Precision Pain Management
23521 Paseo de Valencia, Suite 204
Laguna Hills, CA 92653

New Patient Information

Name: _____ _____ _____
First Middle Last

DOB:_____SSN: _____-_____-_____ **Gender:** ☐Female☐ Male

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Cell Phone #: _____ Home Phone #: _____

Work Phone #: _____ Occupation: _____ E-Mail: _____

Emergency Contact: _____ Relation: _____Phone: _____

Ethnicity: ☐African American ☐Caucasian ☐Hispanic ☐Asian Other: _____
Primary Language: _____

Primary Care Provider (PCP): _____ Phone: _____

Referring Provider: _____ Phone: _____

Referral Source: _____

PRIMARY INSURANCE INFORMATION

Policy Holder's Name: _____

Policy Holder's Date of Birth: _ _____

Relationship to Patient: _____

SSN: _____

Insurance Name: _____

Subscriber ID: _____

Group # _____

SECONDARY INSURANCE INFORMATION

Policy Holder's Name: _____

Policy Holder's Date of Birth: _ _____

Relationship to Patient: _____

SSN: _____

Insurance Name:_____

Subscriber ID:_____

Group#:_____

Insurance Coverage Declarations

1. Are you involved in any litigation or lawsuit regarding your pain? ☐Yes ☐ No

2. Are you seeking Workers' Compensation as a result of your pain? ☐Yes ☐ No

Precision Pain Management
23521 Paseo de Valencia, Suite 204
Laguna Hills, CA 92653

