# How do I get to Mission Pain and Spine?

**We are located in the Oso Medical Plaza Complex at:**

**26932 Oso Parkway, Suite 275Mission Viejo, CA 92691**

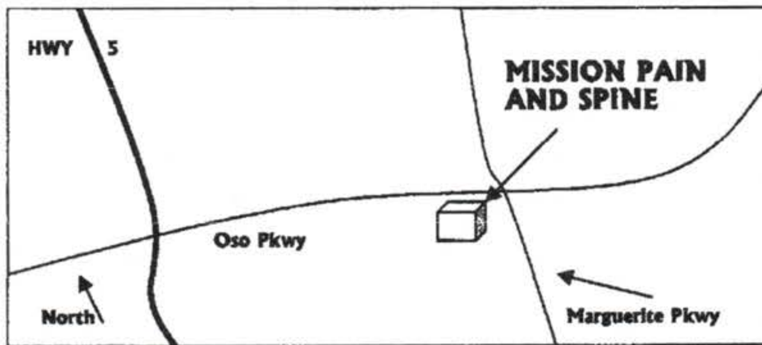
**Phone: (949) 916-8100 Fax: (949) 916-8555**

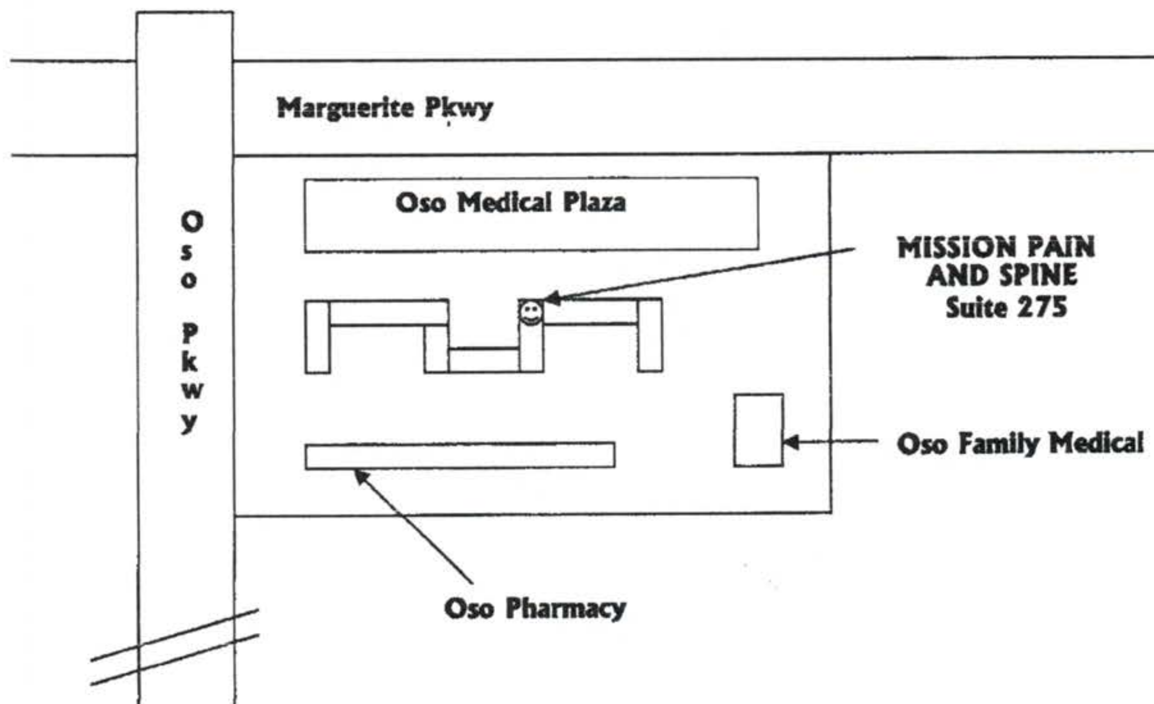
From the 5 Freeway traveling southbound: Exit Oso Parkway and go LEFT (East)

From the 5 Freeway traveling northbound: Exit Oso Parkway and go RIGHT (East)

Continue on Oso Parkway about ½ mile and turn RIGHT into the Oso Medical Plaza driveway.

