authorization. You may revoke such authorization at any time, except to the extent that San Diego Pain Institute have acted in reliance thereon. Any revocation must be in writing.

Your Rights Regarding Your Protected Health Information

You are permitted to request that restrictions be placed on certain uses or disclosures of your protected health information by San Diego Pain Institute to carry out treatment, payment. or healthcare operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree. we must adhere to the restriction, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would not apply when we are required by law to disclose certain healthcare information.

You have the right to review and/or obtain a copy of your healthcare records, except for psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. San Diego Pain Institute may deny access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You may request that San Diego Pain Institute send protected health information, including billing information, to you by alternate means or to alternative locations. You may also request San Diego Pain Institute not send information to a particular address or location or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing. We will accommodate reasonable requests by you.

You have the right to request that San Diego Pain Institute amend portions of your healthcare records if we maintain such information. You must submit this request in writing, and under certain circumstances the request may be denied.

You may request to receive an accounting of the disclosures of your protected health information made by San Diego Pain Institute for the six years prior to the date of the request. beginning with disclosures made after April 14, 2003. We are not required, however, to record disclosures we make pursuant to a signed consent or authorization.

You may request and receive a paper copy of this Notice, if you had previously received or agreed to receive the Notice electronically.

Any person or patient may file a complaint with San Diego Pain Institute and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with San Diego Pain Institute please contact the Privacy Officer at the following: Contact office manager at 858) 576-1011.

> You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

It is the policy of San Diego Pain Institute that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

This Notice of Privacy Practices is effective July 1, 2013

The Notice is prepared in accordance with the Health Insurance Portability and Accountability Act, 45 C.F.R. 164.520

San Diego Pain Institute

Douglas Dobecki, M.D.
5395 Ruffin Road, Ste 202
San Diego, CA, 92111
T (858) 576-1011
F (858) 576-1025

RETRIEVE MEDICAL RECORDS

Patient's Name:_____ **Date of Birth:**____/___/____

I voluntarily authorize and direct the healthcare provider named below to disclose my health information during the term of this authorization to **San Diego Pain Institute**.

Provider Releasing Records:

Name:_____

Address: _____

_____

Phone #: _____

Fax #: _____

Provider Receiving Records:

San Diego Pain Institute
5395 Ruffin Rd, Unit 202
San Diego, CA 92111
Phone #: 858-576-1011
Fax #: 858-576-1025/1026

Information to be disclosed: This authorization permits the above named health provider to disclose the following medical records. **(Please check one box)**

☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation: x-rays, HIV/AIDS status, genetic testing, psychotherapy or other mental health information, drug, alcohol or other controlled substance information, billing information, correspondence, and records from my other healthcare providers that the above-named healthcare provider may hold.

☐ All of my health information described above except the following: _____

_____

☐ Only the following records or types of health information (please specify dates of treatment, types of treatment or other designation): _____

_____

Term: This authorization will remain in effect for one (1) year from the date this authorization is signed.

Refusal to sign/Right to revoke: I understand that I may refuse to sign or may revoke at any time this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health provider. I understand that this authorization will remain in effect until the term of this authorization expires or I provide a written notice of revocation to my healthcare provider, except that the revocation will not have any effect on any action taken by my healthcare provider in reliance on this authorization before it received my written notice of revocation.

Questions: I may contact my provider's office for answers to my questions about the privacy of my health information. I understand that I have the right to receive a copy of this authorization from my health care provider. A photocopy, fax, or electronic copy of this authorization shall be considered as effective and valid as the original.

Printed Name of Patient and/or Representative: _____

Signature of Patient or Representative:_____ **Date:**___/___/____

Signature of Witness:_____ **Date:** ___/___/____

San Diego Pain Institute

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to delivering outstanding healthcare. Your clear understanding of our Patients Financial Policy is important to our professional relationship. Please understand that payment of services is part of that relationship. The following is a summary of our payment policy, which we require you to read and sign prior to any treatment.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER & AMERICAN EXPRESS

Insurance Claims

We will bill all medical insurance companies as a courtesy to you at no additional charge. We do collect any copayments or past due balances prior to treatment. **You are responsible for knowing the insurance benefits, deductibles and exclusion(s) of your policy.**

Failure to provide our office with accurate and complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the financial determination for your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of our usual and customary charges not covered by insurance. Please understand that we cannot waive deductibles, coinsurances or copays that are required by your insurance. This is a violation of our contacts with the insurance plans.

Self-Pay Accounts

If you do not have medical insurance, payment for all professional services is expected at the time of your visit. If you pay the charges in full on the day of the service, you will be eligible for our timely payment discount rate. Partial payments or payments made after the date of service will be subject to our full usual and customary rates. All quoted fees may be subject to change after 30 days. **The flat rate only covers standard office visits, injections, procedures, or labs will be charged extra.**

Missed Appointments

Unless canceled or rescheduled at least 24 hours in advance, you may be charged **$25** for missed follow up appointments. For any missed injections you may be charged **$50**. If you had an emergency on the day of the appointment documentation must be provided for the fee to be waived.

Past-Due Accounts

All patient-responsible balances that remain delinquent after 90 days, with no response from our requests for payment may be referred to a collection agency. Once an account is turned over to the collection agency, the patient or responsible party will need to settle the debt in full with the agency prior to scheduling any further treatment. An administrative fee of $5 per month (not exceeding a total of $15 for three months) may be applied to balances forwarded to collections.

Payment is due and payable at the time services are rendered unless prior arrangements have been made with a billing coordinator. Treatment cannot continue with our office until balances are paid in a timely manner. All bounced checks are subject to a $25 return check fee. Check writing privileges will then be revoked and all future payments will be accepted only as cash or credit card.

Under no circumstances will post-dated checks be accepted.

Statements are sent out monthly, and we ask that balances due be paid when you receive your statement or at the time of your next appointment, whichever is sooner. Patient payments are typically applied to the oldest balances first, except for copayments and coinsurances – they are applied to the current date of service.

Our office charges a fee for any forms patient's need completed by a provider. We do not put patients on disability.

I understand that I am financially responsible for all charges whether paid by insurance or not.

I authorize and request my insurance company to pay all claims directly to San Diego Pain Institute and will relinquish any payments assigned to me to San Diego Pain Institute.

I authorize the doctor to release all information necessary to secure the payment of benefits. I

authorize the use of this signature on all insurance submissions.

I have read and understand this Financial Policy and by signing below, agree to be bound by its terms.

I also understand and agree that such terms may be amended from time-to-time by the practice.

Signature of Patient/Responsible Party: _____

Printed Name: _____ D a t e : _____

Personal Release of Information:

I,_____give my full permission to San Diego Pain Institute to disclose details of my billing records and discuss my treatment/care either verbally or in written form with _____ _____

Name Relationship to patient

❑ Please check this box if you decline the above. In this case, information will only be released to you directly.

Patient Signature:_____Date:_____/_____/_____

Print Patient Name: _____

Witness: _____Date: _____/_____/_____

If the patient is a minor or unable to sign, check one of the following:

❑ The patient is a minor: I/We sign consent to the foregoing.

❑ The patient is unable to sign because _____ and I/we sign the foregoing consent on his/her behalf.

_____ _____/_____/_____

Authorized Signature/Parent or Legal Guardian Date

_____

Printed Name of Parent or Legal Guardian. Authorized