



15901 Hawthorne Blvd Suite 240
Lawndale, CA 90260
14350 Whittier Blvd Suite 310
Whittier CA. 90603

Phone: (424) 360-0066
Fax: (424) 360-0077
www.biohealthpain.com
DOI / INS: _____

Patient Information

Patient Name: _____ Date: _____
Last First
Date of Birth: _____ Check Preferred Contact Method: ☐ PHONE ☐ EMAIL ☐ TEXT
Mailing Address (incl. city & zip): _____
Cell Phone: _____ Email Address: _____
Pharmacy Name: _____ Pharmacy Address: _____
Current Employer: _____ Occupation: _____
Employer Address: _____
Primary language: _____ Sex : Male _____ Female _____
Ethnicity: Hispanic/Latino / Asian / African American / Caucasian / Other _____
Race: White / Black / Hispanic / Asian / Other _____

Payer Information

Date of Injury/Accident: _____ Attorney: _____
Primary Insurance Company: _____
Subscriber's Relationship to Patient: SELF SPOUSE PARENT OTHER
Spouse Name: _____
Last First Middle
Spouse's Employer: _____ Telephone # _____
Secondary Insurance Company: _____
Third Insurance, if applicable: _____

Patient Agreement & Authorization For The Release Of Medical And Health Plan Documents For The Claims Processing & Reimbursement As Required by Federal and State Laws:

Legal Assignment Of Benefits And Designation Of Authorized Representative In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand and agree that I am legally responsible for any and all actual total charges expressly authorized by me regardless of any applicable insurance or benefit payments. I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named provider(s), to the full extent permissible under the laws, including but not limited to, ERISA §502(a)(1)(B) and §502(a)(3), under any applicable employee group health plan(s), insurance policies or public policies, any benefit claim, liability or tort claim, chose in action, appropriate equitable relief, surcharge remedy or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s), with respect to any and all medical expenses legally incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the laws to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Patient Signature: _____ Date: _____

Referral Information

(Please tell us how you were referred to our practice)

- ☐ Referring Physician _____
- ☐ Other Source _____ (W/C Adjuster, Case Manager, Website, Friend etc.)

Chief Complaint: _____

In the diagram, please shade the areas of your pain

(Circle your answer)

Pain Scale: From 0 - 10 what is your pain level today?
(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (WORST PAIN)

What treatments have you had for your pain? Check all that apply.

- | | | |
|---|--|---------------------------------------|
| ☐ Physical Therapy | ☐ Favorable Results | ☐ Poor Results |
| ☐ Acupuncture | ☐ Favorable Results | ☐ Poor Results |
| ☐ Chiropractor | ☐ Favorable Results | ☐ Poor Results |
| ☐ Trigger Point Injections | ☐ Favorable Results | ☐ Poor Results |
| ☐ Epidural Injections | ☐ Favorable Results | ☐ Poor Results |
| ☐ Nerve Blocks | ☐ Favorable Results | ☐ Poor Results |

Under each Category, please check any symptoms that apply:

Cardiovascular

- ☐ Hypertension High)
- ☐ Hypotension (Low)
- ☐ Anemia
- ☐ Heart Disease
- ☐ Stroke
- ☐ Swelling of Feet
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Rheumatic Fever

Gastrointestinal

- ☐ Chronic Diarrhea
- ☐ Chronic Constipation
- ☐ Incontinence
- ☐ Ulcers
- ☐ Hepatitis
- ☐ Ulcers
- ☐ Liver Disease
- ☐ Diabetes
- ☐ Gout
- ☐ Other: _____

Neurological

- ☐ Migraines
- ☐ Frequent Headaches
- ☐ Weakness
- ☐ Numbness
- ☐ Restless Leg
- ☐ Syndrome
- ☐ Dizziness
- ☐ Other: _____

Musculoskeletal

- ☐ Arthritis
- ☐ Osteoarthritis
- ☐ Rheumatoid
- ☐ Low Back Syndrome
- ☐ Cane
- ☐ Walker
- ☐ Wheelchair
- ☐ Prosthesis
- ☐ Other: _____

