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Advanced Pain Diagnostic & SolutionS

Phone: 888-543-2243 | Fax: 855-864-7246

Medical Registration Form

Patient's Name:_____
(Last) (First) (Middle Initial)

Address:_____
(City) (Zip Code)

SSN#_____-_____-_____ Birth Date:_____ Sex: Male / Female

Phone#: Home: (_____)_____ Cell: (_____)_____

Spouse/Legal Guardian:_____

Address:_____

Contact Phone: (_____)_____

Who referred you: _____ Phone# (_____)_____

Primary Care Doctor_____ Phone# (_____)_____

Address:_____

PRIMARY Insurance:_____ ID#_____ Group#_____

Address:_____ Phone# (____)_____

Insured Name:_____ Birth date:_____

Relationship to Insured:_____ Insured SSN#_____-_____-_____

SECONDARY Insurance:_____ ID#_____ Group#_____

Address:_____ Phone# (____)_____

Insured Name:_____ Birth date:_____

Relationship to Insured:_____ Insured SSN#_____-_____-_____

Consent for Treatment/ Responsibility Statement:

-I consent to be treated by medical providers of Advanced Pain Diagnostic & SolutionS at any of their facilities.
-I consent to have Physical Examinations, Diagnostic Procedures, Surgical and Medical Treatment, Local Anesthesia (if necessary), and/or the Prescription of Medication at APDSS. I understand that **I am financially responsible to APDSS for all charges for services rendered to me, including the balance remaining after insurance reimbursement. I authorize payment of medical benefits for myself to APDSS and authorize the release of any medical information necessary to process this claim. I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on any outstanding balances on my account.** I have read this form or have had it read to me. I agree with and understand what it says.

Patient/Legal Guardian Signature:_____ Date:_____

729 Sunrise Ave. #602
Roseville, CA
95661

1 Scripps Dr. #102
Sacramento, CA
95825

2160 Sunset Blvd. #502
Rocklin, CA
95765

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Assignment and Instruction for Direct Payment to Doctor

Patient Name:_____

Address:_____

City:_____ State:_____ Zip:_____

I hereby instruct the _____ Insurance Company to pay by check made out to and mailed directly to

ADVANCED PAIN DIAGNOSTIC & SOLUTIONS
729 Sunrise Ave. Suite 602
Roseville, CA 95661
(888) 543-2243

for professional and/or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to may case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance.

Patient Signature: _____ Date: _____

**********PLEASE PROVIDE COPIES OF**********
**********ALL INSURANCE POLICIES/CARDS**********

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

TO:_____ FAX: _____

ADDRESS:_____

PATIENT:_____ DATE OF BIRTH:_____

SSN# _____ ID# _____

I _____ REGUEST THE FOLLOWING INFORMATION

☐ Imaging (i.e. MRI, CT, Xray, Ultrasounds) ☐ Records ☐ Diagnosis ☐ Treatment ☐ Report

Concerning my : ☐ Accident ☐ Injury ☐ Other: _____

To be released to :

ADVANCED PAIN DIAGNOSTIC & SOLUTIONS [Fax: 855-864-7246]

☐ 1 Scripps Dr Ste 102, Sacramento CA 95825

☐ 729 Sunrise Ave Ste 602, Roseville CA 95661

☐ 2160 Sunset Blvd Ste 502, Rocklin CA 95765

For the purpose of :_____

According to Section 123.110 of The California Health & Safety Code, these records/films must be provided within 15 days of your receipt of this notice.

Signed: _____ Date:_____

☐ Patient ☐ Spouse ☐ Parent ☐ Guardian

The medical information in this AUTHORIZATION is confidential and protected by both the state and federal law. It is unlawful for unauthorized persons to review, copy, disclose, or disseminate confidential medical information. If the reader of this warning is not the intended recipient of the recipient's agent, you are hereby notified that you have received this AUTHORIZATION in error. Please notify us immediately at 888-543-2243, and either return to us by mail, or destroy. Thank you!

