James T. Lin, MD

Comprehensive Pain Management Center

Title: Mr. Mrs. Miss Dr.

Patient Name:_____ DOB:____-_____-_____ SEX: F M

Street Address:_____ Suite/Apartment #:_____

City:_____ State: _____ Zip Code:_____

Home Phone: (____)_____-_____ Cell Phone: (____)_____-_____

Driver License#_____ Issued State:_____

Social Security #: _____-_____-_____ Email: _____@_____.com

Background Information

Marital Status: Single Married Divorced Widowed Separated Live-In

Preferred Language:_____ Race: _____

Ethnic Background: _____ Religion:_____

Pharmacy Details

Preferred Pharmacy:_____ Pharmacy Phone #: (____)_____-_____

Physician and Referral details

Primary Physician:_____ Primary Physician Phone #: (_____)_____--_____

Referral Physician/Source:_____

Employer Details

Employer Name: _____ Employment Status:_____

Occupation:_____ Work Phone#: (_____)_____-_____

Employer Adress:_____

Primary Insurance

Insurance Name:_____ Subscriber ID# :_____

*Please provide Copy of Insurance Card, Front and Back.

Secondary Insurance

Insurance Name:_____ Subscriber ID#:_____

*Please provide Copy of Insurance Card, Front and Back.

Emergency Contact Details

Name:_____
Relation:_____

Address:_____ Phone #: (____)_____-
_____

Spouse / Parent / Guardian Details

Name:_____ Relation:_____

Address:_____

SSN:_____ DOB_____ Phone #: (____)_____-_____

COMPREHENSIVE PAIN MANAGEMENT CENTER

James Lin, M.D.
Pain Management
Anesthesiology
558 St. Charles Dr. Suite 110
Thousand Oaks, CA 91360
805 557-7050 OFFICE
805 557-4992 FAX

Financial Agreement

1. PAYMENT is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. We do ask for a copy of an ID card of license due to the many cases of identity theft in the news lately. (Please do not be offended!)

2. INSURANCE We are out-of-network providers. We will file all of these insurance claims. A list of these insurance plans is available upon request. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment for your insurer, we will refund any overpayment to you.

If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with you insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejects for the lack of one.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

Patients who insist on "day of" urgent/emergent scheduling or care after hours or on days the clinic is closed will be assessed an additional urgent care or after hours fee. These fees will be billed to your insurance carrier or collected as part of the office charges for self-pay patients.

3. LATE CHARGES of 12% annually will be applied to all patient balances 90 days old or greater.

4. RETURNED CHECKS will incur a $35.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $35 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments

constitute a breach of payment and are subject to the $35 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted in Ventura County.

5. ACCOUNTING PRINCIPALS Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

6. FORMS FEES: completing insurance forms, copying medical records, etc... Requires office staff time and time away from patient care for our doctors. We require pre-payment for completing forms, copying medical records, notarizing, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. Base form charges are $35.00 per occurrence plus and applicable postage or notary fees. Postage is additional and payment is required in advance. For copying fees for Medical Records, please ask for our office fee schedule. Comprehensive Pain Institute will have 15 business days in which to copy records before making them available for patient to pick up, and these 15 days will commence after payment for copying has been received and after patient has signed this form authorizing records' release.

7. BILLING OFFICE: If you have questions in regard to any of your billing statements, our billing department is available to assist you. Please CALL 805-557-7050 ext 119.

8. CANCELLATIONS OR MISSED APPOINTMENTS: If you do not cancel your appointment at least 24 hours before, or if you no-show, we will assess you a $50 missed appointment fee.

9. RESPONSIBILITY FOR PAYMENT: I understand that I, personally, am financially responsible to James Lin, MD/Comprehensive Pain Institute for charges not covered by the assignment of insurance benefits.

10. ASSIGNMENT OF INSURANCE BEBEFITS: I hereby assign, transfer, and set over directly to James Lin, MD/Comprehensive Pain Institute sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic. I authorize James Lin, MD/Comprehensive Pain Institute to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to James Lin MD/Comprehensive Pain Institute. I authorize James Lin, MD/Comprehensive Pain Institute to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

11. CHANGING INSURANCE: I am responsible to notify Dr. Lin/Comprehensive Pain Institute immediately if I change my insurance carrier, policy or status of coverage. I understand that failure to notify Dr. Lin/CPI will result in incorrect billing in eligibility. This means that I am responsible for all balance of the services that incurred during this time.

12. RELEASE OF INFORMATION: I hereby authorize the and direct James Lin, MD/Comprehensive Pain Institute, to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to

substantiate claim and payment.

14. COLLECTION FEES: I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.

15. DIVORCED PARENTS of PATIENTS: By signing below, the adult who signs a minor child into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

I have read and understand the practice's financial policy and I agree to be bound by its terms.

I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____

Signature of Patient
(or Guarantor, if applicable)

Date

_____

Please Print the Name of the Patient

Comprehensive Pain Institute
Office (805) 557-7050 Fax (805) 557-4992
558 St. Charles Dr. Suite 110
Thousand Oaks, CA 91360

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

- o I would like to receive a copy of any amended Notice of Practices by email at: _____.

