ORTHOPEDIC PAIN MANAGEMENT CENTER
INJURY INSTITUTE
You are not alone in managing pain

PATIENT REGISTRATION FORM

Date of injury: ____ / ____ / ____

Last Name, FirstName: _____

*Date of Birth:*____ / ____ / _____

*Address:*_____

*City:*_____ *State:* _____ *Zip Code:* _____

Home Phone: ( ) _____ *Cell:* ( ) _____

Work: ( ) _____ *Email:*_____

Emergency contact: _____ *Phone:* _____

Your Attorney Information:

*Attorney Name:*_____

*Address:*_____

*City:*_____ *State:* _____ *Zip Code:* _____

Phone: _____ *Fax:* _____

ORTHOPEDIC PAIN MANAGEMENT CENTER
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Tel: (818) 290-5949
Fax: (888) 885-5414

Patient's name: _____

Date of injury: ____ / ____ / ____ *Date of birth: ____ / ____ / _____*

Attorney:_____

Phone: ( ) _____ *Fax: ( ) _____*

Notice of Doctor's Lien

I do hereby authorize Dr. Pejman Eli Shirazy to furnish you, my attorney, with a full report of his/her examination, diagnosis, treatment, prognosis, etc, of myself in regards to the accident in which I was involved on the above mentioned date.

I hereby authorize and direct you my attorney, to pay directly to said doctor such sums as may be due and owning him/her for medical service rendered me both by reason of this accident and by reason for any other bills that are due his/her office and to withhold such sums for any settlement judgment, or verdict as may be necessary to adequately protect said doctor. And I herby farther 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, attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney, hereby instruct that in the event that another attorney is submitted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it was executed by him/her.

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

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's interest, the doctor will not await payment but may declare the entire balance due and payable.

Date: ____ / ____ / ____ *Patient Signature:_____*

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

Date: ____ / ____ / ____ *Attorney's Signature:_____*

Please date, sign and return one copy to doctor's office. Also keep one copy for your records

MULTI-SPECIALTY HEALTHCARE GROUP

16952 Ventura Blvd.
Encino, CA 91316

Tel: (818) 290-5949
Fax: (888) 885-5414

Attorney:_____

Phone Number: ( ) _____ Fax Number: ( ) _____

Patient's name:_____ Phone: ( )_____

Date of injury: ____ / ____ / ____ Date of birth: ____ / ____ / ____

I, the above named patient authorize and directs his/ her attorney or insurance, the above pharmacy, Multi-Specialty Healthcare Group, to furnish you, my attorney, with full Pharmacy service, dispensing, etc., of mys elf in regard to the accident in which I was recently involved.

I, the patient hereby authorize and direct his/ her attorney or insurance company to pay directly to Multi - Specialty Healthcare Group such sums as may be due and owing for Multi - Specialty Healthcare Group services rendered me both by reason of this accident and by reason of any other judgment or bills that are due to and to withold such sums from any settlement, judgement or verdict as maybe necessary to said adequately protect and fully compensate said Pharmacy. And I hereby further give a lien on my case to Multi - Specialty Healthcare Group against any and all proceeds of my settlement, judgment or verdict which may be paid to you by my attorney or myself in connection as the result of the injuries for which I have been treated of' injuries in connection there with.

This agreement is in no way relieves patient of his/ her responsibility to compensate Multi - Specialty Healthcare Group for all Pharmacy service bills submitted by said Pharmacy for services rendered to patient. Patient understands and acknowledge she/he is directly and fully responsible to Multi - Specialty Healthcare Group for any account balance, which is not contingent on the results of any third party claim Multi - Specialty Healthcare Group reserves the right to require regular payments on patient's account until his/ her third party claim is resolved.

Patient directs his/ her attorney to promptly pay the full amount due to Multi - Specialty Healthcare Group up on resolution of his/ her claim with any third party. Payment shall be rendered without regard to set off unresolved claims against other third parties or pro-rated distribution to other health care providers.

Patient agrees to promptly notify of any change or addition of attorney (s) used by patient in connection with this accident, and patient instructs their attorney to do the same aand promptly deliver a copy of this lien to any such substituted or added attorney(s).

I, the patient, have been advised that if my attorney does not wish to cooperate in protecting the Pharmacy's interest, the Pharmacy will not await payment but may declare the entire balance due and payable.
I have read and fully understand this. Multi - Specialty Healthcare Group Lien and agree to be bounded by its terms.

