GUARDIAN HEADACHE & PAIN MANAGEMENT INSTITUTE

ØRRPLQJWRQ
2203 Eastland Dr. Suite #7 Bloomington, IL 61704
Tel: (309) 808-1700 Fax: (309) 585-2951

Newport Beach
361 Hospital Rd, Suite #324, Newport Beach, CA 92663
Phone: 949-548-5119 Fax: 949-548-2074

Eureka
101 S. Major Street Eureka, IL 61530
Tel: (309) 808-1700 Fax: (309) 585-2951
Hospital: (309) 467-2371
www.guardianpaininstitute.com

Dear patient,

Welcome to Guardian Headache & Pain Management Institute. We take pride in practicing the shared responsibility model in providing health care services to our patients. As such we appreciate your understanding that as our new patient we need to gather as much information as possible to better treat and/or manage your pain. This may involve contacting your primary care physician to get a complete medical history, review your prior medical records, and communicate with all prior medical providers. Upon completion of this process and following obtaining proper medical history, a complete physical examination, and necessary laboratory tests, a proper medical or interventional pain management plan will be fashioned to meet your exact medical condition. Following discussing all of the above with you or your parent/guardian, this treatment plan may be implemented.

If your insurance carrier requires you to have a preauthorization or a referral, this is needed before your appointment.

*If you are scheduled for a procedure, or think you might have a procedure, please refrain from eating or drinking anything for **6 hours** prior to your appointment. If you are currently taking any anti-coagulant (blood thinner) medication, this needs to be stopped **7 days** before a procedure (examples include: Aspirin, Coumadin, Plavix). Also, another responsible adult must accompany you for safe transportation home. **Please inform the staff before a procedure if you have not done any of the above mentioned.**

Once again, welcome to Guardian Headache & Pain Management Institute, we look forward to meeting you and providing you with excellent care! If you have any questions, please contact our office.

Sincerely,

Dr. Taimoorazy and the staff at Guardian Institute

Please complete this check list and bring to your first appointment:

- ✓ Completed New Patient Information forms (enclosed)
- ✓ Driver's license or other photo identification
- ✓ Insurance card or Workman's Compensation/Claim information
- ✓ Medical records and imaging results (eg. MRI, CT, X-Ray)
- ✓ List of current medications

NEW PATIENT INFORMATION SHEET

Please print clearly. Please complete all information so that your claim can be processed efficiently. Thank you!

PATIENT INFORMATION

Name: ______________________________ Social Security #: ______________
First MI Last

Date of Birth ______________ Sex: Male / Female Marital Status: S M W D

Address: ______________________________
Street City State Zip Code

Cell Ph: ______________ Home Ph: ______________ Other (specifiy): ______________

Employer: ______________________________ Work Ph: ______________

Employer's Address: ______________________________

If Student, School Name: ______________________________ Full / Part Time? ______________

WORKER'S COMP/ACCIDENT INFORMATION

Insurance Name: ______________________________

Address: ______________________________ Phone #: ______________

Adjuster's Name: ______________________________ Adjuster Phone #: ______________

Date of Injury or Accident: ______________ Claim #: ______________

Type of Injury: ☐Back ☐Leg ☐Hip ☐Neck ☐Shoulder ☐Arm ☐Head ☐Other: ______________

Place of work during time of accident: ______________________________

In Litigation: ☐Yes ☐No Amount of Medical Benefits: ______________ Notice of Compensation Payable: ☐Yes ☐No

INSURANCE INFORMATION

Insurance Co. ______________________ Phone #: ______________________

Insurance Address: ______________________

Identification #: ______________________ Group #: ______________________

Insured's Name: ______________________ Relationship to Patient: Self / Spouse / Dependent

Insured's Employer: ______________________ Phone #: ______________________

Employer's Address: ______________________

Insured's Social Security #: ______________ Date of Birth: ______________ Sex: Male / Female

If the patient is covered by another insurance policy, please complete the following information for coordination of benefits. This information will enable your insurance company to process your claim more quickly. Thank you!