Oso Medical Plaza is located at the intersection of Oso Parkway and Marguerite Parkway



# MISSION PAIN AND SPINE

Frank King, M.D. Hamid Fadavi, D.O. DATE:__________________

PATIENT NAME:_____________________________________________
(Last) (First) (Middle)

CHECK ONE: SEX: M_______ F______ CHECK ONE: MARRIED_____ SINGLE_____ WIDOWED_____DIVORCED_____

DATE OF BIRTH: ____________________________ SOCIAL SECURITY #:______________________________

ADDRESS:_________________________________________________
(Street) (City) (Zip)

HOME TELEPHONE #: (_____) ________________________CELL #: (____) ___________________________

EMAIL:_____________________________________________________

EMPLOYER: ____________________________________________ OCCUPATION:____________________

BUSINESS ADDRESS: _________________________________________________

WORK PHONE: (____)_________________________________________________

EMERGENCY CONTACT:______________________________________ RELATIONSHIP:__________________

PHONE #: (____)__________________________ CELL #: (____)______________________________

PRIMARY PHARMACY: ____________________________________ PHONE #: (___)__________________

PHARMACY ADDRESS: _________________________________________________

PRIMARY CARE PHYSICIAN: ______________________________ PHONE #: (____)__________________

REFERRED BY:_________________________________________________

RESPONSIBLE PARTY (IF PATIENT IS MINOR)__________________________________________

RELATIONSHIP TO MINOR PATIENT:___________________________ Phone #: (______)_________________

**INSURANCE INFORMATION**------------------------------------------------------------------------

NAME OF PRIMARY INSURANCE COMPANY:___________________________ HMO____ PPO ____ POS__

POLICY/ID#_________________________________________ GROUP #___________________________

POLICY HOLDER NAME:______________________________________ RELATIONSHIP:________________

POLICY HOLDER'S DATE OF BIRTH:______________________ SOCIAL SECURITY #:____________________

SECONDARY INSURANCE COMPANY NAME:_________________________________________

POLICY/ ID#__________________________________________ GROUP #_____________________________

POLICY HOLDER NAME:_________________________________________________

RELATIONSHIP:________________________________ POLICY HOLDER'S DATE OF BIRTH:__________________

MPS 26932 Oso Parkway, Suite 275 Mission Viejo, CA 92691 (949) 916-8100 FAX (949) 916-8555

*Mission Pain and Spine* F J. King H. Fadavi Date ______________

PATIENT NAME_____________________________DOB___________AGE___________

Who referred you to this office? ___________________________________________

Who is you primary treating physician? ______________________________________

**HPI**

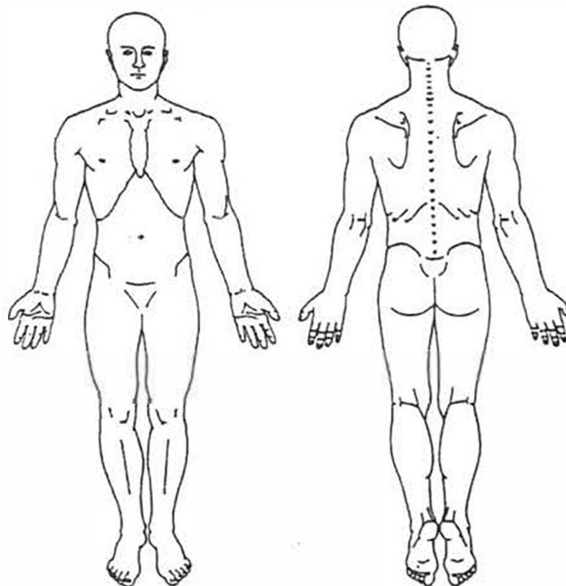
Why are you seeing the doctor today?_____________________________________

