Stephen H. Barkow, MD, DABPM

ORANGE COUNTY
Pain Management

Mission Viejo Office
Oso Medical Plaza
26902 Oso Parkway, Suite 120
Mission Viejo, CA 92691

T: (949) 364-9595
F: (949) 364-9040

Newport Beach Office
Hoag Hospital Neuroscience Center
3900 West Coast Highway, Suite 330
Newport Beach, CA 92663

PATIENT QUESTIONNAIRE

Initial Information	**Today's date:**
Last Name:	First Name:
Date of Birth:	Height: Weight:
Home Phone:	Email:
Work Phone:	Cell Phone:
Home Address:	City: State: Zip:
Primary Care Physician:	Referring Physician:
Phone / Fax:	Phone / Fax:
Emergency contact: Phone:	Relationship

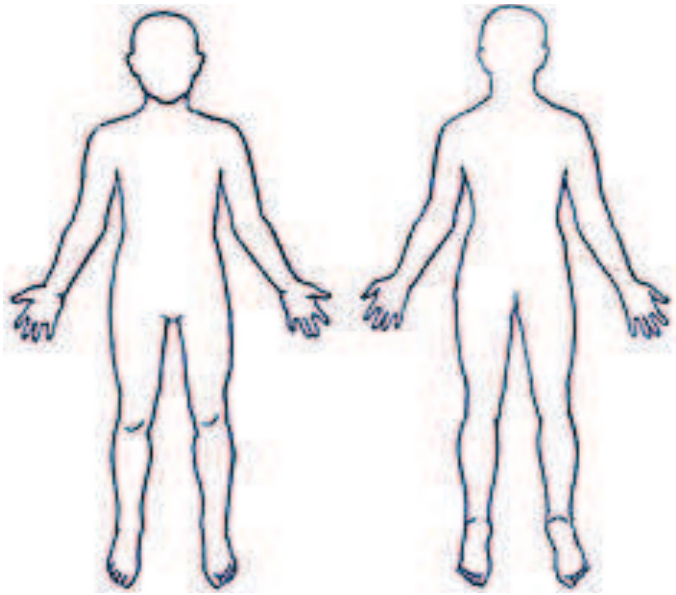
Pain History

When did the pain problem begin? _____/_____/_____

Where is your pain located? _____

Which area gives you the most pain?

Which side is worse?



Right Left Front

Left Right Back

When did your condition start?

How did your condition start?

Character of Your Pain

Average Pain level: 1 2 3 4 5 6 7 8 9 10

Please circle all that apply:

Continuous	ACHING	BURNING	DULL	NUMBNESS	SHARP	SHOOTING	THROBBING	TINGLING	HOT	COLD
Intermittent	ACHING	BURNING	DULL	NUMBNESS	SHARP	SHOOTING	THROBBING	TINGLING	HOT	COLD
Occasional	ACHING	BURNING	DULL	NUMBNESS	SHARP	SHOOTING	THROBBING	TINGLING	HOT	COLD

What triggers your pain or makes it worse? (example: coughing, sneezing, walking, sitting)

What relieves your pain? (example: lying down, walking, massage)

Does your pain limit your daily life? YES NO (please circle)

If yes, what percentage of the day day and how? 10% 25% 50% 75% 100% Other

What can you NOT do now due to your pain?

Does the pain affect your sleep? YES NO (please circle)

If yes, please describe your sleeping habits:

Are you depressed?	YES	NO
Have you been depressed in the past?	YES	NO
Do you have any thoughts of doing harm to yourself or others?	YES	NO
Do you see a psychiatrist or psychologist?	YES	NO
Have you ever had problems with addiction or control with drugs?	YES	NO
Have you have had problems with addiction or control with alcohol?	YES	NO

What are your Treatment Goals?