INSURANCE INFORMATION

Insurance Co. ______________________ Phone #: ______________________

Insurance Address: ______________________

Identification #: ______________________ Group #: ______________________

Insured's Name: ______________________ Relationship to Patient: Self / Spouse / Dependent

Insured's Employer: ______________________ Phone #: ______________________

Employer's Address: ______________________

Insured's Social Security #: ______________ Date of Birth: ______________ Sex: Male / Female

I hereby assign, transfer, and set over to Guardian Headache & Pain Management Institute all my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that I am financially responsible for all medical services rendered by G.H.P.M.I. LLC., whether or not they are covered by insurance. If I fail to pay my charges, I agree to pay the cost of collection, including reasonable attorney fees.

Patient's Signature ______________________ Date ______________

GUARDIAN HEADACHE & PAIN MANAGEMENT INSTITUTE

Benjamin Taimoorazy, M.D. FAHS DABPM DAAPM

DATE: ___________________________ REFERRING PHYSICIAN: ___________________________

NAME:__________________________________ FAMILY DOCTOR: ___________________________

DOB: ___________________________

PLEASE COMPLETE THESE FORMS PRIOR TO YOUR APPOINTMENT AND BRING THEM WITH YOU TO THE DAYS OF YOUR SCHEDULED APPOINTMENT. If you are unable to fill them out yourself, please have your family doctor give you a list of your medical history and current medication. You will need to arrive at our clinic 30 min prior to your appointment so we can assist you with this form.

- ***What is your chief complaint?*** (example: 30% low back pain and 70% right leg pain)

____

____

- ***When did it start?*** (example: 2 months ago, or July 2003, etc)

____

____

- ***Did you sustain any trauma immediately prior to the onset?*** YES NO
- ***Is this work related or motor vehicle accident related?*** YES NO
- ***Do you have an attorney?*** (Please provide their contact information) YES NO

____

____

- ***Please describe the trauma.***

____

____

____

- ***Is this pain there constantly, intermittently, or both?*** (example: constant back pain with intermittent left leg pain)

____

____

- ***Please describe the characteristics of your pain*** (sharp vs. dull, burning, squeezing, throbbing, tingling, etc.)

____

____

- ***What makes the pain worse?*** (Please circle)

Sitting Standing Walking Lying flat Lifting Bending over Others_____________________________

____

____

- ***What makes the pain better?*** (Please circle)

Sitting Standing Walking Lying flat Lifting Change Positions Other___________________________

Taking medications (please list____)

- ***What have you tried?***

	Dosage?	How long?	Helpful?	Reason stopped
Ibuprofen (Advil, Motrin)				
Acetominophen (Tylenol)				
Aspirin				
Naproxen (Aleve, Naprosyn)				
Diclofenac (Voltaren)				
Etodolac (Lodine)				
Ketorolac (Toradol)				
Nabumetone (Relafen)				
Meloxicam (Mobic)				
Celecoxib (celebrex)				
Carisoprodol (Soma)				
Cyclobenzaprine (Flexeril, Amrix)				
Diazepam (Valium)				
Metaxalone (Skelaxin)				
Methocarbamol (Robaxin)				
Tizanidine (Zanaflex)				
Gabapentin (Neurontin)				
Pregabalin (Lyrica)				
Topiramate (Topamax)				
Amitriptyline (Elavil)				
Duloxetine (Cymbalta)				
Venlafaxine (Effexor)				
Nortriptyline (Pamelor)				
Hydrocodone/APAP (Vicodin, Lortab, Norco)				
Oxycodone/APAP (Percocet, Endocet, Tylox, Roxicet)				
Methadone				
Morphine				
Fentanyl patch				
Oxycontin				
Lidoderm Patches				
Flector Patches				
Voltaren Gel				
Other medications				

	How long?	Helpful?	Reason stopped
Chiropractors			
Massage therapy			
Physical therapy / Aquatic therapy			
Tens Unit			
Heat Compress			
Cold compress			
Acupuncture therapy			
Psychotherapy / Biofeedback			
Behavior modification therapy			

- ***Images*** (X-Ray, CT Scan, Bone Scan, etc.)