When did your problem start?___________________________________________

What caused your problem (fall, accident, etc)?_____________________________

How has the pain changed recently? (better, worse, same, different)_______________

**Please use the diagram below to indicate where your pain is**



Have you had any numbness or tingling? Yes or No. If yes, where? ________________

Have you had any weakness associated with your problem? If so, where? ____________

_________________________________________________________________________

**Intensity of pain: 1-2**(tolerate without medications) **3-4**(tell someone about my pain, take a Motrin) **5-6** (mild narcotic, Tylenol #3) **7-8** (go to ER, strong narcotics) **9-10** (admit to hospital due to pain)

**How would you describe your pain?** constant, intermittent, dull, sharp, aching, cramping, hot-burning, numb, pressure-like, shooting, stabbing, throbbing, tingling, twisting, deep, superficial, heavy, gnawing, other:_______________________________

At what **time of day** is your pain the worst? ______________________

What makes your pain **WORSE**? ______________________

What makes your pain **BETTER**? ______________________

**Current PAIN medications:** (if you have a medication list, you may attach it to this form)

| Medication | Dose | Frequency | % of relief from medication |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Please list any allergies you may have:** (medications or environmental)

| Allergy | Reaction |
|---|---|
| | |
| | |
| | |

**Have you had any of the following treatments for your current condition?** (circle all that apply)

Epidurals, Facet Blocks, Ablations, Spinal Cord Stimulator, Pump, Physical Therapy, Chiropractic, TENS, Acupuncture, Other: ______________________

**Please list any recent Procedures or EMG:** ______________________

**Please list any recent MRI, CT scan or X-rays:** ______________________

**Past Medical History** (please circle all that apply to you)

High blood pressure Heart disease Pacemaker Diabetes Thyroid problems Arthritis Rheumatoid

Nerve Disorders Multiple Sclerosis Spinal cord injury Migraines Headaches Stroke Gastritis

Ulcers GERD Liver disease Hepatitis Sleep apnea Asthma COPD TB Kidney disease

Enlarged prostate Prostate cancer Pelvic pain Endometriosis Blood clots Blood vessel disease

Anemia Bleeding problems Cancer Depression Anxiety ADHD PTSD Claustrophobia

Alcoholism Opioid dependency Illicit drug use/abuse Chronic pain

Other: ______________________

Patient's name ______________________

**Have you ever been diagnosed with fibromyalgia? _____ Chronic fatigue syndrome?____**
**Are you pregnant?____________________**

**Surgical History** (please list all surgeries, with dates if possible)

__________________ __________________ __________________
__________________ __________________ __________________
__________________ __________________ __________________

List medication for other medical conditions:

| Medication | Strength | Dose |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Family History**

**Do any of the following diseases/conditions run in your family?** (please circle all that apply)

**Low Back Pain** Low back Surgery **Neck Pain** Neck Surgery **Psychiatric illness**

Alcoholism **Opioid dependency** Drug abuse **Diabetes** Cancer **Heart Disease**

Nerve Disease **Bleeding Disorder** Muscle Disease

**Social History** (answer/circle all that apply)

**Marital Status:** Married **Single** Divorced **Separated** Widowed **DP**

How many children do you have?_________

**I am currently:** **In School** Working **Unemployed** **Retired**

Are you on disability?________ Date disability began_________________

Education level________________ What kind of work do you do?______________________________

How long have you worked there?_____________When did you last work there?________________

List your hobbies or pastimes:______________________________________________________

Do you smoke?_____ Packs per day?_____ Years smoking? ________

Do you drink alcohol? _____How often? ______________________________________________

Do you use illicit drugs?______ Type__________________________________________________

**Review of Systems** (Please circle any symptom listed below that **currently** applies to you)

**General:** unexpected weight loss or gain, fever, chills, fatigue, appetite changes, night sweats

**Eyes:** loss of vision, double vision, blurred vision, blind spots, drainage from eyes, pain from light, corrective lenses/contacts, redness