Decrease pain level	Return to Work
Decrease use of Pain Medication	Increase Activity

Review of Symptoms

Do you CURRENTLY have any of the following?:

Fatigue	Insomnia	Tinnitus (ringing in the ears)
Chest Pain	Easy Bruising	Shortness in Breath
Abdominal Pain	Ankle Swelling	Cough
Headaches	Problems with Bowel Movement	Problems with Urination

Past Medical History

Please circle any of the following conditions that you **HAVE A HISTORY OF**:

Asthma	Heart Disease	Pregnancy
Bleeding Problems	Hepatitis (Circle: A, B, C)	Prostate Problems
Constipation	High Blood Pressure	Rheumatoid Arthritis
Depression	Kidney Infection	Seizures
Diabetes	Kidney Stones	Stomach Ulcer
Dizziness / Fainting	Lung Problems	Stroke
Fibromyalgia	Migraines	Other:
Heart Attack	Osteoarthritis	

Past Surgical History

Please list all the surgeries you have had:

Surgery	Date	Physician

Treatments

	Dates	Did the Treatment help your pain?	
		Yes	No
Physical Therapy			
T.E.N.S (Nerve Stimulator)			
Heat Treatment			
Ice Treatment			
Acupuncture			
Epidural Injection(s)			
Facet Injection(s)			
Trigger Point Injection(s)			
Other			

Tests

	Dates	Facility / Requesting MD
X-Rays		
MRI		
Cat Scan		
Other		

Medications

Allergies: do you have any allergies to medications? YES NO (please circle)

Medication	Reaction

Do you have any other type of Food or Environmental Allergy

Allergy	Reaction

Please list all Medications you are currently taking:

Medication	Dose	Frequency (# / Day)

Social History

Marital Status: Married Single Separated Divorced Widowed (please circle)

Children, how many: _____ Do they live with you? _____

Highest level of Education: _____

Alcohol, how much and how often? _____

Street Drugs: _____

Tobacco – daily amount: _____

Do you exercise? ____ If yes, type and frequency: _____

Work Related Injuries

If your pain is due to an accident at work:

Date of Injury: _____/_____/_____

Occupation: _____ Social Security Number: _____ ___ _____

Date started: _____/_____/_____

Are you still working? YES NO (please circle)

If no, what is the last date you worked? _____/_____/_____

If you are still working, are your activities or hours restricted because of pain? YES NO

Are you receiving disability benefits? YES NO

If yes, Disability Status: Temporarily Disabled Permanently Disabled (please circle)

Is your case in litigation? YES NO

Attorney:	Attorney's Phone:
Adjustor:	Adjustor's Phone:
Employer:	Employer's Phone:
Employer's Address:	
Claim Number:	

What are your job duties?

How and when did you hurt yourself?

Who first treated you, and where?

Please list all work-related injuries or past accidents (car)

Behavioral Assessment

Part One

1. Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.

   a. Little interest or pleasure in doing things
   Not at all **Several days** **More than half the days** **Nearly every day**

   b. Feeling down, depressed, or hopeless
   Not at all **Several days** **More than half the days** **Nearly every day**

   c. Trouble falling asleep, staying asleep, or sleeping too much
   Not at all **Several days** **More than half the days** **Nearly every day**

   d. Feeling tired or having little energy
   Not at all **Several days** **More than half the days** **Nearly every day**

   e. Poor appetite or overeating
   Not at all **Several days** **More than half the days** **Nearly every day**

   f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down
   Not at all **Several days** **More than half the days** **Nearly every day**

   g. Trouble concentrating on things such as reading the newspaper or watching television
   Not at all **Several days** **More than half the days** **Nearly every day**

   h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual
   Not at all **Several days** **More than half the days** **Nearly every day**

   i. Thinking that you would be better off dead or that you want to hurt yourself in some way
   Not at all **Several days** **More than half the days** **Nearly every day**

2. If you checked off any problem on **Question 1**, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
   Not Difficult at All **Somewhat Difficult** **Very Difficult** **Extremely Difficult**

PART TWO

		Mark each box that applies
1. Immediate Family History of Substance Abuse	Alcohol	[ ]
	Illegal Drugs	[ ]
	Prescription Drugs	[ ]
2. Personal History of Substance Abuse	Alcohol	[ ]
	Illegal Drugs	[ ]
	Prescription Drugs	[ ]
3. Age (Mark box if 16-45)		[ ]
4. History of Preadolescent Sexual Abuse		[ ]
5. Psychological Disease	Attention Deficit Disorder	[ ]
	Obsessive Compulsive Disorder	
	Bipolar	
	Schizophrenia	
	Depression	[ ]
6. None of the Above Apply		[ ]

I acknowledge that the above information is correct to the best of my knowledge _____
Initials

PAIN MANAGEMENT AND MEDICATION AGREEMENT

This agreement between _____(patient) and the Orange County Pain Management (OCPM) Medical Personnel is for the purpose of establishing an agreement between the doctor and patient on clear conditions that the patient agrees to in order to receive Pain management treatment. This may include care from multiple disciplines, diagnostic and/or therapeutic interventions, behavioral medicine (psychology, psychiatry, coping strategies, and biofeedback), alternative therapies, physical therapy and the prescription and use of medications. The doctor and patient understand that this agreement is an essential factor in maintaining the trust and confidence necessary in a doctor/patient relationship.