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PERSONAL INJURY INSURANCE

Was this accident (circle one) Auto Slip/Fall Motorcycle Pedestrian

Date of Injury:_____

Auto Insurance:_____ Policy#:_____

Address:_____

Phone#:_____ Claim#:_____

Relationship to Insured (circle): self spouse child other:_____

Adjustor:_____ Phone#: _____

Have you reported the accident to your insurance company? Yes No

Third Party (Other Party)

Car Insurance:_____ Policy#:_____

Adjustor:_____ Phone#:_____

Attorney Information

Name of Firm:_____ Phone#_____

Attorney's Name:_____ Fax#:_____

I hereby authorize _____ to make payment directly to Advanced Pain Diagnostic & SolutionS, 729 Sunrise Avenue Suite 602, Roseville, CA 95661. This is a direct assignment of my rights and benefits under this policy. A photocopy shall be considered as valid as the original.

Signature:_____ Date:_____

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NOTICE OF DOCTOR'S LIEN

Kayvan Haddadan, MD.
Tax ID# 45-4465270

Date:_____

Name:_____ DOB:_____ DOI:_____

Procedure:_____

I do hereby authorize **Kayvan Haddadan, MD** to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was recently involved.
I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for the medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself, as the result of the injury for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

I agree to promptly notify said doctor of any change or addition of attorney(s) used by me in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of this lien to any such substituted attorney(s).

Please acknowledge this letter by signing below and returning to the doctor's office. I have been advised that if my attorney does not wish to cooperate in protecting the doctor interest, the doctor will not await payment and may declare the entire balance due and payable.

_____ _____
Date *Patient's Signature*

The undersigned being attorney of record for the above patient does hereby agree to observe all terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect and fully compensate said doctor above-named. Attorney further agrees that in the event this lien is litigated, that the prevailing party will be awarded attorney fees and costs.

_____ _____ _____
Date *Attorney Name* *Attorney Signature*

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Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of Advanced Pain Diagnostic & SolutionS (APDSS) Notice of Privacy Practices. I also understand that APDSS has the right to change its Notice of Privacy Practices, and that I may contact APDSS at any time to request the most current copy of the Notice of Privacy Practices.

_____ _____

Patient Signature Date

_____

Patient Name Printed

For Office Use Only

The following attempts to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices have been made:

Date: _____ Date: _____ Date: _____

Describe attempt: _____

_____

_____

_____ _____

Staff Name Printed Staff Signature

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Guidelines for Requesting Paperwork Filled Out

ANY paperwork that needs to be filled out **MUST** be completed by your primary care physician.

ANY paperwork that your primary care physician refuses to fill out AND is related to your pain management diagnosis will require a **PAPERWORK ONLY APPOINTMENT**. This means that no medication refills will be prescribed at this time nor any other issues will be discussed at the Paperwork Only Appointment.

ANY paperwork the provider agrees to fill out for you can take up to **seven (7) business days** to be completed and returned to you. This does not include weekends or holidays.

ALL paperwork the provider agrees to fill out is charged at a flat rate of $40 per document regardless of the amount of pages in each document. Insurance does NOT cover this charge.

By signing below I acknowledge that I have read and understand the policies regarding paperwork.

_____ _____

Patient Signature Date

_____

Patient Name Printed

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Pharmacy Policy

Advanced Pain Diagnostic & SolutionS sends all medication electronically to ONE PHARMACY ONLY, of your choosing.

For this reason, if your pharmacy is "out" of the medication(s), you can either:

1) Wait until the pharmacy receives their next stock of medication, or
2) Speak with the pharmacy about forwarding your prescription to a different pharmacy. This is solely based upon the individual pharmacy and their policies.

In either case, our office cannot intervene. Per the "Controlled Substance Agreement", switching your pharmacy can be done once per calendar year, except in the case of a change of address.

Please plan ahead for any trips you may be taking, and make the proper arrangements with your pharmacy before our office sends the electronic prescription. Once a prescription is sent to a pharmacy, we cannot cancel it, and you will have to make arrangements with the pharmacy in order to receive your medication.

APDSS will NOT send prescriptions to multiple pharmacies for ANY reason.