**Head:** pain, jaw pain, nose bleed

**Ears:** ringing in ears, vertigo, loss of hearing

**Heart:** chest pain, palpitations, chest pressure, murmurs, irregular heartbeat, fainting

**Lungs:** shortness of breath, cough, wheezing, bloody sputum, chest tightness, snoring

**Gastrointestinal:** abdominal pain, constipation, diarrhea, bloating, nausea, vomiting, difficulty swallowing, heart burn, bloody or tarry stools

**Urological:** frequency, urgency, burning/painful urination, difficulty voiding, bloody urine, incontinence

**Musculoskeletal:** joint pain, joint swelling, joint instability, stiffness, redness, heat, muscle pain.

**Neurological:** weakness, loss of balance, numbness, tingling, seizures, dizziness, fainting, loss of consciousness, deafness, pins and needles, headache, loss of consciousness

**Psychiatric:** nervousness, anxiety, depression, hallucination, anger, panic attacks, difficulty sleeping, suicidal thoughts, homicidal thoughts

**Hematology:** easy bleeding, easy bruising, swollen glands, bleeding problems,

**Allergy/Immunology:** infections, seasonal allergies, latex

**Endocrine:** very hungry, very thirsty, tremors, hot/cold intolerability

**Skin:** rash, scars, skin ulcers, pigmentation, bruising, bleeding under skin, spots, lesions, itching

**Are you considering harming yourself or harming others?** ______________

Patient Signature____________________________ Date______________

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For office use:

HT_________ WT_________ BP_________ Temp______ Pulse_________

Mod 11/14/2015

**Please Print Patients Full Name AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO MISSION PAIN AND SPINE, FRANK KING, M.D., INC, HAMID FADAVI, D.O., INC. & CONSENT FOR TREATMENT**

I hereby authorize MISSION PAIN AND SPINE (MPS) and its employees and agents to release my medical records documenting me examination and treatment, including AIDS related testing, psychiatric or substance abuse information, upon valid request.

I hereby assign payment directly to Mission Pain and Spine and its physicians for any medical/surgical procedures performed. I agree that this authorization shall be valid until rescinded in writing or replaced be one of a later date. I agree to be financially responsible to Mission Pain and Spine and its physicians for all charges in the event that I have no insurance or my insurance is rejected, and for any balance or fee not covered by my insurance and/or determined to be my responsibility. I understand and acknowledge that if Mission Pain and Spine and its physicians file my insurance claim, I will remain responsible for the account, and I will be expected to pay any amount due if my insurance does not pay the claim within 45 days. I acknowledge that any amounts quoted as my "out-of-pocket" costs are only an estimate and that the exact determination of my financial responsibility will be made after my insurance company processes the claim. Payment is expected at the time of service. Methods of payment include check, cash, and credit card.

I further agree to pay all costs of collection, including reasonable attorneys' fees, at the legal rate of interest on the account until paid in full, and I agree to waive all rights of exemption under the Constitution and the laws of the State of California.

I hereby request and authorize all doctors, nurses, technicians or affiliated medical personnel, hospitals, and health care facilities to furnish all records and reports, including x-rays, photostatic copies, and abstracts or excerpts of all records, and any other information requested relating to any hospitalizations, examinations, treatments, tests or opinions concerning any condition for which I am presently being treated, including AIDS related testing, psychiatric or substance abuse information. A copy of this authorization shall be as valid as the original of this document.

I understand that my MPS physicians have a financial interest in the California Specialty Surgery Center to which I may be referred. I acknowledge that I may receive these services at an MPS facility or other facilities whose names and addresses I have been provided.

**GENERAL CONSENT TO TREATMENT**

By signing below, I (or my authorized representative on my behalf) authorize MPS physicians, practitioners and their staff to conduct any diagnostic examinations, test and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test, or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

**RIGHT TO REFUSE TREATMENT**

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy, or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

______________________________ ______________________________

**Please Print Patients Full Name** **Patients Signature**

______________________________ ______________________________

**Date** **Witness Signature**

## AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

### AUTHORIZATION

I hereby authorize: ______________________________________________

Physician/Healthcare Facility

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax or other electronic medical records.