Patient's signature:_____ Date: ____ / ____ / _____

Attorney's signature:_____ Date: ____/____/_____

Attorney agrees to observe all the terms and conditions of this Health Care Lien and withhold from any third party, without deduction of the attorney's fees, an amount necessary to pay the outstanding account balance to Multi-Specialty Healthcare Group. Attorney agrees to promptly notify Multi-Specialty Healthcare Group in the event legal representation is terminated Attorney agrees to promptly provide a copy of his Health Care Lien to any additional or subsequent attorney's. Attorney farther agrees that in the event this lien is litigate that the prevailing party will be awarded attorney fees and costs

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AUTHORIZATION TO RELEASE INSURANCE INFORMATION

I,_____hereby give permission to Orthopedic Pain Management Injury Institute to obtain the insurance information (Insurance Carrier, Claim Number, Adjuster, and Phone Number) of the responsible party regarding my injury claim that happened on_____This information is to be given as additional consideration in conjunction with the medical lien to provided services on a lien basis. This information is not to be used to negotiate outstanding liens directly with the responsible party but merely as reference to provide additional protection to the medical lien outstanding.

Signature:_____ Date:_____

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DECLARATION UNDER PENALTY OF PERJURY

I, the undersigned hereby acknowledge that I have, in fact, been involved in the accident that took place on or about _____ and that as a result of such accident, I sustained bodily injuries.

I know, understand and acknowledge California Code Section 556.1, which states the following:

It is unlawful to

(a) Knowingly present or cause to be presented any false or fraudulent claim for the payment of a loss under a contract of insurance.
(b) Knowingly file multiple claims for the same loss or injury with more than one insurer with the intent to defraud the insurer.
(c) Knowingly prepare, make or subscribe any writing, with intent to present or use the same or allow it to be presented or used in support of any such claim.
(d) Every person who violates any provision of this section is punishable by imprisonment in the state prison for two, three or four years or by fine not exceeding ten thousand dollars ($10,000) or both.

I declare under penalty of perjury that the above is true and correct to the best of my knowledge.

Print Name	Signature	Date

Witness Name	Signature	Date

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16952 Ventura Blvd Encino, CA 91316
Ph: 818-290-5949 Fax: 888-885-5414
Encino – Los Angeles – Rancho Cucamonga

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's name: _____

DOB: ____ / ____ / _____

OFFICE USE ONLY:

I request and authorize _____ to release health information from the health care provider:

Name of facility: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Information requested:

- ☐ All general medical information
- ☐ X-ray
- ☐ Films
- ☐ Reports
- ☐ Other: _____

Patient signature: _____ Date: ____ / ____/ ____

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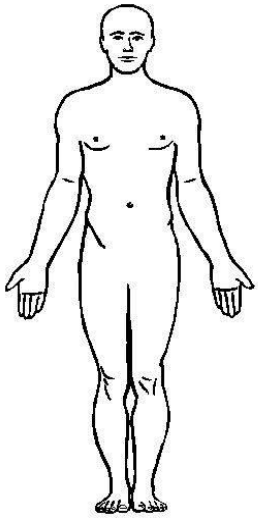
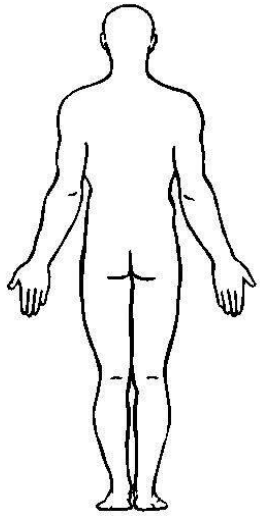
NAME:_____ Date: ____ / ____ / ____



Front



Back

Please indicate the areas where you are having pain

Please mark the areas of impact to your vehicle

DUTIES UNDER DURESS INDEX

Name: _____

Work Duties:

1. At the time of injury were you currently employed?
   - ☐ Yes
   - ☐ No (If no skip down to domestic duties)

2. Since your injury have you continued working?
   - ☐ Yes
   - ☐ No (If no skip down to domestic duties)

3. Why have you continued to work?
   - ☐ I would lose my job if took time off
   - ☐ I couldn't support my family otherwise
   - ☐ I don't believe in taking time off even when I am injured or in pain
   - ☐ My business would fall if I did not work
   - ☐ I cannot take time off, because I care for my own children

4. Have you experienced any of the following changes in your ability to perform at work?
   a. Mobility/Stability Problems
      - ☐ Climbing
      - ☐ Lifting
      - ☐ Walking for long periods
      - ☐ Kneeling

   b. Dexterity Problems
      - ☐ Finger Movements
      - ☐ Wrist Movements

   c. Problems with fatigue
      - ☐ Fatigue

   d. Postural Difficulties
      - ☐ Bending
      - ☐ Stooping
      - ☐ Sitting for long periods of time
      - ☐ Standing for long periods of time

   e. Problems with Vertigo or Spinning Movements

   - ☐ Dizziness
   - ☐ Giddiness
   - ☐ Sensation of Irregular Motion
   - ☐ Sensation of Whirling Motion

   f. Problems with Anxiety/Depression
      - ☐ Anxiety
      - ☐ Depression

g. Problems with Tinnitus or Ringing in the Ears

- ☐ Tinnitus
- ☐ Ringing in the Ears

h. Problems with reduced concentration

- ☐ Making Mistakes
- ☐ Can't concentrate
- ☐ Can't think properly

i. Pain

- ☐ Yes, what areas?