By signing below you indicate that you have read and understand the policy regarding prescriptions sent to pharmacies.

_____ _____

Patient Signature Date

_____

Patient Name Printed

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No Show/Cancellation Policy

We understand that there are times when you must miss an appointment due to an emergency, work obligations, or family emergencies.

However, when you do not call in advance to cancel an appointment, you may be preventing another patient from getting much-needed treatment.

For this reason, APDSS policy states that if you do not cancel your appointment at least 24 hours in advance, not including weekends or holidays, you will be charged the following fee:

- $25 for your first missed appointment
- $50 for a second missed appointment within 6 months
- For any additional missed appointments within a period of 6 months may lead to being discharged from our practice.

These fees are not covered by your insurance company.

By signing below you indicate that you have read and understand the policy regarding missed appointments.

_____ _____

Patient Signature Date

_____

Patient Name Printed

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Controlled Substance Agreement

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe them to you. Please initial every numbered clause to indicate that you have read and agree to the terms and conditions of controlled substances prescribed by medical providers of Advanced Pain Diagnostic & SolutionS, hereafter indicated as APDSS.

The long-term use of substances such as opioids (narcotic pain medicines), benzodiazepine tranquilizers, and barbiturate sedatives is controversial, because it is not certain whether they help chronic pain patients over the long term. Patients who are prescribed these drugs have a risk of developing an addictive disorder or suffering a relapse for a prior addiction. The extent of this risk is not certain. Because these drugs can be abused by the patients who receive them, or by others, it is necessary to observe strict rules when they are prescribed. For this reason we require each patient receiving treatment with these medications to read and agree to the following policies. **Failure to comply with any part of this agreement will result in the immediate termination of your treatment.**

It is agreed by you, the patient, to allow any of the providers working at APDSS to prescribe controlled substances for treatment of your chronic pain at the provider's discretion under the following terms and conditions:

_____ 1. All controlled substance prescriptions must come from a medical provider at APDSS.

_____ 2. I understand that tampering with a written prescription may be prosecuted as a felony, and I will not change or tamper with my provider's written prescription. I am aware that attempting to obtain a controlled substance under false pretense is is illegal.

_____ 3. I understand that any medical treatment is initially a trial, and that continued prescription is based on whether my provider believes that the medication is beneficial to me.

_____ 4. I understand that these drugs should not be stopped abruptly, as withdrawal symptoms will likely develop.

_____ 5. I will obtain all controlled substances from the same pharmacy. I can change my pharmacy once per calendar year, except in the case of a change of address. The pharmacy I am selecting is:

Name, address AND phone number: _____

_____ 6. If the responsible legal authorities have questions concerning my treatment, for example as may occur if I obtain medication at several pharmacies or obtain similar medication from an unauthorized physician, all confidentiality is waived, and these authorities may be given full access to my complete medical records on file with APDSS.

_____ 7. I agree that my provider has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide my healthcare for purposes of maintaining accountability.

_____ 8. I will inform the APDSS medical provider of any current or past substance abuse by me, or any current or past substance abuse by any member of my immediate family or person residing in my household.

_____ 9. I will inform APDSS staff of any new medications or medical conditions, and of any adverse effects I experience from any of the medications that I take.

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_____ 10. I understand that these drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, and I must keep them out of reach of such people for their own safety.

_____ 11. I will not use any illegal substances, including but not limited to marijuana, cocaine, amphetamines, etc. Presence of illegal substances on my drug test will lead to immediate termination of my treatment.

_____ 12. I agree to cooperate with unannounced urine or serum toxicology screens. I understand that tampering with these tests in any way will lead to immediate termination of treatment.

_____ 13. I will take my medication as prescribed and I will not exceed the maximum prescribed dose. If I exceed my prescribed dose, I understand that this will lead to my being without medication until it is time for my scheduled refill. I understand that I will be unable to make an emergency appointment if the schedule is booked.

_____ 14. I will keep my scheduled appointments in order to receive medication renewals. No refills will be given at night or on weekends. Prescription refills are given by appointment early. No walk-ins will be seen.

