Dr. Anuj Gupta, MD
2023 W. Vista Way Suite D Vista, CA
92083619-330-8771 (P) / 619-330-8772 (F)
Email: drgupta@sdpainmanagement.com
www.sdpainmangement.com

PATIENT REGISTRATION FORM

Date:_____ EMAIL ADDRESS:_____

Name:_____ _____ _____
Last First Middle Initial

Address:_____

City:_____ State:_____ Zip:_____

Home: ( )_____ Cell Phone: ( )_____

Birth Date: _____ Age:_____ Sex :☐Male ☐Female Ethnicity: _____

Marital Status: :☐ Single☐ Married ☐ Widowed☐ Separated Divorced Race: _____

Patient SS# _____-_____-_____ Occupation:_____

Employer _____ Work Phone: _____

Employer Address _____ City: _____ State:____ Zip:_____

INSURANCE INFORMATION
Primary Insurance Company: _____ Subscriber _____ DOB:_____

ID Number _____ Group Number _____

Secondary Insurance Company _____ Subscriber _____ DOB:_____

ID Number _____ Group Number _____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Emergency Contact Information
Name:_____ Relationship:_____

Home Phone:_____ Work Phone: _____

I hereby assign and authorize payment directly to the physician named above of all benefits due to me under Medicare, Medicaid, or any insurance policy providing benefits for services rendered by physician.

_____ _____ _____
Patient Signature Date Guardian Signature

ADVANCED PAIN MANAGEMENT 2023 W. VISTA WAY, SUITE D, VISTA, CA 92083

PLEASE CHECK ALL THAT APPLY TO THE BODY PART IN QUESTION

MUSCULOSKELETAL

	Yes	No
Arthritis		
Back Problems		
Muscle Cramps		
Restricted Motion		
Joint Pain		
Deformities		
Muscle Stiffness		
Weakness		
Gout		
Joint Stiffness		
Paralysis (loss or impairment to move body part)		

EYES

	Yes	No
Blurry Vision		
Double Vision		
Eyeglass Use		
Pain with Light		
Unusaual Sensations		
Cataracts		
Excessive Tearing		
Glaucoma		
Recent Injury		
Vision Loss		
Discharge		
Eye Pain		
Infections		
Redness		

NOSE

	Yes	No
Discharge		
Infections		
Sinus Infections		
Frequent Colds		
Nasal Obstruction		
Hay Fever		
Nosebleeds		

MOUTH

	Yes	No
Bleeding Gums		
Postnasal Drip		
Change in Dentition		
Tongue Burning		
Hoarseness		
Voice Change		

PSYCHIATRIC

	Yes	No
Depression		
Disturbing Thoughts		
Memory Loss		
Psychiatric Disorders		
Behavioral Change		
Excessive Stress		
Mood Changes		
Diorientation		
Hallucinations		
Nervousness		

RESPITORY

	Yes	No
Asthma		
Bronchitis		
Pleurisy		
Short of Breath		
Cough		
Coughing Blood		
Positive TB Test		
Sputum		
Wheezing		
Pain		
Recent Chest X-Ray		
Tuberculosis		

EARS

	Yes	No
Discharge		
Hearing Impairment		
Ringing in Ears		
Dizziness		
Infections		
Hearing Aid		
Pain		

HEAD

	Yes	No
Dizziness		
Headaches		
Fainting		
Pain		
Head Injury		
Sweats		

THROAT NECK

	Yes	No
Frequent Sore Throats		
Tonsils Enlarged		
Lumps		
Tenderness		

PLEASE RETURN FORM WHEN COMPLETED

ADVANCED PAIN MANAGEMENT 2023 W. VISTA WAY, SUITE D, VISTA, CA 92083

QUESTIONAIRE

1. Where on your body is the pain complaint located?

2. Where does your pain radiate?

3. How would you describe the quality of your pain complaint?

	Yes	No		Yes	No		Yes	No
Aching			Stabbing			Cold		
Numbing			Shooting			Pins/Needles		
Burning			Hot			Nagging		

	Yes	No		Yes	No
Heavy			Dull		
Sharp			Gnawing		
Tingling			Excruciating		

Questions 4 - 8 is based on a scale of 1 thru 10 1 being low 10 being high please circle the number that applies to the question being asked.

