11190 Warner Avenue, Suite 305
Fountain Valley, CA 92708
Telephone: 714-433-2000

WELCOME – YOUR APPOINTMENT IS SCHEDULED ON:
_____________________ AT: __________ WITH DR. _________________.

PLEASE COMPLETE THE FOLLOWING PAPERWORK PRIOR TO YOUR OFFICE VISIT AND BRING WITH YOU AT THE TIME OF YOUR VISIT.

Name: ____ Today's Date: ___________________
First Middle Last

Home Address: ____
City: _________________________________ State: _________ Zip: ______________
Telephone: ( ) _______________________ Alt./Cell No. : ( ) ____________________
Date of Birth: ________________ Age: _______
Email Address: _________________________________ May we send information here? Yes No
Occupation: ____________________________________ SSN: ___________________________
Employer: ____ Years There: ____________
Employer's Address: ____
City: _________________________________ State: _________ Zip: ______________
Work Phone: ( ) _______________________________
May we contact you at work? (circle one) Yes No

Name of Spouse: __________________________ Birthdate: ______________ Age: ______

In case of emergency, contact: _______________________________ Relationship: __________
Home Phone: ( ) _________________________ Work Phone: ( ) ____________________
Please ensure this contact information differs from your own.

How did you learn about our practice? ____

Do you wish correspondence to be confidential? Yes No
Do you wish phone calls to be confidential? Yes No

Please list all languages you speak fluently: ____

Referring Physician: ____

Specialty: ____

Office Phone Number: ___________________________________

Primary Care Physician (if other than referring physician): _____________________________

Office Phone Number: ___________________________________

COMMUNICATION CONSENT AGREEMENT

I understand that under federal law ("HIPAA"), the office of Orange County Brain & Spine Group may NOT release any medical information to any individual, without my express written permission. Law enforcement and court order are two exceptions to this requirement. I, therefore, GIVE permission to the office of Orange County Brain & Spine Group to release medical information on my behalf, to the following person(s): (Please note – any family member/friend – other than your doctor's office – can be listed. If none – please check the "I do not wish…" box and sign below.)

Name: ____ Relationship: ________________

Address: ____

Phone #: _______________________________ Age: ___________ Birthdate: ____________

Name: ____ Relationship: ________________

Address: ____

Phone #: _______________________________ Age: ___________ Birthdate: ____________

Name: ____ Relationship: ________________

Address: ____

Phone #: _______________________________ Age: ___________ Birthdate: ____________

☐ You may release my medical information to the above list of persons.

Patient Signature: ____ Date: _______________

☐ I do not wish to release any of my medical information at this time to family members and/or friends.

Patient Signature: ____ Date: _______________

PROBLEM LIST

NAME: ______________________________________ DATE: _______________

1ST DATE OF SERVICE: __________________ DATE OF BIRTH: ______________ AGE: ____________

ALLERGIES TO MEDICIATIONS	TYPE OF REACTION
1	
2	
3	
4	
5	

ARE YOU ALLERGIC TO LATEX? YES OR NO (CIRCLE ONE)

☐ **NO KNOWN ALLERGIES**

CHRONIC MEDICAL PROBLEM	DATE	SURGERIES	DATE
1		1	
2		2	
3		3	
4		4	
5		5	

MEDICATION FLOW SHEET – LIST ALL MEDICATIONS INCLUDING ASPIRIN

MEDICATION	REFILL	DOSE	FREQ	ROUTE (oral or inj)	START	STOP
1	Y N					
2	Y N					
3	Y N					
4	Y N					
5	Y N					
6	Y N					
7	Y N					
8	Y N					
9	Y N					
10	Y N					

PLEASE COMPLETE ALL SECTIONS

NAME: ______________________ **DATE:** ____________

PRIMARY CARE DOCTOR: ______________ **WHO REFERRED YOU HERE:** ______________

AGE ______ **HEIGHT** ______ **WEIGHT** ______ **ARE YOU RIGHT OR LEFT HANDED? Circle one**

ARE WE SEEING YOU TODAY FOR A WORK RELATED INJURY? **YES OR NO** (circle one)