_____

Domestic Duties

1. Have you experienced any pain while performing any of the following activities inside your home?

- ☐ Laundry
- ☐ Vacuuming
- ☐ Cleaning
- ☐ Dishwashing
- ☐ Washing Windows
- ☐ Preparing Meals

Household Duties

1. Which, if any, of the following activities have you experienced pain while performing outside your home?

- ☐ Painting the outside of the house
- ☐ Mowing the Grass
- ☐ Gardening
- ☐ Washing the cars
- ☐ Maintain Yard equipment
- ☐ Doing other External Housework; Specify: ___
- ☐ Landscaping
- ☐ Trimming the bushes/ trees
- ☐ Taking the trash
- ☐ Maintaining the cars

Studies/Educational Duties

1. Were you currently involved in any educational program at the time of injury?
   - ☐ Yes
   - ☐ No (If no·, you have completed this survey)

2. At the time of injury, how would you best describe your educational status?
   - ☐ High School
   - ☐ Technical College
   - ☐ Correspondence Course
   - ☐ Apprenticeship studies
   - ☐ University

3. As a student have you experienced any problems with any of the following activities since the injury:

- ☐ Looking down to read textbooks
- ☐ Sitting in classes
- ☐ Carrying Books
- ☐ Other:_____

4. Have you experienced any of the following changes in your ability to perform at school since the injury?

a. Mobility/Stability Problems

- ☐ Climbing
- ☐ Walking for long periods
- ☐ Lifting
- ☐ Kneeling

b. Dexterity Problems

- ☐ Finger Movements
- ☐ Wrist Movement

c. Problems with fatigue

- ☐ Fatigue

d. Postural Difficulties

- ☐ Stooping
- ☐ Bending
- ☐ Sitting for Long Periods
- ☐ Standing for Long Periods

e. Problems with Anxiety/Depression

- ☐ Anxiety
- ☐ Depression

g. Problems with Vertigo or Spinning Movements

- ☐ Dizziness
- ☐ Sensation of irregular motion
- ☐ Giddiness
- ☐ Sensation of Whirling Motion

g. Problems with Tinnitus or Ringing in the Ears

- ☐ Tinnitus
- ☐ Ringing in the Ears

h. Problems with reduced concentration

- ☐ Making Mistakes
- ☐ Can't concentrate
- ☐ Can't think properly

i. Pain

- ☐ Yes, what areas?_____

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The Rivermead Post-Concussion Symptoms Questionnaire

NAME: _____ Date: _____

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer from any of the symptoms given below. As many of these symptoms occur normally, we would like you to *compare yourself now with before the accident.* For each one, please circle the number closest to your answer.

O=Not experienced at all

1=No more of a problem

2= A mild problem

3= A moderate problem

4= A severe problem

Compared with before the accident, do you now (i.e., over the last week) suffer from:

Headaches	0	1	2	3	4
Feelings of Dizziness	0	1	2	3	4
Nausea and/or Vomiting	0	1	2	3	4
Noise Sensitivity, or easily upset by loud noise	0	1	2	3	4
Sleep Disturbance	0	1	2	3	4
Fatigue, tiring more easily	0	1	2	3	4
Being Irritable, easily angered	0	1	2	3	4
Feeling Depressed or Tearful	0	1	2	3	4
Feeling Frustrated or Impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor Concentration	0	1	2	3	4
Taking Longer to Think	0	1	2	3	4
Blurred Vision	0	1	2	3	4
Light Sensitivity, or Easily upset by bright light	0	1	2	3	4
Double Vision	0	1	2	3	4
Restlessness	0	1	2	3	4

Are you experiencing any other difficulties? Some other symptoms of Post Concussion Syndrome include the following: Reading problems, writing problems (the wrong letter first), typing problems, inability to remember ATM or other numbers, attention impalement, personality changes, intolerance to heat, intolerance to cold, intolerance to alcohol, and loss of your drive/libido. Please specify any of these additional problems you experience, and rate as above:

1. _____	0	1	2	3	4
2. _____	0	1	2	3	4
3. _____	0	1	2	3	4
4. _____	0	1	2	3	4

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PATIENT NOTIFICATION

PATIENT RIGHTS:

- The patient has the right to be informed of his/her rights in advance of receiving care. The patient may appoint a representative to receive this information should he/she so desire.
- Exercise these rights without regard to sex, cultural, **economic, education, religious background or the source of** payment for care.
- Considerate, respectful and dignified care, provided in a safe environment, free from all forms of abuse, neglect, harassment and/or exploitation.
- Access protective and advocacy services or have these services accessed on the patient's behalf.
- Appropriate assessment and management of pain.
- Knowledge of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians and healthcare providers who will see them. The patient has a right to change providers if other qualified providers are available.
- Be advised if the physician has a financial interest in the surgery center.
- Receive complete information from his/her physician about his/her illness, course of treatment, alternative treatments, outcomes of care (including unanticipated outcomes), and prospects for recovery in terms that he/she can understand. Receive as much information about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically risks involved in the treatment, alternate courses of treatment or non-treatment and the risks involved in each and the name of the person who will carry out the procedure or treatment.
- Participate in the development and implementation of his/her plan of care and actively participate in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment.
- Be informed of the facility's policy and state regulations regarding advance directives and be provided advance directive forms if requested.
- Full consideration of privacy concerning his/her medical care. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual involved in his/her health care.
- Confidential treatment of all communications and records pertaining to his/her care and his/her stay at the facility. His/her written permission will be obtained before medical that he/she understands. Communications with the patient will be effective and provided in a manner that facilitates understanding by the patient. Written information provided will be appropriate to the age, understanding and, as appropriate, the language of the patient. As appropriate, communications specific to the vision, speech, hearing, cognitive and language-impaired patient will be appropriate to the impairment.
- Access information contained in his/her medical record within a reasonable time frame.
- Be advised of the facility's grievance process, should he/she wish to communicate a concern regarding the quality of the care they received. Notification of the grievance process includes: who to contact to file the grievance and that he/she will be provided with a written notice of the grievance determination that contains the name of the facility's contact person, the results of the grievance and the grievance completion date.
- Be advised of contact information for the state agency to which complaints can be reported, as well as contact information for the Office of the Medicare Beneficiary Ombudsman.
- Be advised if facility/personal physician proposes to engage in or perform human experimentation affecting their care of treatment. The patient has the right to refuse to participate in such research projects. Refusal to participate or discontinuation of participation will not compromise the patient's right to access care, treatment or services.
- Full support and respect of all patient rights should the patient choose to participate in research, investigation and/or clinical trials. This includes the patient's right to a full informed consent process's it relates to the research, investigation and/or clinical trial. All information provided to subjects will be contained in the medical record or research file, along with the consent form(s).

- Be informed by his/her physician or a delegate thereof of the continuing healthcare requirement following his/her discharge from the facility.
- Examine and receive an explanation of his/her bill regardless of source of payment.
- Know which facility rules and policies apply to his/her conduct while a patient.
- Have all patient rights apply to the person who may have legal responsibility to make decisions regarding medical on behalf of the patient.

PATIENT RESPONSIBILITIES:

- The patient has the responsibility to provide accurate and complete information concerning his/her present complaints, past illnesses, hospitalizations, medications (including over-the-counter products and dietary supplements), allergies and sensitivities and other matters relating to his/her health.
- The patient and family are responsible for asking questions when they do not understand what they have been told about the patient's care or what they are expected to do.
- The patient is responsible for following the treatment planestablished by his/her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders.
- The patient is responsible for keeping appointments and for notifying the facility or physician when he/she is unable to do so.
- Provide a responsible adult to transport his/her home from the facility and remain with him/her for 24 hours unless exempted from that requirement by the attending physician.
- The patient is responsible for his/her actions should you refuse treatment or not follow your physician's orders.
- The patient is responsible for assuring that the financial obligations of his/her care are fulfilled as promptly as possible.
- The patient is responsible for following facility policies and procedures.
- The patient is responsible to inform the facility about the patient's advance directives.
- The patient is responsible for being considerate of the rights of other patients and facility personnel.
- The patient is responsible for being respectful of his/her personal property and that of other persons in the facility.

ADVANCE DIRECTIVE NOTIFICATION

- All patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Power of Attorney that authorize others to make decisions on their behalfbased on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. The Surgery Center of Irvine respects and upholds those rights.
- Therefore, it is our policy, regardless of the contents of any Advance Directive or instructions from a health care surrogate or attorney-in-fact, that if an. adverse event occurs during your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatments or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive, or healthcare Power of Attorney. Your agreement with this facility's policy will not revoke or invalidate any current health care directive or health care power of attorney.
- If you wish to complete an Advance Directive, copies of the official state forms are available at our facility.
- If you do not agree with this facility's policy, we will be pleased to assist you in rescheduling your procedure.

PATIENT COMPLAINT OR GRIEVANCE

- If you have a problem/complaint, please speak to the receptionist. We will address your concern(s) promptly.
- If necessary, your problem or complaint will be advanced to the Administrator or a coordinator for resolution.

BY SIGNING THIS DOCUMENT I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ITS CONTENTS

_____ _____

Patient/Patient Representative Signature Date