Today's Date:_____

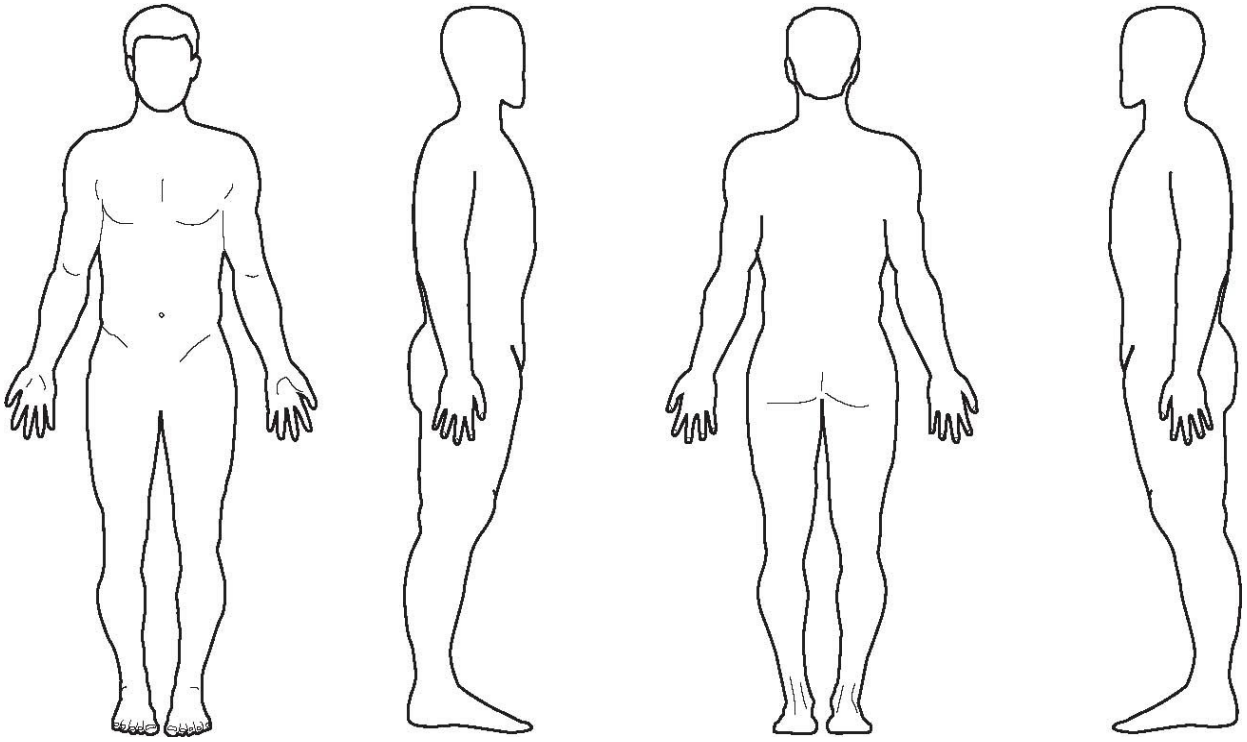
New Patient Intake Form

Full Name: _____ Age: _____ Occupation: _____

1. Chief complaint (pain): _____
2. Onset of symptoms (date/description):_____
3. Are you experiencing radiating pain? (description): _____

Shade areas of pain or discomfort on the images below:

Front Right Side Back Left Side



1. Please rate your pain on a scale of 0-10, with 0 being no pain and 10 being the worst pain imaginable:
   At its best: _____ At its worst:_____ At this moment: _____
2. Select the frequency at which your pain occurs (check):
   ☐ Continuously ☐ Several times a day ☐ Intermittently ☐ Occasionally ☐ Less than daily
3. When is your pain worse? ☐ Morning ☐ Afternoon ☐ Evening ☐ All the Time ☐ No Usual Pattern
4. Describe any changes in pain intensity since its onset: ☐ Better ☐ Worse ☐ No Change

5. Select one or more items below to describe your pain (check all that apply):
☐ Aching ☐ Burning ☐ Cramping ☐ Dull ☐ Electric Shock ☐ Sharp ☐ Shooting
☐ Stabbing ☐ Throbbing ☐ Deep ☐ Numb ☐ Tingling ☐ Other: _____

6. Please check the ones your pain interferes with (check all that apply):
☐ General Activity ☐ Mood ☐ Walking Ability ☐ Normal Work
☐ Sleep ☐ Enjoyment of Life ☐ Intimacy

7. What makes the pain worse? (check all that apply):
☐ Standing ☐ Sitting ☐ Walking ☐ Movement ☐ Lying down ☐ Bending forward
☐ Arching backward ☐ Coughing ☐ Sneezing ☐ Using the restroom ☐ Other: _____

8. What makes the pain better? (check all that apply):
☐ Standing ☐ Sitting ☐ Walking ☐ Movement ☐ Lying down ☐ Coughing ☐ Sneezing
☐ Bending forward ☐ Arching backward ☐ Using the restroom ☐ Other: _____

9. What tests have been done and when? (check all that apply & give dates and location of imaging):
X-ray: _____ MRI: _____ CT: _____ EMG: _____ Bone Scan: _____
Other: _____

10. Do you have any of the following symptoms associated with your pain?
Numbness/Tingling If yes, where?_____
Weakness If yes, where? _____
Bowel/Bladder Incontinence If yes, when did it start? _____

11. List the names of other doctors or specialists you have seen for your pain or who have treated your pain:
_____
_____

12. Please check all procedures or modalities you have tried to manage or treat your pain: Did it help?
Acupuncture_____ Massage _____
Biofeedback_____ Meditation_____
Chiropractor_____ Nerve Blocks _____
Epidural_____ Physical Therapy _____
Facet Block_____ Psychotherapy_____
Ice/Heat_____ Surgery_____
Medications_____ TENS_____
Other _____

13. Medical Illnesses (please check all that apply):
☐ Arthritis ☐ Cancer: _____ ☐ Diabetes ☐ Headaches ☐ Hepatitis ☐ Asthma ☐ COPD ☐ Stroke
☐ Hypertension ☐ Kidney Disease ☐ Thyroid Disease ☐ Seizure Disorder ☐ GERD ☐ Other: _____