CURRENT INJURY/PROBLEM DETAILS:

REASON FOR VISIT: ______________________ **DATE PROBLEM BEGAN:** ______________

HOW DID INJURY OR PROBLEM OCCUR? ______________________

WHERE IS YOUR PAIN LOCATED NOW? NECK ARM LEFT OR RIGHT
(Please use the Back Pain Drawing on the next page to mark specific areas) BACK LEG LEFT OR RIGHT

HOW LONG HAVE YOU HAD PAIN? ______________________

ON A SCALE OF 0-10 (10 BEING THE WORST PAIN), RATE THE PAIN THAT YOU ARE EXPERIENCING? ____________

PAIN QUALITY IS: (circle all that apply) **SHARP, STABBING, DULL, ACHY, THROBBING, ELECTRIC, PINS AND NEEDLES**

PAIN FREQUENCY IS: (circle all that apply) **CONSTANT, FREQUENT, INTERMITTENT, RARE, POSITIONAL, ACTIVITY RELATED, UNPREDICTABLE**

LIST WHAT RELIEVES YOUR PAIN: ______________________

LIST WHAT AGGRAVATES YOUR PAIN: ______________________

ANY NUMBNESS OR TINGLING? (circle one) **YES OR NO** **WHERE?** ______________

ANY WEAKNESS IN YOUR LEGS OR ARMS? YES OR NO **WHERE?** ______________

ANY BOWEL OR BLADDER PROBLEMS (INCONTINENCE OR RETENTION)? (circle one) **YES OR NO?**

WHAT PREVIOUS TREATMENT HAVE YOU HAD FOR THIS CONDITION? CIRCLE ALL THOSE THAT APPLY

EPIDURAL INJECTIONS (IF SO - HOW MANY)? ____________ **PHYSICAL THERAPY - (IF SO - FOR HOW LONG)?** ____________

CHIROPRACTOR (IF SO - FOR HOW LONG)? ____________ **MEDICATIONS: PLEASE LIST ALL** ____________

ARE YOU CURRENTLY SEEING A PAIN DOCTOR? YES OR NO? If yes, who are you seeing? ____________

WHAT PREVIOUS TESTS HAVE YOU HAD ON YOUR BACK OR NECK? (INCLUDE DATE & NAME AND LOCATION)

XRAY: ______________ **MRI:** ______________

CT MYELOGRAM: ______________ **CT:** ______________

EMG/NCV ______________ **BONE SCAN** ______________

REGARDING MRI'S: ARE YOU CLAUSTROPHOBIC? YES OR NO (CIRCLE ONE)
DO YOU HAVE METAL IMPLANTS YES OR NO (CIRCLE ONE) **IF YES - LIST IMPLANTS:** ______________