To:

MISSION PAIN AND SPINE

Name

26932 Oso Parkway #275

Mission Viejo, CA 92691

Address

(949) 916-8100 (949) 916-8555

City ______________ State ______ Zip Code ______

This authorization is:

[ ] Unlimited (all records, excluding substance abuse, mental health, HIV diagnosis/treatment)

[ ] Limited to the following medical information:

______________________________________________

I also consent to the specific release of the following records:

Drug/alcohol/substance abuse_____ (initial)

Psychiatric/mental health _____ (initial)

Tests for antibodies to HIV_____ (initial)

HIV diagnosis/treatment _____ (initial)

**DURATION** This authorization shall be effective immediately and remain in effect until ______________________

Date

**RESTRICTIONS** Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy of facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

______________________________________________

Signature of patient or legal/personal representative

______________________________________________

Relationship if other than patient

______________________________________________

Patients Name (Print)

______________________________________________

Date

______________________________________________

Patients Social Security Number

______________________________________________

Patients Date of Birth

______________________________________________

Witness Name

______________________________________________

Witness Signature

**MISSION PAIN AND SPINE**
26932 Oso Parkway, Suite 275
Mission Viejo, CA 92691
(949) 916-8100 FAX (959) 949-8555

## INFORMED CONSENT AND AGREEMENT FOR THE TREATMENT OF INTRACTABLE PAIN WITH NARCOTIC MEDICATION-Part 1/2

I understand that there are alternatives to narcotic drug therapy which I have discussed with my doctor.

The goal of my therapy is to reduce my pain to a level that is tolerable and that will allow me to improve my daily function.

_______I understand that the use of any narcotic use may increase certain risks, which include, but are not limited to:

- **Addiction** (compulsive behavior used to obtain the medication by any means)
- **Tolerance** (the need to increase the doses of a substance in order to achieve the same result)
- **Dependence** (physical and/or psychological/mood changes resulting from cessation of the medication)
- **Opioid induced hyperalgesia** (increased pain due to the chronic use of narcotics)
- Nausea, vomiting and constipation
- Impair judgment, sleepiness and confusion
- Allergic reactions, overdose and death
- Breathing problem
- Dizziness
- Impaired ability to operate machines or drive motor vehicles

I ______________________________________________________________**(patient name)** agree to the following.

______I will take this medication as prescribed by my provider. I will not vary the dose or interval without approval for my provider. I will not share my medication with anyone, for any reason.

______I will submit to random urine and blood tests if requested by my provider to assess of my compliance.

______I will obtain all my prescriptions for pain medication through providers of Mission Pain and Spine and will fill my prescriptions at:

______________________________________________________________________**pharmacy.**

_____________________________________________________________________________________

Patient Signature Date Provider Signature Date

**MISSION PAIN AND SPINE**
26932 Oso Parkway, Suite 275
Mission Viejo, CA 92691
(949) 916-8100 FAX (959) 949-8555

## INFORMED CONSENT AND AGREEMENT FOR THE TREATMENT OF INTRACTABLE PAIN WITH NARCOTIC MEDICATION-Part 2/2

______Due to the potential for misuse, I know that I will be unable to obtain early refills or replacements of lost or stolen medication. Refills will only be made during regular business hours.

______I agreed to see providers of Mission Pain and Spine and for ongoing pain management and will schedule regular appointments as long as I am taking narcotic medication.

_____ I will refrain from drinking alcohol while on treatment with narcotic medication.

_____ I will not use illicit substances and doing so will result in cessation of all prescription medication.

______I understand that driving a motor vehicle or heavy machinery while using controlled narcotic medication is NOT recommended and I will not hold Mission Pain and Spine or its Physicians and staff responsible for any injuries resulting in any type of accident, vehicle or otherwise. It is my full responsibility to comply with the laws of the state of California and any other state while taking controlled narcotic medication.