Psychiatric

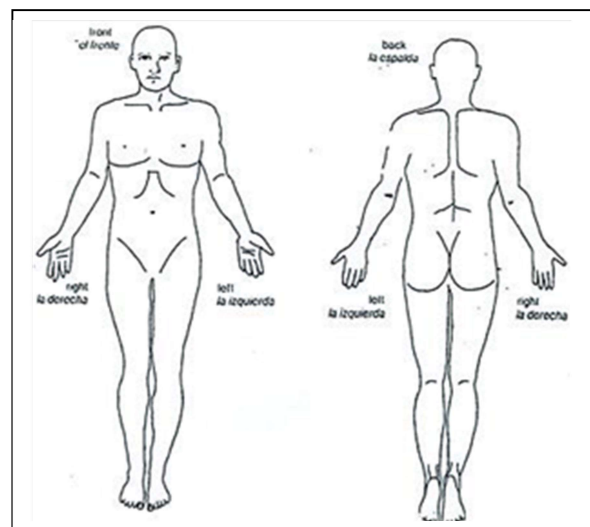
- ☐ Depression
- ☐ Anxiety Disorder
- ☐ Bipolar
- ☐ Disturbed Sleep
- ☐ Worry
- ☐ Suicide Attempt
- ☐ Schizophrenia
- ☐ Other: _____

Genitourinary:

- ☐ Urinary Incontinence
- ☐ Kidney Disease

Respiratory:

- ☐ Asthma
- ☐ Cough





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Patient History: (check each that apply)

Tobacco: ___ do not smoke ___ smoke ___ pack(s) per day
Alcohol: ___ do not drink ___ drink # of drinks per ___ day ___ week
Social History: ___ Married ___ Single ___ Divorced

___ Blind ___ Glasses ___ Contacts ___ Hard of Hearing ___ Deaf ___ HIV+
___ Hearing Aids ___ Cancer ___ Thyroid Disease ___ Gallbladder Disease ___ Birth Defects

Allergies: _____

Medications you are presently taking: **Include Over the Counter & prescription drugs.**
Pain Medications, Muscle Relaxants, Sleep Aid, Anti-anxiety, and Antidepressants.

Medications	Dose	Frequency (use back of paper if needed)
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SURGERIES

MEDICAL HISTORY

FAMILY HISTORY

Relation

Current State of Health & History of Problems

Mother

Father

Siblings

DIAGNOSTIC IMAGING

MRI: _____

XRAY: _____

CT SCAN: _____

DO YOU HAVE ANY METAL IN YOUR BODY? ☐ YES ☐ NO

DO YOU NEED AN OPEN MRI? ☐ YES ☐ NO

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient Signature: _____ Date: _____ Reviewer: _____ Date: _____



Consent for Treatment with Controlled Substances

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 opioid pain medication, benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of the risk of developing an addiction disorder and uncertainty regarding the extent to which they provide long-term benefit.

These drugs are monitored by the State of California and the Drug Enforcement Agency because these drugs have potential for abuse or diversion. Therefore strict accountability is required. For this reason the following policies are agreed to by you, the patient, as a condition for the initial and/or continued prescription of controlled substances to treat your chronic pain.