Study	Date	Where

- ***Spine Injections***

	Doctor	Date	Helpful?	How long did it last?
Epidural steroid inj				
Facet injections				
Radiofrequency ablations				
SI joint injections				

- ***Spine surgery***

	Doctor	Date	Helpful?	How long did it last?

- ***Current Medications*** Please list all, including vitamins and OTC meds *May substitute this section with a copy of your current medications list

Medication	Why prescribed	Dosage

- **Are you allergic to any medications?** (Please list and describe reaction)

Medication	Reaction

IV contrast allergy? YES NO

Shellfish allergy? YES NO

- ***Past Medical History*** (Please circle all that apply)

AIDS / HIV   Alcoholism   Asthma   Cancer   Diabetes   Emphysema   Epilepsy   Heart Disease
Hepatitis   Herpes   High Blood Pressure   Multiple Sclerosis   Pacemaker   Seizures   Stroke
Thyroid Disorders   Tuberculosis   Fibromyalgia   Depression   Bipolar Disorder   Schizophrenia
Anxiety Disorder   Other Psychiatric Issues   Irritable Bowel Syndrome   Chronic Pelvic Pain   Migraine
Other:________________________________

- ***Past Surgical History***

Surgery	**Year**

- ***Family History*** (Please list all significant family medical history such as bleeding problems (hemophilia), psychiatric disorders, chronic pain, or any substance abuse)

____
____
____
____
____

- ***Social history***

Who do you live with now?____

Do you have children? _______ How many? ____ How is their health? ______________________________

Are you currently working? ______ If not, why not/did you stop?_________________________________

What do/did you do for a living?____

Do you smoke? ______ If yes, how much? _________(per day on average)

Do you drink? ______ If yes, how much? _________(per day on average)

Do/did you use any illicit drugs? ____What kind and how much?___________________________________

Have you ever gone through rehab for drug or alcohol abuse?   YES   NO

Are you currently pregnant or plan to become pregnant?   YES   NO

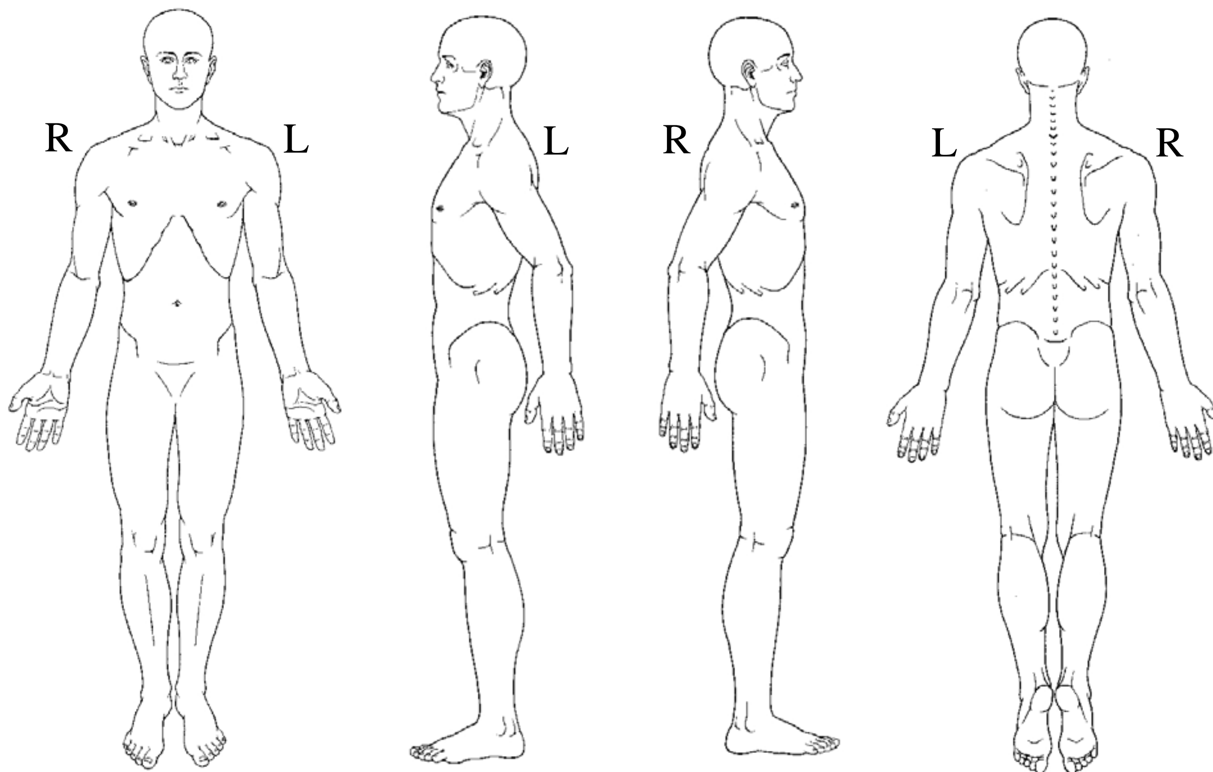
Have you ever been discharged from a doctor's office because of noncompliance not following their directions?