_____ _____
Signature of Patient Date

_____ (_____)_____
Print Name Telephone Number

If not signed by the patient, please indicate relationship:

- o Parent or guardian of minor patient
- o Guardian or conservator of an incompetent patient

Name and Address of Patient:_____

_____

_____

PAIN MEDICATION TREATMENT AGREEMENT
JAMES T. LIN, M.D.
558 St. Charles Dr. Suite 110
Thousand Oaks, CA 91360

This Document is an agreement between _____, patient, and James Lin, M.D., Physician. Patient agrees to the policies as listed below to manage chronic pain. Patient acknowledges the fact of habituation on the opioid medication as a direct consequence of its use. Because of the controlled nature of these medications, strict accountability is required. The following policies are necessary for continued treatment:

1. Regular monthly visits for patient with scheduled II medication must be made to assess response and observe for complications.

2. **ALL** pain medications will be prescribed by **ONE** physician, which in this case, Dr. James Lin.

3. **ALL** pain medication prescriptions will be filled at **ONE** pharmacy. Patient Chooses _____ _____ (Please include address and phone number)

4. Physician has complete liberty to discuss treatment details with the pharmacist at the dispensing pharmacy, and may ask the pharmacy for information about other medications, which have been prescribe for the patient.

5. Random urine drug screens may be requested at any time.

6. Prescribed medication will be closely guarded. Please note these medications could be hazardous or lethal to another person, who is not tolerant to their effect. Patient will take as much care with medications, and written prescription, as they would their driver license or credit cards.

7. Medications **WILL NOT** be replaced if they are lost, fall into the toilet, are eaten by pets, left on airplane or car, pr for any other reason. If your medications are stolen, and you complete a police report regarding the theft, **ONE** exception may be made.

8. Early refills will not be given. If patient uses a months supply of medications within three weeks, the last week will be without medications.

9. All confidentiality of prescription and medication records is waived if there is any request from legal authorities for information concerning inappropriate or unlawful use of controlled substances.

Failure to adhere to these policies will result in permanent cessation of pain medication prescribed by Dr. James Lin. Patient understanding that he/she will not take medications or substances (prescription or recreational), which have not been disclosed to physician.

James Lin, M.D.
Physician Signature Date

_____
Patient Signature Date

Current Medication List:

Pharmacy:_____
Pharmacy #:_____

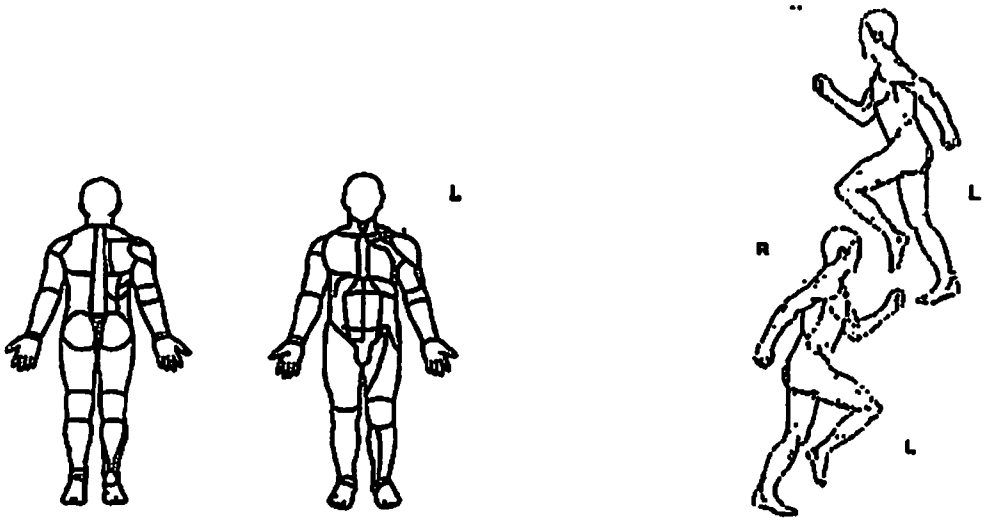
- **Please note all medications prescribed to you at the Comprehensive Pain Institute have to be filled at the same pharmacy.**

Medication:	Dose:	Direction:

Name:_____ Date:_____

What is the major reason you are coming to see the doctor (chief complaint)?: _____

Mark an "X" on the figure below where your pain start and show where it goes with an arrow.



When did the pain start? _____

What were you doing when the pain first started? _____

Does the pain occur at certain times?

- ☐ No
- ☐ Yes, please explain: _____

Describe you pain:

☐ Throbbing	☐ Heavy	☐ Gnawing
☐ Shooting	☐ Sickening	☐ Burning
☐ Stabbing	☐ Fearful	☐ Aching
☐ Sharp	☐ Punishing Cruel	☐ Tender
☐ Cramping	☐ Splitting	☐ Exhausting

Describe your pain at its worst (0 to 10, 10 being the worst): _____
Describe your pain at its best: (0 to 10, 10 being the worst) _____
Describe your average pain: (0 to 10, 10 being the worst) _____

What makes your pain worse?

