ORTHOPAEDIC
SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

Pain Management Questionnaire

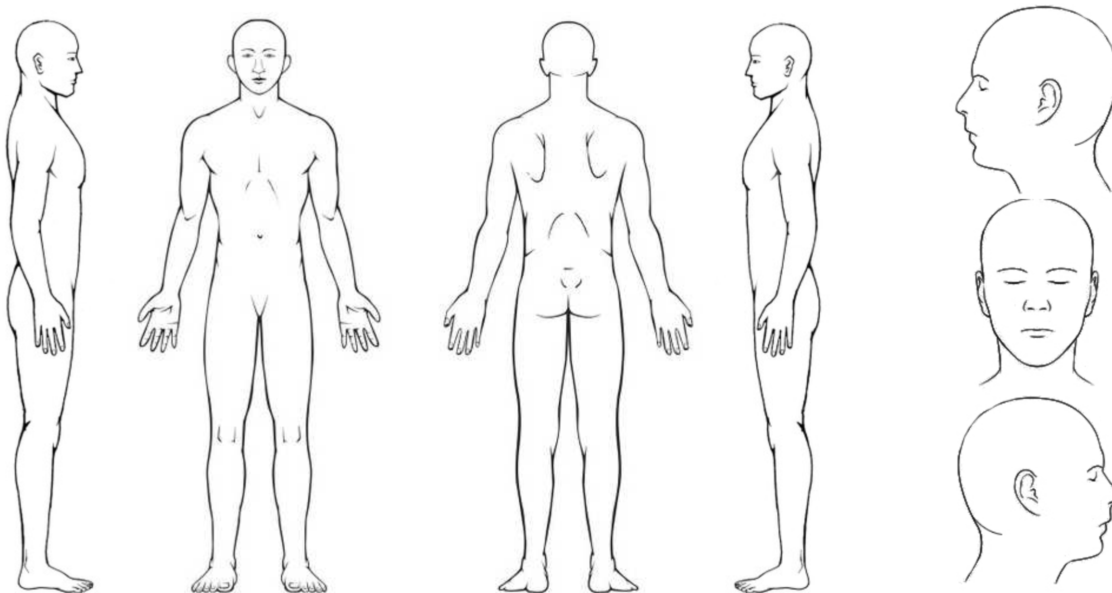
Daniel Q. Le, M.D.

Patient Name: ___________________________________ DOB: ______________ Date: _______________

WHERE is your pain: ____

Please label your pain distribution: ▨ Mild / Moderate ■ Severe

What kind of pain: ☐ Dull ☐ Aching ☐ Sharp ☐ Stabbing
☐ Shooting ☐ Burning ☐ Tingling



Out of 100%, how much pain is in your BACK? _____ And in your LEG(s)?_____

HOW did your pain FIRST start:

☐ suddenly ☐ gradually

From:

☐ lifting ☐ auto accident
☐ fall ☐ injured at work
☐ other: ________________________________

WHEN did you pain FIRST start? __________________________

Is your pain ☐ intermittent or ☐ constant

How many times per day? _____

Patient Name: ______________________________

What makes your pain WORSE?

☐ Sitting ☐ Standing ☐ Walking
☐ Morning ☐ Evening ☐ Night
☐ Bending forward ☐ Bending backwards
☐ Coughing ☐ Sneezing
☐ Touching skin
☐ Other: ____________________________________

What makes your pain BETTER?

☐ Lying down ☐ Sitting ☐ Standing
☐ Walking ☐ Heating pad ☐ Cooling pad
☐ Pain pills ☐ Physical therapy
☐ Other: ____________________________________

Pain Level:

Mark along this line the intensity of your pain using the following letters:

(L): Least pain (M): Most of the time (W): Pain at its worst

No /____/ Worst
Pain 1 2 3 4 5 6 7 8 9 10 Pain

Pain associated with:

Weakness of: ☐ Leg ☐ Arm Numbness of: ☐ Leg ☐ Arm
Recent loss control of: ☐ Bowel function ☐ Bladder function

Previous test done:

X-ray ☐ Yes ☐ No Date: ____________
CT Scan ☐ Yes ☐ No Date: ____________
MRI ☐ Yes ☐ No Date: ____________
EMG/Nerve test ☐ Yes ☐ No Date: ____________
☐ Other: ____

Previous pain treatment(s) tried:	**Relief:**	
☐ Physical Therapy	☐ Yes	☐ No
☐ TENS	☐ Yes	☐ No
☐ Bio-feedback/Relaxation Technique	☐ Yes	☐ No
☐ Trigger Point Injections	☐ Yes	☐ No
☐ Epidural Steroid Injections	☐ Yes	☐ No
☐ Nerve Blocks ____________________	☐ Yes	☐ No
☐ Medications: ____________________	☐ Yes	☐ No
(please list) ____________________	☐ Yes	☐ No
____________________	☐ Yes	☐ No
____________________	☐ Yes	☐ No
____________________	☐ Yes	☐ No
____________________	☐ Yes	☐ No
☐ Other: ____________________	☐ Yes	☐ No

Patient Name: ______________________________

Please check for any medical problems: ☐ **None**

☐ Heart disease	☐ Stroke
☐ Previous heart attack	☐ Bleeding disorder
☐ High blood pressure	☐ Kidney disease
☐ Asthma	☐ Livery disease
☐ Diabetes	☐ Thyroid disease
☐ Ulcer	☐ Other: ___________________________

Previous surgery:

____

____

DRUG ALLERGY: ☐ None Known

____

____

Current MEDICATIONS, strength and directions:

____

____

____

____

____

Do you smoke? ☐ Yes ☐ No How many per day? _________

Do you drink alcohol? ☐ Yes ☐ No How much? ________________

Do you have trouble sleeping?	☐ Yes	☐ No
Do you have any recent weight loss?	☐ Yes	☐ No
Do you have any fevers or chills?	☐ Yes	☐ No
Do you have severe headaches?	☐ Yes	☐ No
Have you had any fainting spells?	☐ Yes	☐ No
Do you have chest pain?	☐ Yes	☐ No
Do you have shortness of breath?	☐ Yes	☐ No
Have you coughed up blood or sputum?	☐ Yes	☐ No
Do you have any abdominal pain?	☐ Yes	☐ No
Have you ever had black tarry stools?	☐ Yes	☐ No
Do you have any joint stiffness or pain?	☐ Yes	☐ No
Do you have skin rashes?	☐ Yes	☐ No
Does your skin bruise easily?	☐ Yes	☐ No

Daniel Q. Le, M.D.
Interventional Pain Management

Telephone (714) 937-2189 – (949) 574-5138 Fax

HOW TO PROTECT YOUR MEDICINES AT HOME

Today the abuse of prescription medications is more widespread that the abuse of traditional street drugs, excluding marijuana. In fact, the number of people who abuse prescription medicines is approximately three times the number of people who abuse cocaine. Thus, **we all need to be vigilant in protecting our own medicines from ABUSE.**

Protect Your Medicines

- Lock medicines in a locking cabinet and secure the key.
- Always store medicines in a cool, dry place protected from light. **Initial _______**
- Do not store prescription drugs in the bathroom medicine cabinet. A bathroom is hot and humid; bathroom medicine cabinets rarely lock. **Initial _______**
- Do not store medicines in the glove compartment of your car or in the kitchen cabinets. Here, too, heat and moisture degrade medicines and make unsafe. **Initial _______**
- Do not store medicines inside purses, coat pockets, nightstands or other locations easily accessed by others. **Initial _______**
- If you are going out of town, take all the necessary precautions with your medication. We will not call in medications early. **Initial _______**
- Store all medications in the original container with the original labels intact. **Initial _______**
- Do not store medicines in the refrigerator or freezer unless directed by your pharmacist. **Initial _______**
- Follow directions carefully. Do not take more than instructed. If you feel that medication is not working properly, contact Dr. Le – he will decide if any change in directions or dosage is necessary. **Initial _______**

Would you like a copy of this for your records? ☐ **Yes** ☐ **No**

Patient Name (Print) ____ Date ________________

ORTHOPAEDIC SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

Daniel Q. Le, M.D.
Agreement for Narcotic Prescriptions

Narcotics (Opioids, tranquilizers, barbiturates), if used properly can be very effective in pain management. If used excessively, they can cause adverse effects such as impaired judgement, lethargy, respiratory depression or even death. Our goal is to relieve distressing pain, with minimal drug side effects, with improved quality of life. It is our job to continually re-evaluate your pain experience.