- ***Review of system***

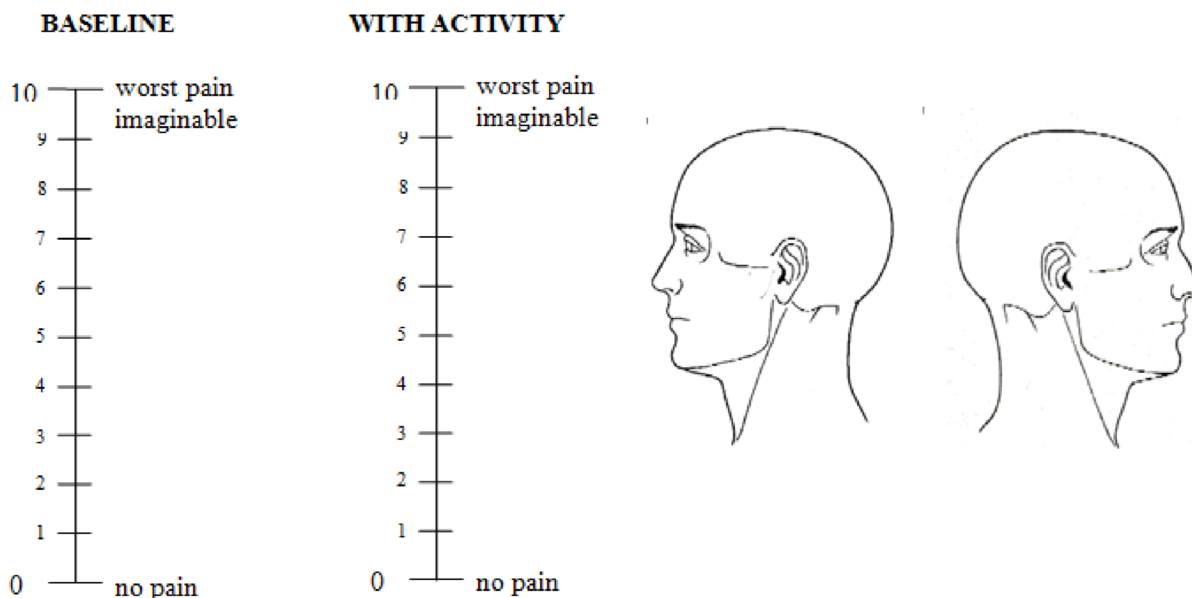
In the past month, have you experience any significant (Please circle)

Weight loss/gain   Fever/chills   Changes in hearing/vision   Dizziness   Pass out   Shortness of breath
Productive cough   Chest pain   Abdominal pain   Diarrhea/constipation   Weakness in the extremities
Lost control of bowel/urinary functions   Bleeding problems   Rashes   Depression   Suicidal thoughts
Homicidal thoughts   Others ________________________

- ***Please shade in on the drawings the areas where you feel pain.***



Please rate the severity of your pain (mark "baseline" and "with activity")



- ***Who has treated you since the onset of the chief complaint?***

____

____

Patient's Signature ____ Date ____________

Financial Responsibilities

I. The Guardian Headache & Pain Management Institute is committed to providing the treatment for your patients, and we charge what is usual and customary for our area.