As consultants in Pain Management, we will recommend and/or initiate, and may continue treatment for your pain condition. A reduction in the intensity of your pain and an improvement in your quality of life are the goals for this treatment.

I agree to and accept the following conditions for my pain management treatment, which may include medications prescribed by my OCPM Doctor(s)/Physician Assistant(s):

1. I understand that strong medications, which may include opioids and other controlled substances, may be prescribed for pain relief. I understand that there are potential risks and side effects involved with taking any medications, including the risk of addiction. Overdose of opioid medication may cause injury or death by stopping breathing. This may be reversed by emergency personnel if they know I have taken opioid painkillers. It is suggested that I wear a medical alert bracelet or necklace that contains this information. Other possible complications include, but are not limited to, constipation which could be severe enough to require medical treatment, difficulty with urination, fatigue, drowsiness, nausea, itching, stomach cramps, loss of appetite, confusion, personality changes, reduced sexual function, sweating, flushing, depressed respiration, increased (rather than decreased) pain, and altered hormone levels.
2. I realize that it is my responsibility to keep others and myself from harm. This includes the safety of my driving and the operation of machinery. If there is any question of impairment of my ability to safely perform any activity, I will not attempt to perform the activity until I have stopped the medication long enough for the side effects to resolve. This applies to all medications prescribed by OCPM.
3. I will not share, sell, or trade my medication or exchange medication for money, goods, or services
4. I understand that changing dates, quantity, or strengths of medication or altering a prescription in any way is against the law. Forging prescriptions or a physician's signature is also against the law.
5. I will not attempt to get additional pain medications from any other source including other health care providers (“doctor shopping“), the internet, or from another state or country.
6. I will keep medications safe from children and maintain reasonable safeguards to prevent theft of my medications.
7. **I understand the OCPM cooperates fully with law enforcement agencies in regards to infractions involving prescription medications**.
8. I realize that all medications have potential side effects and interactions. I understand and accept that there are known and unknown risks associated with both the short and long term uses of substances prescribed.

INITIALS _____

9. I understand that if I am pregnant or become pregnant while taking medications, my child could be physically dependent on the opioids, and withdrawal can be life threatening for a baby. If a female of childbearing age, I certify that I am not pregnant and I will use appropriate contraceptive measures during the course of treatment with medications from OCPM. Many medications used in treating pain could harm the fetus or cause birth defects.
10. I understand I must contact my pain physicians before taking tranquilizers or prescription sleeping medications. I understand that the combined use of various drugs, opioids, as well as alcohol, may produce confusion, profound sedation, respiratory depression, blood pressure decrease, liver damage or failure, and even death.
11. I understand that many prescription and nonprescription medications contain Tylenol (acetaminophen). I am aware that I must check medication labels and not take any other medication containing Tylenol while receiving medication from OCPM unless discussed with medical personnel.
12. I understand that opioids analgesics could cause physical dependence within a few weeks of starting opioid therapy. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (including nausea, vomiting, diarrhea, aches, sweats, chills) that may occur withing 24 – 48 hours of the last dose.
13. I understand that the consumption of alcohol with medication can increase the toxicity and risk of side effects, organ damage and even death. I will refrain from consuming alcoholic beverages while taking any medications prescribed by OCPM.
14. Withdrawal from opioids and other medications can have serious consequences, including the risks of injury or death. I will not discontinue any medication prescribed by OCPM that I take regularly without consulting an OCPM physician.
15. Timely requests for refills of medications are the patient's responsibility.
    a) Refills will be made only during scheduled appointments. Refills will not be made over the phone, at night, or on weekends.
    b) Refills will not be made if I “run out early“ or “lose a prescription“ or “spill or misplace my medication“. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
    c) Refills are done as an “emergency“. I will call at least 48 hours ahead if I need assistance with a medication prescription.
    d) If medications are stolen, and a police report regarding the theft is completed, an exception may be made at the discretion of OCPM.
    e) Medication refills are to be written at office visits. They will not be done on the same day that I present for a procedure.
16. I agree that I will use my medication at a rate no greater than the prescribed rate unless it is discussed directly with OCPM medical personnel.
17. I will not use any illegal substances (cocaine, heroin, methamphetamine, etc.) while being treated medically with controlled substances. Violation of this will result in the cessation of the prescribing of any controlled substances and possibly discharge from care by OCPM.
18. I will not alter my medication in any way (for example: crushing or chewing tablets) or use any other route of delivery other than as prescribed by OCPM (for example injection, or insufflation “snorting“).