I, __________________________, understand that compli8ance with the following guidelines is important to the condition of pain treatment by Dr. Daniel Le.

1. I will take medication **ONLY** at the dose and frequency prescribed.

2. **NO** other pain medications are to be taken unless discussed with Dr. Daniel Le or his designees.

3. **NO** increase in medication will be made without the approval of Dr. Daniel Le.

4. I **will not request** opioids or any other pain medicine from prescribers other than Dr. Daniel Le.

5. **I understand** that **I am NOT** to consume **alcohol with prescribed** narcotics.

6. **I will** consent **to random drug testing.**

7. **I will** protect my prescriptions & medications. **LOST OR STOLEN** prescriptions will not be replaced.

8. I will keep my scheduled appointments and/or cancel my appointments a minimum of 24-hours prior to my scheduled appointment.

9. I understand that my pain treatment may be stopped if any of the following occur:
   - If the practitioner feels that opioids are not effective for my pain or my functional activity is not improved.
   - If I give, sell, or misuse the medication.
   - If I develop rapid tolerance or loss of effect from this treatment.
   - If I develop side effects that are significant in the view of the practitioner.
   - If I obtain opioids from sources other than Dr. Daniel Le.
   - If I miss three scheduled appointments.

10. Medications will be refilled on a timely matter as long as your pharmacy contacts us at least 24 hours before you run out of your medication. Refills of narcotic medications will be made during a scheduled office visit. ***Refills will not be made on the weekends or on holidays under any circumstances.***

11. I have been informed by my physician about narcotic side effects. These can include judgement in making business decisions and in the operation of machinery or equipment such as an automobile. I must use special care while being involved in these activities.
12. If I violate any of the above conditions or decline to take a urine test for controlled substances at any time at my physician's request, my narcotic prescriptions and/or my treatment with Dr. Daniel Le may be terminated immediately.

I have read, understand and consent to the above guidelines:

________________________________	____________________________	________________
Patient's Signature	**Daniel Le, M.D.**	**Date**

ORTHOPAEDIC SPECIALTY INSTITUTE
MEDICAL GROUP OF ORANGE COUNTY

PATIENT REGISTRATION FORM

PATIENT INFORMATION: (Please use full legal name, no nicknames)			
Last Name:	First Name:		Middle Initial:
Date of Birth:	Age:	Sex:	Social Security #:
Address:			
City:	State:	Zip:	
Home Phone #:	Cell Phone #:		
E-mail Address:		Driver's License #:	
Was this an injury? ☐ Yes ☐ No	If yes, where did your injury occur? ☐ Work ☐ Auto ☐ Home ☐ School	Date of injury:	
Employer Name:	Occupation/Title/Position:		
Employer Address and Phone #:			
Emergency Contact Name:	Relationship:	Phone #:	

GUARANTOR INFORMATION: (List person or insured name responsible for bill – use full legal name, no nicknames)			
Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other			
Last Name:	First Name:		Middle Initial:
Date of Birth:	Age:	Sex:	Social Security #:
Address:			
City:	State:	Zip:	
Home Phone #:	Cell Phone #:		
Employer Name:	Occupation/Title/Position:		
Employer Address and Phone #:			

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS

PRIMARY INS	Insurance Company:	Copay:	☐ HMO ☐ PPO ☐ POS
	Policy/ID #:	Group #:	
	Claims Address & Phone #:		
	Insured's Name:	Relationship:	Insured's Date of Birth:
	Insured's Employer:	Insured's Social Security #:	
SECONDARY INS	Insurance Company:	Copay:	☐ HMO ☐ PPO ☐ POS
	Policy/ID #:	Group #:	
	Claims Address & Phone #:		
	Insured's Name:	Relationship:	Insured's Date of Birth:
	Insured's Employer:	Insured's Social Security #:	