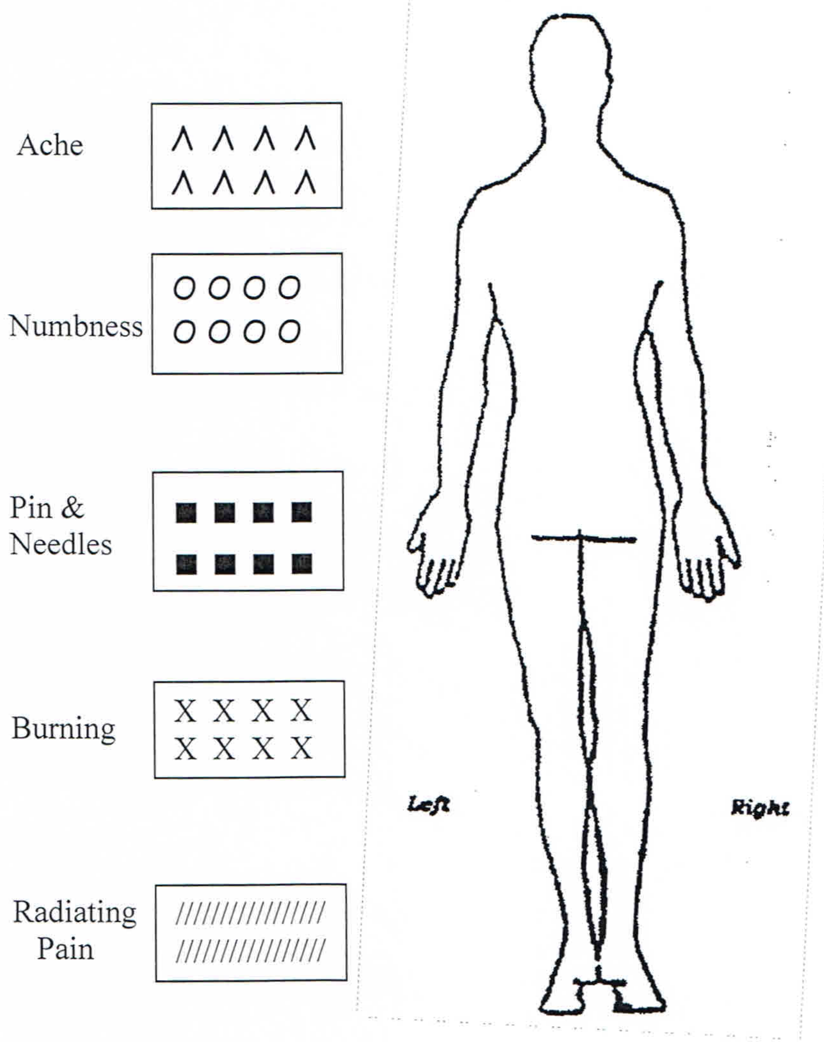
BACK PAIN DRAWING

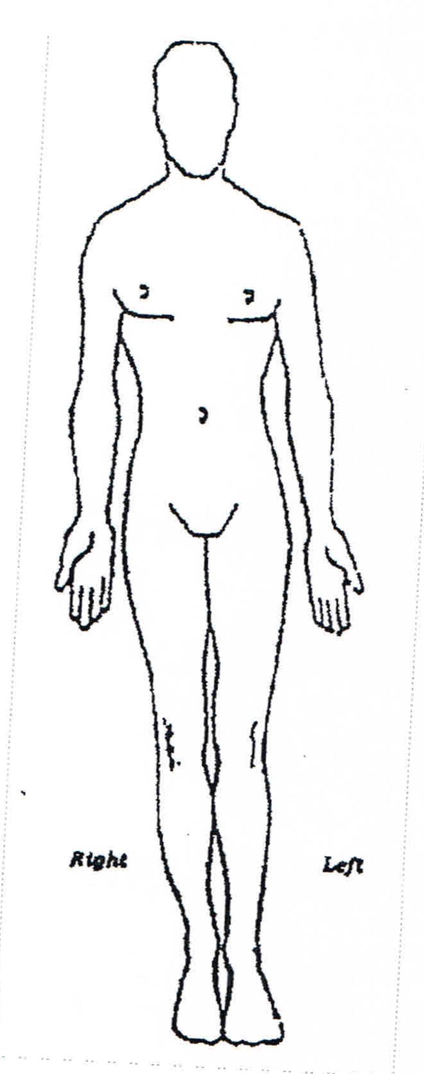
Patient Name: ______________________________ Date : ____________________

WHERE IS YOUR PAIN NOW? DOB: ____________________

Mark the areas on your body where you feel the described sensations. Use the appropriate symptom. Mark the areas of radiation. Include all affected areas