19. I will use pain medications provided by OCPM. If additional medication is needed for a specific reason, e.g. dental work or outpatient surgery, this must be approved by OCPM medical personnel.

INITIALS _____

20. I agree that I will submit to a urine and/or blood test if requested by my OCPM Physician to determine my compliance with this agreement and my regimen of pain control medication. Tests may include screens for illegal substances.
21. I will keep OCPM, and also my Primary Care Physician (PCP) and all other treating physicians informed as to all medications I am taking from all sources.
22. If I have any medication discontinued or no longer being prescribed by OCPM, these medications will be disposed of properly.
23. Overall health is best maintained by having a PCP. OCPM recommends and may require that I have a PCP to participate in my care.
24. I understand that my medication regimen may be continued for a definitive time period as determined by my OCPM Physician. My case may be reviewed periodically. If there are no indications that medications are having a positive effect on my ability to perform activities or my daily living, or that progress is being made to improve my functioning or quality of life the regimen might be tapered or discontinued.
25. I will keep all scheduled appointments in the pain clinic. Frequent cancellations or cancellation with less that 24 hours notice can result in the termination of my treatment by OCPM.
26. If I am receiving any medication from OCPM, I understand that follow-up visits at a minimum of every 90 days are required. If I do not follow-up in person for greater than 90 days for any reason (including moving, receiving care elsewhere and health reasons), I agree the doctor/patient relationship is terminated. Acceptance back as a patient will be at the sole discretion of the OCPM medical personnel after a new office visit consultation.
27. I understand that phone calls after hours should be for issues such as minor post-procedure complications, medication side effects and other urgent matters. For any medical emergencies, “911“ should be called and/or Emergency Room treatment should be sought. For routine matters, the clinic should be called during normal business hours.
28. I understand that the main treatment goal is to improve my ability to function and/or to work and/or to reduce pain. In consideration of that goal, I agree to make a reasonable effort to follow better health habits. This may include exercise, weight control, and avoiding the use of nicotine. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome from my treatment.
29. I agree to comply with all aspects of my treatment program, including requested consultations, behavioral medicine and physical therapy. Failure to do so may lead to discontinuation of my medication and possibly discontinuation as a patient at OCPM.
30. Consultation by another specialty or a specific physician may be required to also evaluate my medication management and overall treatment.
31. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the prescribing of my pain medications and I authorize the doctors, my pharmacy, and insurers to cooperate fully with any city, state, or federal law enforcement agencies in the investigations of any possible misuse, sale, or diversion of my pain medications.
32. I authorize OCPM to provide a copy of this Agreement to my pharmacy, other healthcare providers and any Emergency Department upon request. I give my permission to allow sharing of medical history in regards to medication use with other health care agencies and providers.
33. My Pain Management Physicians and I agree that this agreement is important to my doctor's ability to treat my pain effectively, and that my failure to comply with the agreement may result in the discontinuation of prescribed medication by my doctor and termination of the doctor/patient relationship.

INITIALS _____

The OCPM Physicians understand that emergencies and extenuating circumstances can occur, and under some circumstances exceptions to the above items may be made. Cases will be considered on an individual basis and exceptions to this agreement may be made at the sole discretion of OCPM personnel.If any provision of this agreement is held by a court of competent jurisdiction or applicable state of federal law and their implementing regulations to be invalid, void or unenforceable, the remaining provision will nevertheless continue in full force and effect.

Lack of strict adherence to any provision of this agreement by OCPM, in no way invalidates any other provisions of this agreement.

If at any time you are concerned about your medication or side effects of your medication, you may call OCPM at (949) 364-9595. The on-call physician can also be contacted to receive your message if necessary.

I agree to use one pharmacy for all my pain medications. If I change my pharmacy for any reason, I agree to notify OCPM at the time I receive a prescription. I will also advise my new pharmacy of my prior pharmacy's address and telephone number.

I have thoroughly read, understand and accept all of the above provisions. Any questions I had regarding this agreement have been answered to my satisfaction by my OCPM Physician(s). I understand all the policies regarding the prescribing and use of opioids and other medications. I agree to comply with the pain management program. I also agree to urine or blood testing, and to detoxification if indicated.