______ I understand that my narcotic treatment may be terminated if I do not follow these guidelines

______________________________________________________________________________

Patient Signature Date Provider Signature Date

______________________________________________________________________________

Witness Date Translator Date

Patient name__________________________________________________ Date of Birth______________

Date_______________________

# Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

| Mark each box that applies | Female | Male |
|---|---|---|
| **Family history of substance abuse** | | |
| Alcohol | 1 | 3 |
| Illegal drugs | 2 | 3 |
| Rx drugs | 4 | 4 |
| **Personal history of substance abuse** | | |
| Alcohol | 3 | 3 |
| Illegal drugs | 4 | 4 |
| Rx drugs | 5 | 5 |
| **Age between 16—45 years** | 1 | 1 |
| **History of preadolescent sexual abuse** | 3 | 0 |
| **Psychological disease** | | |
| ADD, OCD, bipolar, schizophrenia | 2 | 2 |
| Depression | 1 | 1 |
| **Scoring totals** | | |

## CONFIDENTIAL COMMUNICATION REQUEST AUTHORIZATION

Many of our patients allow family members such as their spouse, parents, or others to call and request medical or billing information. Under the requirements of HIPPA, we are not allowed to give this information to anyone without the patients consent. If you wish to have information released, you must complete and sign below.

I authorize the use of the following means of communication for information related to my personal health, medical treatment, or payment of treatment/billing information.

**PLEASE SELECT ALL THAT APPLY:**

____Phone Phone Numbers:

Home:____________________

Cell: ____________________

Work:____________________

____You have my consent to leave a message regarding my treatment on my voicemail.

____Do not leave a message regarding my treatment on my voicemail.

____Written communication to mailing address:________________________________

Please specify the person(s) allowed to receive medical information:

| Name | Phone Number | Relationship |
|---|---|---|
| Name | Phone Number | Relationship |
| Name | Phone Number | Relationship |

**Patient Information**

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected information to be disclosed.

I understand that the information disclosed to any above recipient is no longer protected by federal or state law and may be subject to disclosure by the above recipient.

I have the right to revoke this consent in writing.

Signature:______________________ Date of Birth: ______________ Date: ____________

Print Name________________________________________________

**MISSION PAIN AND SPINE**
26932 Oso Parkway, Suite 275
Mission Viejo, CA 92691
(949) 916-8100 FAX (949) 949-8555

**Payment policy**

Payment is expected at that time of service. Your co-pay, coinsurance and/or deductible is due at the time of visit. For your convenience, we accept cash, checks, Visa or MasterCard as a form of payment. Please note that hospitals and surgery centers charge additional and separate fees for any procedure at their facilities. You will be responsible for payment of any remaining balance for both entities after your insurance is billed.

**Insurance policy:**

If we're covered as one of your insurance companies' network providers, you are required to submit your copayment in advance of your appointment. We will also require a digital scan of your insurance card. We will bill your insurance company. Any deductible, co-insurance non- covered services will be your responsibility. For those plans that are non-contracted with our office, as a courtesy, we will submit claims to your carrier; any deductible, co-insurance or non-covered services will be your responsibility. Monthly statements will be sent to collect those balances. Please inform our staff immediately of any insurance changes.

**Non-covered Service Policy**

Certain services performed by our office are NOT COVERED by all insurance plans. Some of these services include Urine Drug Tests (UDT) and injections. We suggest you contact your insurance carrier to verify your benefits and to understand that any non-covered services will be your financial responsibility and payment will be required prior to your appointment. Medicare requires a signature on an Advanced Beneficiary Notice (ABN) for non-covered services.

**Delinquent Accounts Policy**

Delinquent accounts may be reported to our collection agency following normal collection procedures. If an account is reported to our collection agency, a collection fee of 25% will be added to any outstanding balance. If a balance is over 61 days late, a 1.5% monthly interest fee will be added to the outstanding balance. Please inform our billing staff if you know your payment will be late in arriving or if payment arrangements are needed.

**Medical Records**

Should you request a copy of your medical records, please allow 7 to 10 business days for completion.