_____ 15. I understand that a prescription may be given early if the physician or the patient will be out of town when the refill is due. These prescriptions will contain instructions to the pharmacist that the prescriptions may not be filled prior to the appropriate date. This is up to the sole discretion of the provider.

_____ 16. I will not allow anyone else to share, have, use, buy, sell, or otherwise have access to my medications. I will safeguard my pain medication from loss or theft, and I understand that lost or damaged medication will not be replaced. If If my medication is stolen, I will be required to provide an official police report. At that time a determination will be made as to whether I may receive an early refill. If I request an early refill due to stolen prescriptions twice within a period of 12 months, it may lead to the termination of my treatment.

_____ 17. I understand my bahavior at APDSS must be appropriate at all times, conforming to the standard social norms for public places. Any improper behavior towards other patients, APDSS providers, or APDSS staff will result in the immediate termination of my treatment.

I affirm that I have full right and power to sign and be bound by this agreement, and I have read, understand, and accept all of its terms. I understand that failure to comply with any part of this contract can lead to the immediate termination of my treatment.

_____ _____

Patient Name Printed Patient Signature

_____ _____

Physician Printed Name Physician Signature

_____

Date

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Opioid Agreement

Dr. Kayvan Haddadan and/or his associate is prescribing opioid medicine, sometimes called narcotic analgesics, to me for a diagnosis of

_____.

This decision was made because my condition is serious and/or other treatments have not helped my pain.

I am aware that the use of such medicine has certain risks associated with it, including but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reactions, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, development of tolerance to analgesia, addiction, and a possibility that the medicine will not provide complete pain relief.

I will tell my doctor about all other medicines and treatments that I am receiving. I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include but are not limited to: operating heavy equipment or a motor vehicle, working at unprotected heights or being responsible for another individual who is unable to care for himself or herself.

I am aware that certain other medicine such as nalbuphine (Nubain*), pentazocine (Talwin*), buprenorphine (Buprenex*), and butorphanol (Stadol*), may reverse the action of the medicine I am using for pain control. Taking any of these other medicines while I am taking my pain medicines can cause symptoms like a bad flu, called withdrawal syndrome. I agree not to take any of these medicines and to tell any other doctors that I am taking an opioid as my pain medicine and cannot take any of the medications listed above.

I am aware that addiction is defined as the use of the medicine even if it causes harm, having cravings for a drug, feeling the need to use a drug, and a decreased quality-of-life. I am aware that the chance of becoming addicted to my pain medicine is very low, I am aware that the development of addiction has been reported rarely in medical journals and is much more common for a person who has a family history or personal history of addiction. I agree to tell my doctor my complete and honest personal drug history and family history to the best of my knowledge.

I understand that physical dependence is a normal, expected result of using these medicines for an extended time. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine use is markedly decreased, stopped, or reversed by medication listed previously, I will experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, ache throughout my body and flu-like feelings. I am aware that opiate withdrawal is uncomfortable, but not life-threatening.

I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain; however, it has been seen and may occur to me. If it occurs, increasing doses may not always help and may cause unacceptable side effects. A failure to respond well to opioids may cause my doctor to choose

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another form of treatment.

(Males only) I am aware that chronic opiate use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

(Females only) If I plan to become pregnant or believe that I have become pregnant while taking the pain medicine, I will immediately call my obstetric doctor's office to inform them. I am aware that should I carry a baby to delivery while taking these medications, the baby will be physically dependent upon opioids. I am aware that the use of opiates is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there's always the possibility that my child will have a birth defect while I'm taking an opioid.

I have read this form or have had it read to me. I understand all of it. I have had a chance to have all my questions regarding this treatment answered to my satisfaction. The risks and potential benefits of these therapies have been explained to me, including but not limited to psychological addiction, physical dependence, withdrawal, and overdose. By signing this form voluntarily, I give my consent for treatment of my pain with opioid pain medicines.

DO NOT SIGN UNTIL YOU ARE IN THE PRESENCE OF THE PROVIDER YOU ARE SEEING.

_____ _____

Patient Name Printed Patient Signature

_____ _____

Physician Printed Name Physician Signature

_____

Date