This agreement is entered into on this _____ day of _____, 20____.

_____
Patient

_____
Doctor

Summary Notice of Privacy Practices
Ciro Elgueta, Privacy Officer (949) 365-9595

This notice is a summary of how medical information about you may be used and disclosed and your right to access this information. A copy of the full Notice of Privacy Practices is available in our reception area.

The law permits us to use or disclose your health information for the following purposes:

1. Treatment: To provide your medical care, your information will be disclosed to employees, other physicians, pharmacies, laboratories, family members and others who are involved n your medical care. While receiving treatment in open areas, discussions may be incidentally overheard by others receiving treatment.
2. Payment: To obtain payment from your insurance company or health plan.
3. Health Care Operations: To manage the daily operations of this medical practice.
4. Appointment Reminders: Messages may be left on your answering machine or with the person answering your phone.
5. Sign in Sheet: You may be asked to sign in and your name may be called when we are ready to see you.
6. Notification and communication with family: In the case of an emergency we will use our best judgment in communication with family members.
7. Marketing: To give you information about products or services related to your treatment.
8. Other Instances: Required by law, public health, health oversight activities, judicial and administrative proceedings, law enforcement, coroners, organ and tissue donation, public safety, specialized government functions, change or ownership.
9. Worker's Compensation: For coordinating your care with your adjustor and obtaining payment.

Except as described in this Notice, health information that identifies you will not be used without your written authorization. If you do authorize the use of this information, you may revoke your authorization in writing at any time.

You have the right to:

- Request special privacy protections,
- Request confidential communications,
- Inspect and copy (for a reasonable fee as allowed by California law),
- Amend or supplement,
- Request an accounting of disclosures,
- Make a complaint without penalty.

Please see the completed notice for the procedures for making any of these requests, or phone our privacy officer identified above. We reserve the right to amend this Notice at any time in the future. Until such amendment is made, we are required by law to comply with this Notice.

Stephen H. Barkow, MD, DABPM

ORANGE COUNTY
Pain Management

Mission Viejo Office
Oso Medical Plaza
26902 Oso Parkway, Suite 120
Mission Viejo, CA 92691

T: (949) 364-9595
F: (949) 364-9040

Newport Beach Office
Hoag Hospital Neuroscience Center
3900 West Coast Highway, Suite 330
Newport Beach, CA 92663

Acknowledgment of Receipt of Notice of Privacy Practices
Orange County Pain Management

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practice. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy at each appointment.

_____ _____

Patient Date

If not signed by the patient please indicate:

Relationship:

- Parent or guardian of minor patient.
- Guardian or conservator of an incompetent patient.
- Beneficiary of personal representative of deceased patient.

Name of the Patient: _____

Authorization for Release of Information

Section A: **Must be completed for all authorizations**:
I hereby authorize _____ and/or his/her staff to disclose my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer protected by federal and state law.

_____ _____
Patient Name Date of Birth

Organization receiving this information: _____

Specific description of information to be disclosed, including dates:

Section B: **Must be completed only if health-plan/provider has requested authorization**:

1. Health plan/Provider must complete the following:
   a) What is the purpose of disclosure? _____

(No purpose need to be stated if patient does not wish plan/provider to)

   b) Will the plan/provider receive financial or in kind compensation for using PHI described above? ____ Yes _____.
2. The patient or patient's representative must read and initial the following statement:
   a) I understand that my health care & payment for my health care will not be affected if I do not sign this form. _____ Initials.
   b) I understand that I may see and copy the information described on this form if I ask for it.

Section C: **Must be completed for all authorizations**:
The patient or patient's representative must read and initial the following statement:

1. I understand that his authorization will expire on _____/_____/_____
2. I understand I may revoke this authorization at any time by notifying Orange County Pain Management, Stephen H. Barkow, M.D., in writing, but if I do, it won't have any effect on any actions taken before receipt of my revocation. _____ Initials.

Orange County Pain Management, Dr. Stephen H. Barkow, M.D. Will not condition my treatment on whether I provide authorization for the request use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating PHI from disclosure to a third party.

_____ _____
Signature of Patient or Patient's representative Date

_____ _____
Printed name of patient and representative (if applicable) Relationship

FINANCIAL POLICY

You are financially responsible for the medical services you receive at Orange County Pain Management. Please review our policies below and sign at the end to indicate your agreement to these terms. If you have any questions, please do not hesitate to ask a member of our staff.