BackPain __________% **Leg Pain**__________% **Total 100%**





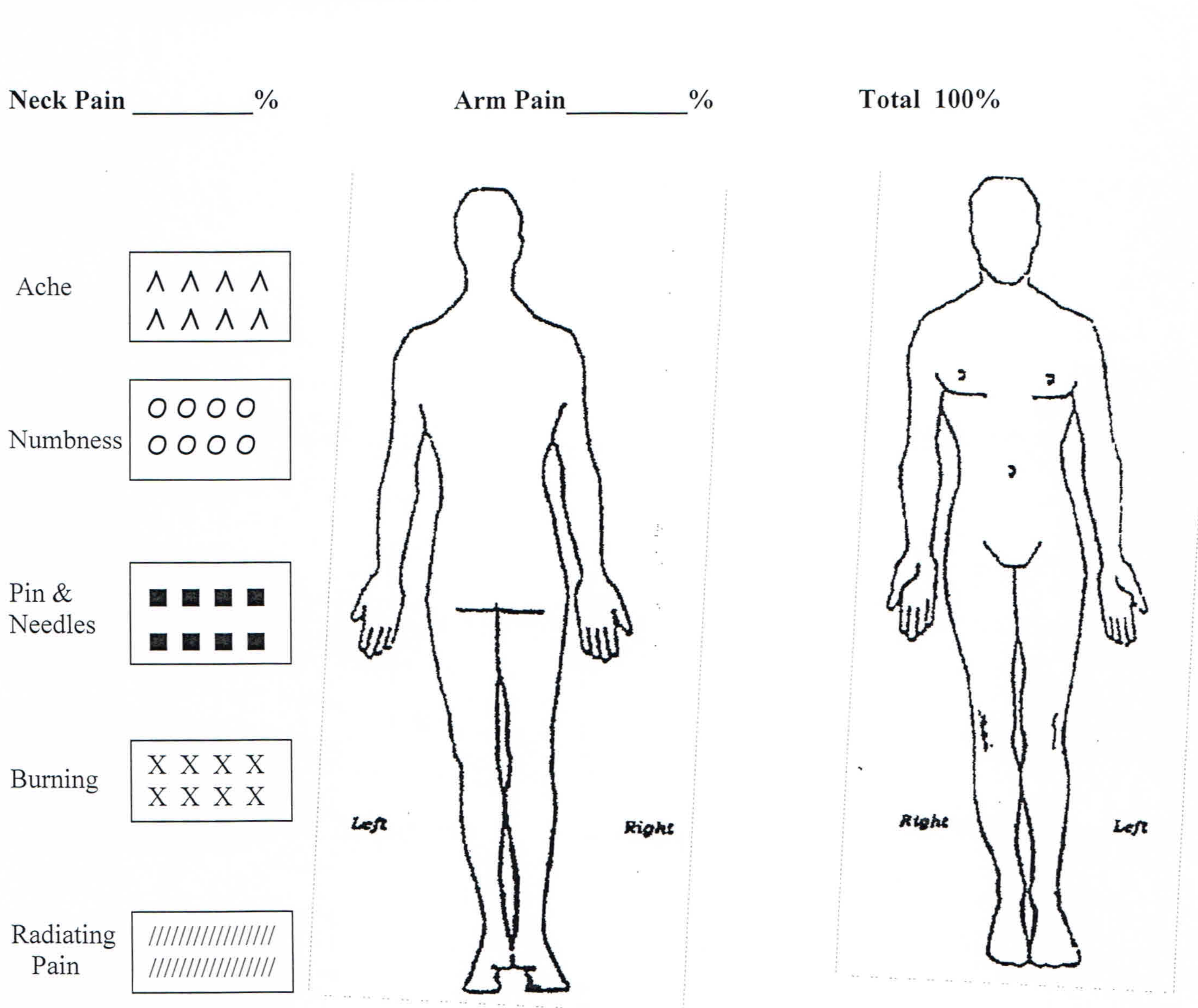
NECK PAIN DRAWING

Patient Name: ______________________________ Date : ____________

WHERE IS YOUR PAIN NOW? DOB: ____________

Mark the areas on your body where you feel the described sensations. Use the appropriate symptom. Mark the areas of radiation. Include all affected areas