1. Controlled substances must come from the physician who signs below or, during his or her absence, by the covering physician. Exceptions apply only when a controlled substance is being prescribed in a routine manner by another provider who is aware of all medications.
2. All controlled substances must be obtained at the same pharmacy, notwithstanding pharmacy-related issues made known by you to the practice.
3. You will 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, or if you change pharmacies.
4. The prescribing physician has permission to discuss treatment details with dispensing pharmacists, or other professionals who provide you health care, to maintain accountability.
5. Unannounced urine, serum, or saliva toxicology screens may be requested and your cooperation is required.
6. You may not use any illicit substances while taking controlled substances including, but not limited to cocaine, heroin, methamphetamine, ecstasy, etc.
7. You may not share, sell, or otherwise permit others to have access to these medications.
8. You will take these medicines as prescribed or you will otherwise notify the physician.
9. **Original containers of medication will be brought to each visit for which a medication refill is being requested with the remaining corresponding medication inside.**
10. **You will maintain a journal of your medication use and bring it to each visit for which a medication refill is being requested.** An example will be provided to you. Maintain a blank original and make copies for use.
11. If your medication has been damaged, misplaced, or stolen you must complete a police report regarding the theft and provide a copy to this office.
12. Renewals are contingent on keeping scheduled appointments no less than 3 days in advance of the end of your current medication cycle. Urgent appointment requests for this purpose will not be honored and it is your responsibility to plan accordingly. Phone calls for prescriptions after hours or on weekends are not compliant with this requirement.
13. Early refills will generally not be given. You may not run out of your medications before an appointment for medication refill.
14. It is understood that any medical treatment is initially a trial and that continued prescription is contingent on evidence of benefit and safety.
15. The risks and potential benefits of these therapies are explained elsewhere (and you acknowledge that you have received such explanation). You agree to not operate heavy machinery while under the influence of these medications.
16. If the legal authorities have questions concerning your treatment all confidentially is waived and these authorities may be given full access to our records of controlled substance administration.
17. You understand 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
18. 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.

Initial below

Violation of any component of this contract may be met with one warning and repeat review of this agreement. No further warnings will be given. Final violation of this agreement indicates that safe outpatient management using these medications has not been demonstrated and therefore results in immediate termination of controlled substance prescribing. A referral to a detoxification program will be provided at that time.

Patient Name: _____

Patient DOB: _____

Patient Signature: _____

Physician Signature: _____

Date: _____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

**Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:
Effective as of the date of first medical services**

Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By:

Physician's or Authorized Representative's Signature

Date

By:

Patient's or Patient Representative Signature

Date

BioHealth Pain Management

Print or Stamp Name of Physician, Medical Group,
or Association Name

Print Patient Name

Date

(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records. (2-08)



HIPPA AUTHORIZATION

FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Name of Patient: _____

Date of Birth: _

MY AUTHORIZATION

I authorize BioHealth Pain Management, its agents and employees to use or disclose the following health information.

☐ All of my health information

My health information for the following condition: _____

I do not authorize disclosure of my health information

☐

☐

The above party may disclose this health information to the following recipient(s), please include family and friends:

Name	Relationship

MY RIGHTS

- + I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.
- + I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.
- + I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

Signature of Patient

Date

If the patient is a minor or unable to sign please complete the following:

Patient is a minor: _____ years of age.

Patient is unable to sign because: _____

Signature of Authorized Representative

Date

Print Name of Authorized Representative

Date

Authority of representative to sign on behalf of patient:

☐ Parent

☐ Legal Guardian

☐ Court Room



AUTHORIZATION TO RELEASE RECORDS TO BIOHEALTH PAIN MANAGEMENT

Patient Name: _____

Date of Birth: _____

I hereby authorize _____

(Phone: _____ Fax: _____)

or its agent(s) to disclose my health information as described in this authorization to:

Rostam Khoshsar, MD
15901 Hawthorne Blvd. Suite 240
Lawndale Ca 90260
Phone 424-360-0066
Fax 424-360-0077

The health information is being disclosed for the following purpose: (check appropriate box):

☐ Change of Insurance or Physician

☐ Continuation of Care

- I understand that the health information authorized to be disclosed under this Authorization may include information regarding drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases and communicable disease-related information.
- I understand that BPM may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that the Recipient may re-disclose the records and that the records may no longer be protected by Federal privacy regulations.
- I also consent to electronic prescribing (e-prescriptions) which includes creating the prescription, receiving automated decision support (including drug and allergy information, medication history, and eligibility), sending the prescription electronically to the pharmacy, and receiving medication renewal requests from the pharmacy.

I have read this Authorization and I acknowledge that I am familiar with and fully understand its terms and conditions.

Signature of Patient or Authorized Representative

Date

Printed name of Authorized Representative

Telephone Number

Relationship