☐	Bending	☐	Sexual Intercourse	☐	Coughing
☐	Lifting	☐	Standing a long time	☐	Sneezing
☐	Defecation	☐	Sitting a long time	☐	Other_____

What makes your pain better?

☐	Ice	☐	Activity	☐	Bending backwards
☐	Heat	☐	Bending forward	☐	Medications
☐	Sitting	☐	Fetal Position	☐	Other_____

Are there any other symptoms/ problems associated with your pain?

☐	Difficulty Sleeping	☐	Depression
☐	Difficulty with Intercourse	☐	Other(s) _____

Treatment History

Which of the following types of caregivers have you visited?

☐	Sports Medicine	☐	Neurology
☐	Orthopedics	☐	Spine Surgeon
☐	Rehabilitation Medicine	☐	Chiropractor

Which of the following have you taken prior to your visit here today?

☐	Tylenol (acetaminophen)	☐	Opioids	☐	Lyrica
☐	Anti-inflammatory agents	☐	Steroids	☐	Amitriptyline (Elavil)
☐	Muscle relaxers	☐	Neurontin	☐	Other _____

Have you had any of the following interventions done for your pain?

☐	TENS unit	☐	Nerve Blocks	☐	Radiofrequency
☐	Cryotherapy	☐	Trigger Point Injs	☐	Sacroiliac Joint Inj
☐	Ultrasound	☐	Facet injections	☐	Other_____
☐	Diskography	☐	Epidural steroid injs		

Have you ever had any of the following surgical interventions done for your pain?

☐	Disectomy	☐	Fusion	☐	Spinal Cord Stimulator
☐	Laminectomy	☐	Pain Pump	☐	Kyphoplasty
☐	Other_____				

Have you undergone any of the following for your pain?

☐	Bed Rest	☐	Physical Therapy	☐	Medications
☐	Lumbar Traction	☐	Biofeedback	☐	Prolotherapy
☐	Exercises	☐	Acupuncture	☐	Couseling
☐	Manipulations	☐	Loss of Work	☐	Other_____

James T. Lin, M.D.
Comprehensive Pain Management Center

Past Medical History

Drug Allergies and Reactions:

_____

List all medications:

_____

_____

List all medical problems:

_____

_____

List all surgeries and date of service:

_____

_____

Social History

Any use of tobacco?(Type and for how long): _____

Any use of alcohol?(Tyoe and for how long): _____

Any use of recreational drugs?(Type and for how long): _____

Family History

Please list all pertinent information regarding each family members health:

_____

_____

Comprehensive Pain Institute (CPI)

James Lin, MD
Linda Yu, PA

Patient Name:_____ Date_____

A. How much does your chronic pain limit your abilities to perform these activities?

	Not at all	Mildly	Moderately	Severely
Physical Activities-Lower Body				
Walking				
Climbing stairs				
Bending				
Physical Activities-Upper Body				
Carrying groceries				
Reaching above				
Turning your head				
Personal/Household Care				
Bathing or dressing				
Getting in/out of bed				
Performing housework				
Work				
Concentrating at work				
Working with hands				
Performing tasks at work				
Social Activities				
Visiting family/friends				
Getting out of house				
Pursuing hobbies/recreation				

- **Review of Systems (√ if abnormal)**

-Constitutional: ▢fever ▢weight ▢fatigue
-Eye Problems: ▢blurred vision ▢loss of vision ▢eye pain ▢eye dryness ▢other_____
-Ear/Nose/Throat: ▢loss of balance ▢ringing in ears ▢dizziness ▢trouble hearing ▢other
-Cardiac: ▢chest pain ▢irreg heart beat ▢high blood pressure ▢limb swelling ▢other_____
-Resp: ▢trouble breathing ▢chronic cough ▢coughing blood ▢other_____
-GI: ▢nausea ▢heart burn ▢abdominal pain ▢vomiting ▢constipation ▢diarrhea ▢other_____
-Musculo: ▢muscle pain ▢joint pain ▢back pain ▢neck pain ▢muscle cramp ▢joint swelling ▢loss of muscle bulk ▢other_____
-Neurologic: ▢headache ▢tremors ▢seizures ▢weakness ▢trouble concentrating ▢other_____
-Endocrine: ▢heat/cold intolerance ▢excessive urination ▢excessive thirst ▢other_____
-Psychiatric: ▢feeling depressed ▢trouble sleeping ▢hallucinations ▢inappropriate crying
-Allergic/Immunologic: ▢skin rash ▢joint pain ▢dry eyes ▢other_____
-Hematologic: ▢abnormal bleeding ▢anemia ▢lumps/swelling ▢other_____

- Average Pain Level with Medications_____Without Medications_____
- Has you pain level changed in the last month?

___Improved ___Same ___Worse ___Gone