I hereby assign the insurance benefits to which I am entitled, directly to ORTHOPAEDIC SPECIALTY INSTITUTE, a medical group. I understand that I am financially responsible for all charges regardless of insurance verification, benefits and eligibility. I authorize release of medical records and information regarding medical history that is requested by the insurance company. A photocopy of this authorization is accepted with the same authority as original. **Photo identification and insurance cards must be presented at the time of service to enable OSI to submit claims to your insurance carrier. Should identification and insurance cards not be presented, you will become a cash patient with payment in full due at the time of service.** This agreement will remain valid from this day forward to include all future services relating to the above patient.

SIGNATURE OF PATIENT/GUARDIAN **DATE**

ORTHOPAEDIC SPECIALTY INSTITUTE

Medical Information Release Form (HIPAA Release Form)

Patient Name: ______________________________Date of Birth: ___/___/_____ MR #: ______________

If minor, Parent/Guardian Name: ______________________________

Release of Information

I authorize the release of information including diagnosis, records, examination results, medication dose changes and billing/collection/claims information.
This information may be released to:

[ ] Spouse/Name: _________________________________

[ ] Child(ren)/Name(s): ____________________________

[ ] Other: ____

[ ] Information is not to be released to anyone other than me.

Messages

Please call: [ ] my home phone # ________________ [ ] my cell phone # ________________.
If unable to reach me:

[ ] you may leave a detailed message.
OR
[ ] please leave a message asking me to return your call.

[ ] Do not leave messages on my voicemail.

The best time to reach me is (day of week) ___________________ between (time) _________________.

E-mail Messages/Portal

[ ] Use my e-mail or portal contact to send messages for me to contact the nurse for information.
OR
[ ] Use my e-mail or portal contact to leave detailed messages and information.
[ ] Attach lab results to e-mail/portal message.
My e-mail address is: ____.

This Release of Information will remain in effect until termination by me in writing. This release specifically excludes any psychiatry and psychology evaluations/records which are further restricted by HIPAA regulations.

Signature: ____ Date: ______________________

Witness: ____ Date: ______________________

Acknowledgement of Receipt of Notice of Privacy Practices and Notices to Consumers

Orthopaedic Specialty Institute

I hereby acknowledge that I received a copy of the medical practice's Notice of Privacy Practices as well as Consumers Notices. 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 Practices and/or Consumer updates at each appointment.

NOTICE TO CONSUMERS

PHYSICIAN ASSISTANTS ARE LICENSED AND REGULATED BY

THE PHYSICIAN ASSISTANT COMMITTEE
(916) 561-8780
WWW.PAC.CA.GOV

NOTICE TO CONSUMERS

MEDICAL DOCTORS ARE
LICENSED AND REGULATED BY
THE MEDICAL BOARD OF CALIFORNIA

(800) 633-2322
WWW.MBC.CA.GOV

Signature: ___________________________________ Date: __________________________________

Print Name: _________________________________ Telephone: _____________________________

If not signed by the patient, please indicate
Relationship:

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

Name of Patient: ____

280 S. Main Street · Suite 200 · Orange, CA 92868 · Tel. (714) 634-4567 · Fax (714) 634-4569
16300 Sand Canyon Ave · Suite 511 · Irvine, CA 92618 · Tel. (949) 255-9890 · Fax (949) 255-9776

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CONSENT FOR TREATMENT – NOTICE OF POLICIES

I hereby consent and authorize Orthopaedic Specialty Institute Medical Group of Orange County (OSI) healthcare providers to perform medical care, diagnostic tests, surgical care and other therapeutic measures, as may be indicated for my health and well-being. If I will not comply with the medical program of care provided or recommended, I understand that thereupon I relieve my physician(s), healthcare provider(s), medical staff, and the company, of all responsibility resulting from my action.

I also authorize OSI, all associated physicians and all associated agencies, to gather, maintain and release any and all of my information that might be required for processing of any of all claims for third party payers (including but not exclusive of, private insurance, Medi-Cal, Medicare, Tricare, Work-Comp, etc.)