4. How would you grade the severity of your pain complaint today?

1 2 3 4 5 6 7 8 9 10

5. What was the average pain intensity over the last week?

1 2 3 4 5 6 7 8 9 10

6. What was the worst pain severity in the last month?

1 2 3 4 5 6 7 8 9 10

7. What was the least pain severity over the last month?

1 2 3 4 5 6 7 8 9 10

8. How long ago did your pain complaint first begin?

	Yes	No		Yes	No
Days			10-20 years		
Weeks			>20 years		
Months					

Years

9. How would you describe the onset of your pain complaint?

	Yes	No
Sudden		
Gradual		

10. Is your pain complaint constant or intermittent (comes and goes)?

	Yes	No
Intermittent		
Constant		

11. If your pain complaint comes and goes what best describes when you notice the symptoms more?

	Yes	No		Yes	No
in the morning			after intercourse		
in the evening			after exercise		
after meals			after lifting		
before meals					

12. What makes your pain worse?

13. What makes your pain better?

14. Do any of the following symptoms also occur with your pain complaint?

	Yes	No
Numbness		
Tingling		
Paresthesia		
Weakness		

Paresthesia Definition
(abnormal or inappropriate sensation in an organ, part, or area of the skin, as of burning, prickling, tingling, etc.

15. Have you tried any over-the-counter medications to treat your pain complaint?

Yes	No

If yes what is name or type of medication?

16. Which treaments have you tried for your pain complaint?

	Yes	No		Yes	No		Yes	No
Opioids			Physical Therapy			Psychiatric		

Muscle Relaxants		Chiropractic Care		Acupuncture	
anticonvulsants		TENS unit		Acupressure	
antidepressants		Topical creams		Injections	
NSRI		Psychologic			

17. What was the result?

18. Have you had any recent radiologic exam(s) related to your pain complaint? Examples of some radiologic exmas include plain x-rays, CAT scans, MRIs, ultrasound, bone scans or mammograms.

Yes	No

If yes what is name or type of radiologic test?

	Yes	No
Plain x-ray		
CAT scan		
MRI		
ultrasound		
bone scan		

20. What best describes your recent sleep habits?

	Yes	No
Regular		
Normal		
Poor		
Worse than normal		

19. Has the pain complaint caused you not be able to perform your daily activities? including work and or homemaking.

Yes	No

20. Do you take any blood thinning medications like Coumadin, ASA or Plavix?

Yes	No

21. Do you have pain anywhere else in your body?

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Past Medical History

Major events, hospitalizations, surgeries:

Allergies (free text): Drug or food

Ongoing Medical Problems: Present health

Family Medical History: Cancer or disease

Preventative Care: Rehabilitation

Social History: Do you smoke or drink alcohol?

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FINANCIAL AGREEMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF RECORD

I hereby assign to authorize payment directly to the physician named above of all benefits due to me under Medicare, Medicaid, or any insurance policy providing benefits for services rendered by physician.

A photo static copy of this agreement shall be considered effective and valid as original.

I irrevocably agree that the physician may disclose, to the extend allowed by law, my medical and financial record to (a) any affiliate of the physician including employees, agents, and entities under contract with same to provide quality and/or utilization review; (b) any person or entity which may be liable under contract or by law to physician or to me, or any person or entity responsible for all or part of the physician's charges, specifically including any insurance company or their agents or employees; (c) any person or entity to whom I have been referred for continuing care; (d) any physician treating, consulting or otherwise performing services for me, including his or her employees and agents; (e) the Centers for Medicare and Medicaid Services, and other governmental or accrediting agency, or their agents or employees.

The above named physician will use and disclose your personal health information to treat you, to receive payment for the care we provide, and other health care operations. Health care operations generally include those activities we perform to improve the quality of care. The undersigned acknowledges receipt of this release.

_____ _____

Patient/Responsible Party Signature Date

All charges are due and owing at time of service. In consideration of the services to be rendered, to the extend not expressly prohibited by law or by the contract between the physician and my third party payor. I HEREBY AGREE, WHETHER I AM SIGNING AS PATIENT OR GUARANTOR, TO PAY ALL SUMS DUE TO THE PHYSICIAN AT THE USUALY AND CUSTOMARY CHARGE OF THE PHYSICIAN. I hereby waive all claims of exemption. Should the account be referred to an attorney or collection agency for collection. I shall pay reasonable attorney's fees and collection expenses whether suit is filed or not. Delinquent account and amounts (those not paid within 60 days from the date of service) may bear interest on the unpaid amount up to the maximum amount allowed by law. I understand that I am financially responsible for charges not paid within said 60 days and for charges not covered by this assignment. I understand that the physician files for reimbursement from my insurer or other payor as a courtesy, and failure on the part of the insurer to make payment shall not relieve me of my obligation to pay the physician.