II. Payment for services (insurance co-payment, or full payment) is required at the time of your visit. Your insurance requires that we collect your designated co-pay at the time of service. Please be prepared to pay the co-pay at each visit. Without it, you may be required to reschedule. If the services you receive are not covered by your plan, payment in full is required. Cash, personal checks, money order, credit and debit cards are accepted.

III. All self-pay patients and patients who present without proof of insurance are required to pay the full cost of the visit with check, cash, money order, credit or debit card at the time of service. Payment does not include any procedures that may take place. Please ask for a copy of our fees if applicable.

IV. If you have health insurance, including Medicare and/or Medicaid, we will file for reimbursement for the services provided. Your insurance policy is a contract between you and you insurance company. You are responsible for knowing and understanding what services are and are not covered under your policy. If your insurance carrier denies any or all of the payment, for any reason, you will be responsible for the denied amount of the visit. You are required to notify staff immediately when your insurance coverage changes.

V. **Accident/Workers Comp Cases:** Patient shall be financially responsible for medical services related to accident/workers comp if you fail to notify the Guardian Headache & Pain Management Institute in advance of an accidents/workers comp injury. You will need to supply us with a date of injury, claim number, insurance company address, phone number and a contact person's name prior to coming to the office and sign a separate Financial Agreement with your workers comp adjuster or a Letter of Protection with your attorney, if applicable. If they do not pay, due to any circumstances not related to your case and/or accident, the patient is responsible for payment.

VI. **Returned Check Fees:** Any returned check from the bank for non-payment or insufficient funds shall result in the patient's account being assessed a $35.00 fee per check returned.

VII. **No Show Fees:** Patient will be assessed a $20.00 fee for an office visit or $50.00 for a procedure missed without prior cancellation. Fees will be assessed directly and are not submitted to patient's insurance. Fees will not be waived for any reason. Appointments must be cancelled via phone at least 30 minutes prior to the scheduled appointment time, and 24 hours if cancelled via email or fax.

Should you fail to comply with the above stated responsibilities, The Guardian headache & Pain Management Institute reserves the right to reschedule your visit, refer you to another practice, or dismiss you from our practice.

Patient Signature ____ Date ________________________

Patient Parent/Guardian/Representative Signature (if applicable) ____

Patient Date of Birth (MM-DD-YY) ______________________

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Rights Regarding Your Medical Information

You have the following rights with respect to your medical information:

- You may ask us to restrict certain uses and disclosures of your medical information. We are not required by law, in certain circumstance, to agree to your request, but if we are required, we will obey all state and federal laws.
- You have the right to receive communication from us in a confidential manner.
- Generally, you may inspect and copy your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records.
- You may ask us to amend your medical information. We may deny your request for certain specific reasons. If we deny your request, we will provide you with a written explanation for the denial and information regarding further rights you may have at that point.
- You have the right to receive an accounting of the disclosures of your medical information made by the Guardian Headache & Pain Management Institute during the last three years, except for disclosures for treatment, payment, or healthcare operations, disclosures which you authorized, and certain other specific disclosure types.
- A paper copy of this Notice of Privacy Practices for Protected Health Information is included in the New Patient Information packet, or you may request one if you do not receive this information or have misplaced it.
- You have the right to complain to us and/or to the United States Department of Health and Human Services if you believe that we have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way.

THIS NOTICE IS EFFECTIVE AS OF January 31, 2011
We reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised Notice of Privacy Practice at The Guardian Headache & Pain Management Institute and will make paper copies of the revised Notice available upon request.