Neck Pain ________% **Arm Pain**________% **Total 100%**



NOTICE OF PRIVACY PRACTICES

Effective Date: April 20, 2014

this is your copy please keep for your records

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

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information, especially as we introduce technology in the form of electronic health records, related interoperability and data sharing to increase the timeliness and efficiency of your medical care. Our practice will store clinical information in an electronic health record which will share this information with other professionals involved in the provision of your health care services via a Health Information Exchange (HIE). This is done so that this information may be available at the point of care to providers who are members of the HIE. Your provider may also communicate with your confidentially and securely via the patient web portal. At all times, the sharing and review of your data is kept secure and access is tracked according to HIPAA regulations.

- We record the medical care we provide in a secure EHR and may receive such electronic records form others. All paper information received regarding your care at other locations will be scanned into our EHR.
- We will electronically upload certain aspects of your medical record, to the HIE so that it can be readily accessible to other providers participating in your health care. All data uploaded to the HIE is secure and protected per HIPAA rules and regulations. All access to your information is tracked and you may request a report of who has accessed your information within the EHR and/or HIE at any time.
- We use this electronically recorded information to provide or enable other health care providers who are members of the HIE to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice.

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.

- This Notice describes how we may use and disclose your medical information.
- It also describes your rights and our legal obligations with respect to your medical information.
- If you have any questions about this Notice, please contact our Privacy Officer listed at the end of this Notice.

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.
2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information on to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business Associates," such as our billing service, that performs administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse, or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population- based efforts to improve health or reduce health care costs, protocol development, case management or care

coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts.

4. Health Information Exchange. This practice is participating in the Hoag Health Information Exchange (HIE), an electronic system through which it and other participating healthcare providers can share patient information according to nationally recognized standards and in compliance with federal and state law that protects your privacy. Through the HIE, your participating providers will be able to access information about you that is necessary for treatment, unless you choose to have your information withheld from the HIE by personally opting out from participation. If you choose to opt out of the HIE (that is, if you feel that your medical information should not be shared through the HIE), we will continue to use your medical information in accordance with this Notice of Privacy Practices and the law, but will not make it available to others through the HIE. To opt out if the HIE, please contact the Hoag Director of Health Information Exchange in writing at One Hoag Drive, Newport Beach, CA 92663,or by telephone at (949) 764-8722.
5. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.
6. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
7. Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you have instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
8. Marketing. Provided we do not receive any payment for making these communications, we may contact you to encourage you to purchase or use products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans we participate in. We may receive financial compensation to talk with you face-to-face, to provide you with small promotional gifts, or to cover our cost of reminding you to take and refill your medication or otherwise communicate about a drug or biologic that is currently prescribed for you, but only if you either: (1) have a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise you about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) you are a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these communications while you have a chronic and seriously debilitating or life threatening condition, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration; and (2) your right to opt-out of future remunerated communications by calling the communicator's toll-free number. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.
9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
10. Public Health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
11. Health Oversight Activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.
12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
17. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
18. Worker's Compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
19. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
20. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.
21. Fundraising. We may contact you directly for fundraising activities in which the practice chooses to participate, such as Arthritis Foundation events or other charity organizations. Your information will not be disclosed to outside agencies for fundraising purposes.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization at any time by written request.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject any other request, and will notify you of our decision.
2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. We will attempt to comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications. However, we utilize a variety of automated systems which may restrict our ability to comply with certain requests. For example, patient statements from our automated billing system will always be sent to your home address.
3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by federal and California law. We may your request under limited circumstances. If we deny your request to access your child's records because we believe allowing access would be reasonably likely to cause substantial harm to your child, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.
4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect.
5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs l (treatment), 2 (payment), 3 (health care operations), 7 (notification and communication with family) and 17 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by email.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the bottom of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed below.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to the Department of Health & Human Services
(DHHS), Office of Civil Rights, Hubert H. Humphrey Bldg., 200 Independence Avenue, S.W., Room 509F HHH Building, Washington, DC 20201