**Forms Policy**

Should you request our office to complete forms on your behalf for disability, work status, FMLA, etc., there will be a charge of $25.00 per form. Payment of this charge is expected at time of completion.

**Prescriptions**

Please contact our office a minimum of five days prior to your scheduled refill date

**Returned checks**

Our office charges a $25 dollar fee for all accounts closed, stop payments or returned checks due to insufficient funds.

**Referrals and Authorizations**

If a referral is required by your insurance carrier you'll be asked to obtain the referral prior to your appointment. If no referral exists on file or if the referral has not been received, your appointment might be canceled. Our office will obtain authorization for your procedure prior the scheduling your appointment. We suggest that you contact your insurance carrier to verify your coverage, benefits and pre-authorization requirements prior to having any procedures performed. Claims are paid based on medical necessity. Please be aware that authorizations and referrals are not a guarantee of payment.

**Worker's Compensation**

Our office will require you to inform us of any changes regarding your workers compensation claim. The following information is required: adjuster's name, claims status (litigation, supportive care, claimed close, new injury), date of injury, carrier, claim number and claim's address. Please have this information available prior to your appointment time.

**Missed appointments**

Please notify the office **at least** 24 hours before cancelling your appointment. You will be charged $25.00 for missed appointments if you fail to notify us at least 24 hours prior to cancellation.

Patient name ______________________________ DOB ____________________

______________________________ ____________________

Patient/Guarantor Signature Date

**Patient Demographic Form**

**Preferred Spoken/Written Language:**
- ☐ English ☐ Spanish
- ☐ American Sign Language
- ☐ Other: ____________________

Language interpretation services needed?
- ☐ No
- ☐ Yes, language: ______________

**Sexual Orientation**
- ☐ Lesbian
- ☐ Gay ☐ Straight
- ☐ Bisexual ☐ Something Else
- ☐ Queer ☐ Decline to Answer

**Gender Identity:**
- ☐ Male/Man
- ☐ Female/Woman
- ☐ TransMale/TransMan
- ☐ TransFemale/TransWoman
- ☐ Genderqueer/Gender nonconforming
- ☐ Something Else
- ☐ Decline to Answer

**Race:** *Select all that apply*
- ☐ American Indian/Alaska Native
- ☐ Black and/or African American
- ☐ White/Caucasian

Asian:
- ☐ Asian Indian
- ☐ Chinese ☐ Korean
- ☐ Filipino ☐ Vietnamese
- ☐ Japanese ☐ Other

Native Hawaiian/Pacific Islander:
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander
- ☐ Decline to Answer

**Sex Assigned at Birth:**
- ☐ Male ☐ Intersex
- ☐ Female ☐ Decline to Answer

**Ethnicity:**
- ☐ Non-Hispanic/Latino
- ☐ Dominican
- ☐ Cuban
- ☐ Mexican, Chicano/a
- ☐ Puerto Rican
- ☐ Other Hispanic/Latino
- ☐ Decline to Answer

**Housing Status:**
- ☐ Stable Housing
- ☐ Homeless
- ☐ Decline to answer

If homeless,
select which best applies:
- ☐ Street
- ☐ Homeless Shelter
- ☐ Transitional
- ☐ Doubling Up (not paying rent)

**Tobacco use questionnaire:**

1. Circle one.

   a. Non-Smoker
   b. Ex-Smoker
   c. Smoker

**Alcohol use questionnaire:**

1. How often do you have a drink containing alcohol?

   a. Never
   b. Monthly or less
   c. 2-4 times a month
   d. 2-3 times a week
   e. 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?

a. 0
b. 1 or 2
c. 3 or 4
d. 5 or 6
e. 7 to 9
f. 10 or more

3. How often do you have 6 or more drinks on 1 occasion?

a. Never
b. Less than monthly
c. Monthly or less
d. Weekly
e. Daily or almost daily

**Physical activity questionnaire:**

1. How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days?

2. On those days that you engage in moderate to strenuous exercise, how many minutes, on average, do you exercise?