APPOINTMENTS

1. **Co-payments.** Co-payments are due at the time of service. If you are unable to make your co-payment, OCPM reserves the right to reschedule your appointment until a time that you are able to make your payment. Payment for any outstanding balance is due at your appointment.
2. **Missed Appointments and Late Arrivals.** If you are more than 10 minutes late, we may reschedule your appointment. If you do not show up for your appointment, you will be responsible for a missed appointment fee. Missed office visits are subject to a $25 charge. Missed procedures and initial appointments are subject to a $75 charge. These charges are your responsibility and will not be billed to any insurance carrier.

INSURANCE PAYMENTS

3. **Financial Responsibility.** Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurer will be your responsibility.
4. **Coverage Changes and Timely Submission.** It is your responsibility to inform us in a timely manner of any changes to your billing or insurance information. There is a time limit in which OCPM can submit a claim on your behalf to your insurer. If OCPM is unable to submit your claim within this period because we have not been supplied with your correct insurance information, you will be responsible for the charges.
5. **Self-Pay.** If you do not have health insurance, or if your health insurance will not pay for services rendered by OCPM, you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule (available at our front desk). Self-pay patients are expected to make payment in full at the time of service.

BENEFITS AND AUTHORIZATION

6. **Insurance Plan Participation.** We participate in many but not all insurance plans. It is your responsibility to contact your insurance company to verify that your physician participates in your plan. Out of network charges may have higher deductibles and co-payments. **We are not responsible for the ultimate payment determination by your insurance carrier.**
7. **Referrals.** Referral and prior authorization requirements vary widely among insurance carriers and plans. If your insurance carrier requires a referral for you to be seen by OCPM, it is your responsibility to be aware of this fact, and to obtain this referral.
8. **Prior Authorization and Non-Covered Services.** OCPM may provide services that insurance plans exclude or require prior authorization. It is ultimately your responsibility to ensure that services provided to your are covered benefits and authorized by your insurer. As a courtesy to our patients, OCPM makes an effort to determine if services ordered are covered by your insurance plan, and whether or not a prior authorization is required. If determined that a prior authorization is required, we will attempt to obtain such authorization on your behalf.
9. **Out of Network Payments.** If we are not part of your insurance carrier's network and your insurance carrier pays you directly, you are solely responsible for payment and agree to forward the payment to OCPM, immediately.

ACCOUNT BALANCES AND PAYMENTS

10. **Reassignment of Balances.** If your insurance company does not pay within a reasonable time, we may transfer the balance to your sole responsibility. Please follow up with your insurance carrier to resolve non-payment issues. Balances are due within 30 days of receiving a statement.
11. **Collection of Unpaid Accounts.** If you have an outstanding balance of over 90 days old and have failed to make payment arrangements, we may turn your balance over to a collection agency, which may result in reporting to credit bureaus and/or legal action. OCPM reserves the

right to refuse treatment to patients with outstanding balances.

12. **Returned Check.** Returned checks will be subject to a $35 returned check fee in addition to any bank fees incurred.
13. **Refunds.** Refunds for overpayment or prepayment are only made after there has been full insurance reimbursement for all medical services on your account. Please submit a written refund request and allow four to six weeks for your request to be processed. Send requests to: OCPM, Attn: Billing Department, 26902 Oso Parkway, Ste. 120, Mission Viejo, CA 92691.
14. **Statements.** Charges shown by statement are agreed to be correct and reasonable unless protested within thirty (30) days of the billing dates.
15. **Medical Records.** We charge a fee to copy or transfer your medical records. Please contact OCPM to discuss fees, as they vary.
16. **Forms and Documents.** We charge $35 per page for the physician to complete forms and documents (including disability paperwork). The payment is due **in advance** and we require up to 10 business days to complete the forms. If the form requires the physician to dictate a report, the charge is $150.00 per page.

Agreement and Assignment of Benefits

I heave read and understand the financial policy of Orange County Pain Management, and I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to OCPM. I understand that I am financially responsible for all services I receive from OCPM. This financial policy is binding upon you and your estate, executors and/or administrators, if applicable.

Patient Name: _____ _____ _____

(Printed Name) Signature Date

Responsible Party Name (If different than patient) : _____
Relationship: _____

Responsible Party's Signature: _____ **Date:** _____