I certify that I am the patient or that I am financially responsible for the services rendered and do hereby unconditionally guarantee the payment of all amounts when and as due.

Physician's employees are NOT able to define your insurance coverage. If you have coverage questions, you are advised to call your insurance carrier.

CAUTION: DO NOT SIGN THIS AGREEMENT UNLESS YOU UNDERSTAND ITS CONTENTS.

_____ _____

Patient/Responsible Party Signature Date

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ACKNOWLEDGEMENTS OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Patient Signature: _____ Date: _____
Print Name: _____ Phone: _____

****If not signed by the patient, please indicate relationship:****

_____ Parent or guardian of minor patient
_____ Guardian or conservator of incompetent patient

GUARDIAN/CONSERVATOR SIGNATURE: _____

DISCLAIMER: This document and the information in it do not constitute legal advice. It is also not a substitute for legal or professional advice. Users should consult their own legal counsel for advice regarding the application of the law and this document as it applies to the HIPAA regulations.

I wish to be contacted in the following manner (check all that apply):

___ Home telephone: _____
___ Cell Phone: _____
___ Work telephone: _____
___ Okay to leave a message on my answering machine/voice-mails with detailed information
___ Leave a message with a call-back number only
___ Okay to give health information to the following family member(s):
_____
___ Other: _____
_____

Patient Signature: _____ Date: _____

Print Name: _____ DOB: _____

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patients Name: _____

Patients Date of Birth: _____

I give _____ permission to provide

_____ Medical Records: Dates _____ and/or _____ MRI-XRAY. Dates: _____

to ADVANCED PAIN MANAGEMENT which is to be used for the preparation, review, investigation, evaluation, and handling of medical care. Further, I herby authorize Advanced Pain Management to discuss my medical records with any and all parties involved in my care and/or case, which includes but is not limited to: Insurance companies, ancillary care providers, attorneys, and investigators. This authorization will expire 12 months from the date of signature below.

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this authorization. Neither treatment, payment, enrollment, or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by the Federal Patient's Privacy Law, commonly referred to as HIPAA. However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law. Client can obtain more information about HIPAA from the U.S Department of Health and Human Services at 200 Independence Avenue. S. W. Washington, D.C 20201. Toll Free: 1-877-696-6775

I have read, agree with, and received a copy of this document. I have the authority to execute this document. My facsimile signature shall have the same force and effect as if it were an original.

_____ _____

Patient/Responsible Party Signature Date

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REFUND POLICY

CASH pay and CO-PAY patients by signing this consent you are acknowledging Dr. Anuj Gupta to evaluate and treat. Patients are paying for an EVALUATION by Dr.Anuj Gupta NOT a PRESCRIPTION by signing this document you are acknowledging the policy and agree to the NO REFUND POLICY.

Returns and Refunds: Federal Law
While state laws primarily govern the issue of returned merchandise, there's no federal law that requires a merchant to refund money. Per most state laws, refunds are subject to the established store refund policy at the time of purchase, unless the product purchased is found to be unfit for the purpose of which it was intended. A customer changing his or her mind after making a purchase, such as deciding they want a bigger television screen is not the fault of the merchant and the merchant cannot be held responsible.

Patient Signature _____ **Date:** _____

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Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and other health/medical plan, to issue payment check(s) directly to Dr. Anuj Gupta medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by my insurance.

Authorization to Release Information

I hereby authorize Dr. Anuj Gupta to: (1) Release any information necessary to insurance carriers regarding my illness and treatments; (2) Process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Dr. Anuj Gupta on behalf of myself and/or my dependants, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of treatment authorized.