THE GUARDIAN HEADACHE & PAIN MANAGEMENT INSTITUTE NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I hereby acknowledge that I have received and had an opportunity to ask questions concerning Notice of Privacy Practices for The Guardian Headache & Pain Management Institute.

Patient Signature ____ Date ______________________

Patient Parent/Guardian/Representative Signature (if applicable) ____

Patient Date of Birth (MM-DD-YY) ______________________

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Medication Policy

The following policies are to ensure your safety, and our continued ability to treat you in the most effective way possible. Please read this carefully. **These policies will be enforced. You will be asked to sign a contract stating that you promise to follow these terms.**

1. Medication must be taken only as prescribed by our physicians and you must not take medication given to you by another person or physician.
2. Medication is prescribed to increase your function so that you can work, participate in physical therapy, exercise programs, and weight loss programs. If you activity level does not improve with medication, alternative methods of pain management may be substituted for medication.
3. Any medication that is lost, misplaced, stolen, destroyed, or finished early **will not be replaced for any reason.**
4. If you are unable to tolerate any medication, you must return the unused portion of the medication (in the appropriate amount) to our office before you are given a different prescription.
5. You must not share, sell, or otherwise permit others to have access to these medications.
6. All prescriptions should be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed.
7. The prescribing physician and staff have permission to discuss diagnostic and treatment details with dispensing pharmacists or other professionals who provide you healthcare for the purpose of medication accountability.
8. Refills will be given only during regular office hours.
9. Prescription refills and/or written scripts must be called in at least **3 business days** ahead for pick-up.
10. We require that each time you refill your medication, that you see the physician to ensure the best possible healthcare management.
11. CLASS II medications need to be filled by the pharmacy within 5 days of being written. If your prescription expires you must return the prescription to our office before another prescription will be issued to you.
12. You must keep your scheduled appointments in a timely manner. If you fail to appear for an appointment your medication may not be refilled. If you fail to appear for more than two appointments without prior notification, you could be dismissed from our clinic.
13. You must provide us with 24 hours notice to cancel an appointment. If you fail to provide this notice, you will be considered as a failure to appear and may be subject to the consequences listed in #11 above.
14. Random urine and drug screen may be requested. Presence of unauthorized substances or abnormal results may result in discontinuation of your controlled medications including, but not limited to, opioid analgesics.
15. You must sign a contract indicating that you acknowledge and understand the Medication Policy of The Guardian Headache & Pain Management Institute.

Your healthcare team at the Guardian Headache & Pain Management Institute is dedicated to your safety and good health. This policy is designed to ensure your safety and to help us and you comply with the standards of good medical care practices, as well as state and federal laws.

Patient Signature ______________________________ Date ______________

Patient Parent/Guardian/Representative Signature (if applicable) ______________________________

Patient Date of Birth (MM-DD-YY) ______________

PATIENT RIGHTS AND RESPONSIBILITIES CONFIDENTIALITY

Please retain the following documents for your own records

It is the policy of Guardian Headache & Pain Management Institute to treat all information confidentially. This includes patient records and conversations. We will investigate any reported violation of this policy. If you have any questions, please ask any front desk representative for information. The Guardian Headache & Pain Management Institute makes every effort to provide our patients with an environment that is safe, private, and respectful of our patients' needs. If you have a complaint about our services, facilities, or staff, we want to hear from you. We will do everything that we can to see that your experience with us is a professional one in every way.

ISSUES OF CARE

The Guardian Headache & Pain Management Institute is committed to include your participation in the decisions regarding your care. As a patient, you have the right to ask questions and receive answers regarding the course of clinical care recommended by any of our health providers, including discontinuing care. We urge you to follow the healthcare decisions given to you by our providers. However, if you have any doubts or concerns, or if you question the care prescribed by our providers, please do not hesitate to consult with our staff.

PATIENT RIGHTS

The patient has the right to receive information from health providers and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their health providers as to the optimal course of action. Patients are also entitled to obtain copies or summaries of their medical records, to have their questions answered, to be advised of potential conflicts of interest that their health providers might have, and to receive independent professional opinions.