14. Prior Surgeries (please list type & date, or provide a list):
_____
_____

15. Allergies: _____

16. Current Non-Pain Medications (name and current dose, or please provide list):

17. Do you take any of the following blood thinners? (check all that apply):

☐ Aspirin ☐ Coumadin ☐ Plavix ☐ Heparin ☐ Brilinta ☐ Eliquis ☐ Xarelto ☐ Lovenox

18. Current Pain Medications (name and current dose, or please provide list):

19. Previous Pain Medications (name and previous dose):

20. Social History check: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

Use tobacco? Amount_____ Use alcohol? Amount_____

Use illegal drugs? ☐ YES or ☐ NO Been treated for alcohol or drug addiction ☐ YES or ☐ NO

Type_____

21. **Family History (check all that apply):**

- ☐ **Cancer** Who:_____
- ☐ **Diabetes** Who?_____
- ☐ **Heart Disease** Who?_____
- ☐ **Stroke** Who?_____
- ☐ **Depression/Suicide Alcohol/Drug Abuse** Who?_____

I, the undersigned, have completed this form. The information that I have provided is true and accurate to the best of my knowledge.

X_____ _____
Patient/Legal Guardian Signature Date

X_____ _____
Person signing on patient's Behalf/Relationship Reason patient is unable to sign

Today's Date

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	☐	☐	☐	☐	☐
2. How often have you felt a need for higher doses of medication to treat your pain?	☐	☐	☐	☐	☐
3. How often have you felt impatient with your doctors?	☐	☐	☐	☐	☐
4. How often have you felt that things are just too overwhelming that you can't handle them?	☐	☐	☐	☐	☐
5. How often is there tension in the home?	☐	☐	☐	☐	☐
6. How often have you counted pain pills to see how many are remaining?	☐	☐	☐	☐	☐
7. How often have you been concerned that people will judge you for taking pain medication?	☐	☐	☐	☐	☐
8. How often do you feel bored?	☐	☐	☐	☐	☐
9. How often have you taken more pain medication than you were supposed to?	☐	☐	☐	☐	☐
10. How often have you worried about being left alone?	☐	☐	☐	☐	☐
11. How often have you felt a craving for medication?	☐	☐	☐	☐	☐
12. How often have others expressed concern over your use of medication?	☐	☐	☐	☐	☐

Patient Name: _____ Date of Birth: _____

Today's Date

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	☐	☐	☐	☐	☐
14. How often have others told you that you had a bad temper?	☐	☐	☐	☐	☐
15. How often have you felt consumed by the need to get pain medication?	☐	☐	☐	☐	☐
16. How often have you run out of pain medication early?	☐	☐	☐	☐	☐
17. How often have others kept you from getting what you deserve?	☐	☐	☐	☐	☐
18. How often, in your lifetime, have you had legal problems or been arrested?	☐	☐	☐	☐	☐
19. How often have you attended an AA or NA meeting?	☐	☐	☐	☐	☐
20. How often have you been in an argument that was so out of control that someone got hurt?	☐	☐	☐	☐	☐
21. How often have you been sexually abused?	☐	☐	☐	☐	☐
22. How often have others suggested that you have a drug or alcohol problem?	☐	☐	☐	☐	☐
23. How often have you had to borrow pain medications from your family or friends?	☐	☐	☐	☐	☐
24. How often have you been treated for an alcohol or drug problem?	☐	☐	☐	☐	☐

Please include any additional information you wish about the above answers.
Thank you.

Patient Name: _____ Date of Birth: _____

Insurance Election Form

We will make every effort to verify your eligiblity and benefits prior to your visit. It is your responsibility to ensure that our office and facility are in-network with your insurance if that is your desire, that coverage is reported to us accurately, and that any CHANGES to your insurance and/or coverage is reported to us immediately in order to ensure accurate and timely billing.