I further understand that fees are due payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____

Patient/Responsible Party Signature Date

_____

Witness Signature Date

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NOTICE OF PRIVACY PRACTICES

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

Your health information rights: Although your health record is the physical properly of the healthcare practitioner or the facility that compiled it, the information belongs to you. You have the right to:
-Request a restriction on certain uses and disclosures of your information, however, we are not required to agree to your request for restrictions.
-Inspect and obtain a paper copy of your health records, except in limited circumstances, upon written request. A fee will be charged to copy your records. If you are denied access to your health record for certain reasons, we will tell you why and what your rights are to challenge that denial.
-Amend your health record. Your request must be in writing and state a reason. If we deny your request, we will tell you why and what your rights are to challenge that denial. Even if we accept your request, we will not delete any information already in our records. You have the right to add an addendum (up to 250 words) to your health record.
-Obtain an accounting of disclosure of your health information for purposes other than treatment, payment or health care operations, disclosure to you or authorize by you, incidental disclosures and certain other excluded disclosures. Your request must be in writing.
-Request confidential communications of your health information by alternative means or at alternative locations.
-Revoke authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities
-Maintain the privacy of your health information
-Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
-Abide by the terms of this notice currently in effect
-Notify you if we are unable to agree to a requested restriction
-Accommodate reasonable requests you may have to communicate health information confidentially by alternative means or an alternative locations. Contact your Primary Care Physician to make this request
-Not to use or disclose your health information without your authorization, except as described in this notice

Examples of Disclosure for Treatment, Payment and Health Care Operations
-We will use and disclose your health information.
For example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record. Your physician will document in your record his or her expectations. We may disclose your health information to ancillary or specialty care services that may be requested by your physician for treatment. Those providers will record their care in their records and copy your physician on their observation. In that way, you will be provided treatment and your physician will know how you are responding to treatment.

- We will use and disclose your health information for payment/encounter date.
For example: A bill may be sent to you or a third party payor or HMO. The information on our accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used and your treatment for which payment is requested. We may also disclose your health information to one of your other health care providers to submit requests for payment.

- We will use and disclose your health information for our health care operations.
For example: Members of the medical staff and the risk or quality improvement team of this practice may use information in your health record to assess the care and outcomes in your case.

-We will use and disclose your health information for health care operation of others.
For example: We may disclose your health information to other health care providers or payors for their health care operations only if they already have a relationship with you and the purpose is for quality assurance activities, peer review activities, detecting fraud or other limited purposes.

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Examples:

-*Involvement in your care*: We may disclose information to individuals involved in your care or to individuals who pay or help pay for your care.
-*Abuse, neglect or domestic violence*: We may disclose information for reporting abuse, neglect or domestic violence to a government authority, including a social service or protective services agency as authorized by law.
- *Health oversight activities*: We may disclose health information to a health oversight agency for oversight activities authorized by law.
- *Judicial and administrative proceedings*: We may disclose health information to prevent a serious threat to the health or safety of another.
- *Specialized government functions*: We may disclose health information by command authorities for active military personnel or for veterans.
- *National Security and Intelligence activities*: We may disclose health information for National Securities and Intelligence activities
- *Genetic testing information*: If we keep genetic testing information about you, will release that information only to the State departments that monitor our work or if required by law to release that information. Otherwise, we will only give out that information if given your written authorization to do so.
- *Communicable disease Information*: if you have a communicable disease such as AIDS/HIV, we will provide that information to your health care provider, to providers engaged in organ procurement, or if required by law. For all other purposes we will give our this information only with your written permission.
- *Research*: We may disclose information to researchers when an institutional review board, which has reviewed the research proposal and established protocols to ensure the privacy of your health information, has approved their research.
- *Funeral direction*: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.
-*Patient education*: We may contact you to provide appointment reminders or information about treatment alternative or other health related benefits and services that may be of interest to you.
- *Workers Compensation/Third Party Liability*: We may disclose health information to the extend authorized by and to the extend necessary to comply with laws relating to workers compensation or third party payors or other similar programs established by law.
- *Public Health*: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
- *Correctional institutions*: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof, health information accessory for your health or the health safety of other individuals.
- *Law Enforcement*: We may disclose health information for law enforcement purposes as required by law

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post those changes in our facility.

For more information, to report a problem, or to exercise your rights, you may contact: The Secretary of the Department of Health and Human Services, Office of Civil Rights, San Francisco Office, US Department of Education, Old Federal Building. 50 United Nations, San Francisco, CA 94102.

I acknowledge that I have received this Notice of Privacy Practices

Print Patient Name	Responsible Party Signature	Date