The patient has the right to make decisions regarding their health care that is recommended by his or her provider. Accordingly, patients may accept or refuse any recommended medical treatment.

The patient has the right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs regardless of race, religion, ethnic or national origin, gender, age, sexual orientation, or disability.

The patient has the right to confidentiality. The healthcare provider should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.

The patient has the right to continuity of healthcare. The health provider has an obligation to cooperate in the coordination of medically indicated care with other health providers treating the patient. The health provider may discontinue care provided they give the patient reasonable assistance, direction and sufficient opportunity to make alternative arrangements.

PATIENT RESPONSIBILITIES

1. Good communication is essential to a successful healthcare provider/patient relationship. To the fullest extent possible, patients have the responsibility to be truthful and to express their concerns clearly to the healthcare provider.

2. Patients have the responsibility to provide a complete medical history to the fullest extent possible, including information about past illnesses, medications, hospitalizations, family history of illness, and other matters relating to their present health.

3. Patients have the responsibility to request information or clarification about their health status or treatment when they do not fully understand what has been described by their healthcare provider.

4. Once patients and health providers agree upon goals for therapy, patients have a responsibility to cooperate with the treatment plan. Compliance with health provider instructions is often essential to public and individual safety. Patients also have a responsibility to disclose whether previously agreed upon treatments are being followed and to indicate when they would like to reconsider the treatment plan.

5. Patients should also have an active interest in the effects of their conduct on others and refrain from behavior that unreasonably places the health of others at risk.

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Notice of Privacy Practices

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

The Guardian Headache & Pain Management Institute is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this notice of our legal duties and privacy practices with respect to protected health information. The Guardian Headache & Pain Management Institute is required by law to abide by the terms of this notice.

HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED:

We will use your medical information as part of rendering patient care. For example, your medical information may be used by the doctor or nurse treating you, by the business office to process your payment for the services rendered, and by administrative personnel reviewing the quality of the care you receive

We may also use and/or disclose your information in accordance with federal and state laws for the following purposes:

Appointment Reminders
We may contact you to provide appointment reminders

Treatment Information
We may contact you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Disclosure to the Department of Health and Human Services
We may disclose medical information when required by the United States Department of Health and Human Services as part of an investigation or determination of our compliance with relevant laws.

Family and Friends
Unless you object, when we have been given your consent, we may disclose your medical information to family members, other relatives, or close personal friends, when the medical information is directly relevant to the person's involvement with your care.

Notification
Unless you object, when we have been given your consent, we may use, or disclose your medical information to notify a family member, a personal representative, or another person responsible for your care, of your location, general condition, or death.

Health Disparities Collaborative
We may use or disclose your medical information for public health activities, including the reporting of disease, injury, vital events, and the conducting of public health surveillance, investigation, and/or intervention.

Health Oversight Activities
We may disclose your medical information to a health oversight agency for oversight activities authorized by law, including audits, investigations, licensure, inspections, or disciplinary actions, administrative, and/or legal proceedings.

Abuse or Neglect
We may disclose you medical information when it concerns abuse, neglects, or violence to you, in accordance with federal and state law.

Legal Proceedings
We may disclose your medical information in the course of certain judicial or administrative proceedings

Law Enforcements
We may disclose you medical information for law enforcement purposes or other specialized governmental functions.

Research
We may disclose your medical information for certain research purposes if and Institutional Review Board or a Privacy Board has altered or waived individual authorization, the review is preparatory to research, or the research is on only decedent's information.

Public Safety
We may use or disclose your medical information to prevent or lessen a serious threat to the health or safety of another person or to the public.

Workers Compensation
We may disclose your medical information as authorized by laws relating to workers compensation or similar programs

Business Associates
We may disclose your health information to a business associate with whom we contract to provide services on our behalf. To protect your health information, we require our business associates to appropriately safeguard the health information of our patients.

AUTHORIZATIONS:

We will not use or disclose your medical information for any other purpose without you written authorization. Once given, you may revoke your authorization in writing at any time. To request a Revocation of Authorization form, you may contact our office at any time.