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to the physician or facility named above the following rights, power and authority. During the course of treatment by AHM, charges will be accumulated and routinely filed with your insurance company. **Charges not covered by your insurance company, patient co-pays, deductibles and co-insurance will be your responsibility and are due at the time of service.**

Please select what option best applies below:

☐ **Private-pay Election:** I certify that I have no insurance or have insurance that is not accepted by this medical provider, or that I do not wish my insurance to be billed, and I am solely responsible for all fees assocaited with my care. I acknowledge that I have been told my estimated fees with AHM will be, and that AHM may change the private pay fee schedule as needed at any time at which time I will be notified of that fee in advance. All fees are due at time of service.

☐ **Insured Election:** I certify that the insurance reported to is a complete listing. I understand that the office will not extend credit on, or submit a claim for any insurance not reported at the time of service. I also understand that any claim not paid for by my insurance within 60 days from the date filed, will become my responsibility and payable upon billing. **NOTE: This is not an option if I am currently in personal injury litigation or have an existing Workers Compensation claim realted to my pain.**

☐ **Work Comp/Personal Injury Election:** I certify that I have an active workers' comp or personal injury arrangement in which they have taken full financial responsibility for my treatment process at PPM (AHM)/SPSC, and that proper authroization has been recieved.

Signature of Patient:_____ Date: _____

Print Name: _____

(For Office Staff ONLY)

Witness Signature:_____ Date:_____

SB 1061 Notice: "A holder of this medical debt contract is prohibited by **Section 1785.27** of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable."

Precision Pain Management

23521 Paseo de Valencia, Suite
204 Laguna Hills, CA 92653

P) 949-458-2026 F) 949-273-8053

Financial Policy

We would like to share our financial policies, billing procedures, and required notices with you. We hope you find this information helpful. If you have any questions or concerns, please contact our billing of office manager.

1. **Insurance Claim Filing:** As a courtesy, we are happy to file insurance claims for your primary insurance. If you have Medicare and a secondary insurance, please confirm with Medicare that you are set up for a crossover which will allow Medicare to send their Explanation of Benefit (EOB) directly to your secondary insurance for payment.
   *****You as a Medicare beneficiary are the only person who can contact Medicare and give Medicare permission to send the EOB (Explanation of Benefit) directly to your secondary insurance.
   *****If Medicare does not crossover, you will be responsible for billing your secondary insurance and paying for the balance as well.

2. **Time of Service:** As a patient, you are responsible for co-payment/co-insurance amount, plus any deductible at the time of service.

3. **Insurance Verification:** Insurance verification and network status is the responsibility of the patient. If our office cannot verify your insurance benefits or if you have no insurance, payment in full is expected at the time of the service.

4. **Insurance Payments:** If your insurance carrier sends payment directly to you, then payment is due in full at your visit. In the event that your insurance does not cover all services, you will be billed for services that are not covered.

5. **Statements:** Our statements are sent out on a monthly basis. All charges are due and payable within 30 days of receipt. We will make every effort to work with you, so please contact our billing manager if there is a need for a payment plan.

6. **Account Balances:** If your insurance has not paid your account in full within a reasonable amount of time and after reasonable effort has been made, you will be billed the entire balance. If you are unable to keep your account current, we will not be able to provide additional medical services to you unless an agreed upon reasonable payment as been made and the remainder is pending. We may require that you pre-pay for all future services.

7. **Non-Payment:** In the event that payment is not made on your account, and it is placed in collection, you are required to pay the balance so that medical service can be continued.

8. **Returned Checks:** There will be a $30.00 service fee on all returned checks in addition to the amount of the original check and the bank penalty. Please understand that we can only accept a cash payment to settle this issue. If there is a repeat incident, we will no longer be able to accept your check.

9. **LATE CANCELLATION/"NO SHOW POLICY":** Please notify us with at least 24 hours' notice if you must cancel your appointment so that we may let another patient have your appointment time. If you do not provide at least 24 hours' cancellation notice or do not show up for your appointment, there will be a "no-show" fee of $50.00 for missed office visits and $150.00 for missed facility procedures that will be due prior to rescheduling.