I acknowledge that I have been given the ability to review OSI's policies including Financial Policy.

FINANCIAL POLICY

- We will submit claims to your insurance company for all medical services rendered at OSI. Any other services related to your medical care not rendered at OSI (i.e. laboratory, pathology, hospital fees, outpatient surgery center fees, anesthesiologist, co-surgeon, etc.), will be billed by the entity providing those services. It is **your** responsibility to verify that OSI is part of your insurance plan. We will attempt to verify your eligibility and benefits with your insurance carrier; however, this does not guarantee that they will pay for the services provided, and you will remain financially responsible if they do not provide payment.

- **OSI accepts the following insurance plans**:

  - **Medicare** – pays 80% after the deductible has been met. We will bill your coinsurance for the remaining 20% as a courtesy; however, you are responsible for the 20% coinsurance of the Medicare allowable amount.
  - **Contracted PPOs and HMOs** – you are responsible for the payment of co-pay and deductible at the time of the service, as well as for any charges for which you failed to secure prior authorization (if necessary).
  - **Non-Contracted PPOs** – you are responsible for all non-covered amounts. We will bill the insurance(s) as a courtesy. You are responsible for the balance in full if not paid by the insurance in 60 (sixty) days.
  - **Self-Pay** (uninsured) - you are expected to pay in full at the time of the service.
  - **Worker's Compensation** – you are not responsible for any charges unless the case has been dismissed or denied.

Initials______

- **Personal Injury/Motor Vehicle Accidents -** you are responsible for all non-covered amounts. We will bill the insurance(s) as a courtesy. You are responsible for the balance in full if not paid by the insurance in 60 (sixty) days.
- **Surgery Deposits** – once the decision for surgery is made, our surgery coordinator will contact your insurance carrier to confirm eligibility benefits and obtain authorization. The surgery coordinator will provide you with an estimated cost of your surgery. This amount will be collected as a deposit at or before the time of your pre-operative appointment.
- **Medical Records** – all medical records requests are subject to a preparation fee. Any additional costs related to shipping and handling will be added to these costs (if applicable).
- **Divorce Related** – the parent authorizing treatment for a child will be the parent responsible for the charges related to that care. If the divorce decree requires the other parent to pay all, or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.
- **Bad Debt** - patients who do not pay bills within 90 (ninety) days of the statement date, will be referred to a collections agency, and ***may be discharged from the practice for non-payment.***
- **Failed Appointment Charge for MRI –** we reserve the right to charge $25 (twenty-five) for each failed appointment not canceled at least 24 hours before the scheduled appointment time. This charge is not covered by your insurance.
- **Usual and Customary Rates -** our practice is committed to the best treatment for our patients. Our charges are considered usual and customary for our area. You are responsible for payment, regardless of any insurance company's arbitrary determination of usual and customary charges.

- **Financial Responsibility** – based on our contractual agreements with the insurance companies and our internal policies, we are informing you of the following:
  - Your health insurance deductibles and any expenses deemed not covered by your insurance company will be your financial responsibility.
  - All monies owed by you, such as office visits co-payments and non-covered services or supplies, are due at the time of the service.
  - If you are not prepared to pay any amounts due at the time of the visit, you will be asked to re-schedule the appointment, unless the physician determines that your medical condition prohibits this.

- **Method of Payment** - our office accepts the following forms of payment: credit cards, cash, money order, and checks. A $25 (twenty-five dollar) service charge will be assessed to your account for any returned check by your bank. This charge is not covered by your insurance.

Thank you for understanding our policies. If you have any questions or concerns, please do not hesitate to contact our office at **(714) 634-4567.**

By signing in the box below indicates that you are acknowledging and are in agreement with all of the above. Further, you understand and agree that your consents/assignments remain in effect until you choose to revoke them in writing.

____

(Signature of Patient or Authorized Representative) (Printed Name) (Date)

____

(If signed Above by Representative, Relationship of Signer to Patient) (Name of Patient if Different from Above)

Initials______