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Attestation: By signing below, I am attesting that I have read and understood the foregoing Financial Policy and agree to abide by the terms of the policy and notice.

_____ _____ _____

Print Name Signature Date

Date of Birth:_____

Precision Pain Management

Pharmacy Authorization Form

Name of Patient: _____ Date: _____

I, _____, give permission to the office of Dr. Andrew Messiha to assess my current medication lists through my pharmacy.

My Current pharmacy is _____.

The Pharmacy address is:

_____
Street Name

_____
City, State, Zip Code

_____ _____
Patient Signature Date

Precision Pain Management

23521 Paseo de Valencia, Suite 204
Laguna Hills, CA, 92653
Phone: 949-458-2026 Fax: 949-273-8053

NOTICE OF PRIVACY PRACTICES (HIPPA)

Effective Date: May 1, 2023

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

Date of Birth:_____

We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Date of Birth:_____

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with Dr. Andrew Messiha, Compliance Officer.

Associated companies with whom we may do business, such as an answering service, billing company, or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.

Patient Acknowledgement

I, _____, acknowledge receipt and understanding of this Notice of Privacy Practices.

_____ _____

Patient Signature Date

Date of Birth:_____

Andrew H. Messiha, MD
23521 Paseo de Valencia, Suite 204
Laguna Hills, CA 92653

Disclosure of Physician Ownership and Financial Interest

State and Federal guidelines may require that physicians who may have an affiliation or ownership interest in or with the in and out of network facilities/services to which the physician prefers we must disclose this information. In the interest of providing our patients with complete information, we are providing the names of the out of network facilities where Andrew H Messiha MD may have an ownership interest/ affiliation with.

Saddleback Pain and Surgical Center
23521 Paseo de Valencia, Suite 204, Laguna Hills, CA 92653

Memorial Care Surgical Center at Orange Coast
18111 Brookhurst Street, Fountain Valley, CA 92708

During your course of treatment at Andrew H Messiha MD, Precision Pain Management, you may be referred to one of these facilities for medical services. These in-network or out of network facilities or provider may bill the patient for services not covered by your benefit plan. You have the right to choose the facility where you receive medical treatment/services, including the right to choose a facility/service other than the ones listed above so long as Dr. Messiha has privilleges there.

By signing below, I acknowledge receipt of the above disclosure information and have a right to a copy of this form.

_____ _____

Patient Signature Date Office Staff Signature Date

Date of Birth:_____

Precision Pain Management

23521 Paseo de Valencia, Suite 204 Laguna Hills, CA 92653
Tel: 949-458-2026 Fax: 949-273-8053

Permission for Verbal Communications

_____ _____
Patient's Name **Date of Birth**

I permit Precision Pain Management (AHM, Inc.), their physicians, nurses, and other personnel to contact, in person or by telephone, myself, other healthcare providers invoved in my care, and with the following family members or friends involved in my medical care regarding my medical care.

	Name	Relationship
1.	_____	_____
2.	_____	_____
3.	_____	_____

☐ I **do not** authorize anyone, outside of my healthcare providers, to have access to my health information.

This authorization is limited to discussions regarding the following medical condition(s):

_____

(If no limitations are listed, discussions will be permitted regarding any medical condition for which the patient has received care.)

Release of information under this document is limited to verbal discussions with my Health Care Providers. This document does not permit release of any written health information to the individuals named above.

This authorization is limited to the following time frame from _____ to _____
If no dates are indicated, this form will remain in effect for an unlimited amount of time.

If, at any time, I do not want verbal discussions to be permitted between my Health Care Providers and any of the individuals named above, I must notify my Health Care Provider by contacting the office.

_____ _____
Patient's Signature **Date**

If this Release is signed by a representative on behalf of the patient, complete the following:

_____ _____
Representative's Name Representative's Signature

_____
Relationship to Patient

Date of Birth:_____