**ADVANCED PAIN SOLUTIONS**
6169 N. Thesta Street
Fresno, CA 93710


**PAUL KY D.O.**
PHONE (559) 435 1757
FAX (559) 435 1768

## PATIENT INTAKE FORM

You have been referred to APS for an evaluation. Our goal is to help you improve your level of function and reduce your level of pain while decreasing medication consumption. We specialize in both the evaluation and management of many types of injury and painful disorders.

In order to develop an effective treatment plan, we need to obtain detailed information about you and your health. Please take time to complete the following questionnaire. Please fill in ALL sections carefully. Please DO NOT leave any section blank. If not applicable, just write "N/A". In addition, we will ask to copy your insurance card(s) and state issued identification.

**DEMOGRAPHICS:**

| | |
|---|---|
| Today's Date: | Your Full Address: |
| Referring physician: | |
| Your Full Name (Print) | Home Phone: |
| Social Security # | Cell Phone: |
| Date of Birth: | Your Age: |
| Hand dominance: Right/Left | Gender: Male/Female |

| What Body Parts are painful: (examples: neck, back, left shoulder, right hip, left ankle and foot, etc.): | | |
|---|---|---|
| A. | B. | C. |
| D. | E. | F. |

| **Quality of pain: Please circle the following term to describe your pain** | | | |
|---|---|---|---|
| Throbbing | Cramping | Heavy | Dull, Annoying |
| Shooting | Gnawing | Tender | Sickening |
| Stabbing | Burning | Splitting | Fearful |
| Sharp | Aching | Tiring, exhausting | Punishing, cruel |

| **Pain Rating: Please rate your pain by circling the appropriate numbers.** | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Various Painful Situations** | **No pain** | **Mild Pain** | | | **Uncomfortable** | | | **Distressing** | | **Intense** | **Excruciating** |
| Current Pain level | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Pain score without medications | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Pain score when taking medications | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Worse pain in the past week | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

| **Associated Symptoms: Please circle ALL terms that apply as a result of the pain** | | | |
|---|---|---|---|
| Numbness | Frequent falls/Poor coordination | Locking of knees | Changes in hair distribution/quality |
| Tingling | Difficulty walking/running | Loss of range of motion | Muscle wasting |
| Weakness of limbs | Difficulty with balance | Differences in limbs temperature | Painful to light/air blowing |
| Loss of sensation in the limbs | Dropping objects frequently | Changes in skin color | Alternate swelling/shrinking |
| Loss of bowel/bladder control | Difficulty swallowing | Changes in tissue texture | Difficulty with activities of daily living |
| Headache | Poor concentration | Visual Changes | Loss of memory |

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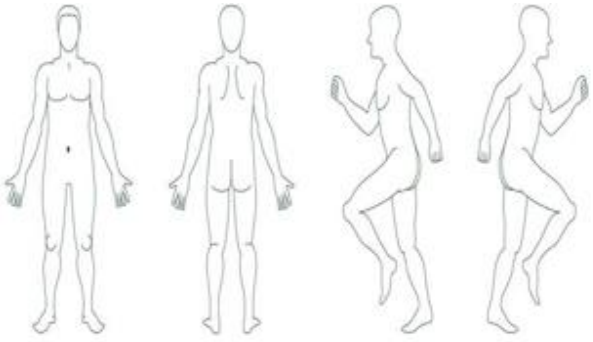
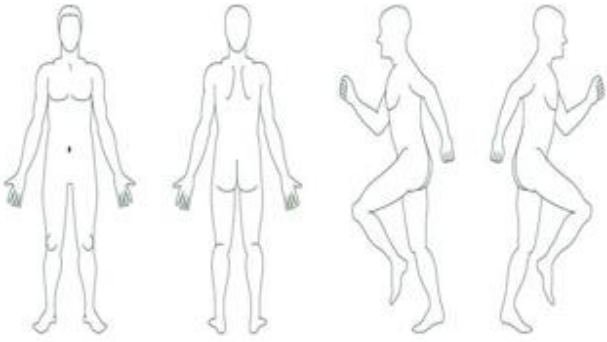
Please shade the areas of your pain (and its **RADIATING** pattern) in the diagrams below:

FRONT BACK LEFT RIGHT



Please shade the areas where there is numbness and tingling in the diagrams below:

FRONT BACK LEFT RIGHT



If you have **BOTH** low back pain, please provide percentage of: _____ (low back) and _____ (leg) component.

If you have **BOTH** neck and arm pain, please provide percentage of: _____ (neck) and _____ (arm) component.

| **AGGRAVATING AND ALLEVIATING FACTORS** | | | | | | | |
|---|---|---|---|---|---|---|---|
| Stimulus/Treatment | Increase | Decrease | No Change | Stimulus/Treatment | Increase | Decrease | No Change |
| Heat | | | | Walking | | | |
| Cold | | | | Pushing shopping cart | | | |
| Physical Activity | | | | Pulling | | | |
| Reaching over head | | | | Twisting | | | |
| Lying down on side | | | | Sneezing/Coughing | | | |
| Lying down on back | | | | Grasping/Gripping | | | |
| Bending/Flexing | | | | Physical Therapy | | | |
| Sexual intercourse | | | | Massage Therapy | | | |
| Sitting | | | | Urination | | | |
| Standing | | | | Bowel Movement | | | |
| Squatting | | | | Tension | | | |
| Others: | | | | Others: | | | |

| **CURRENT MEDICATIONS** | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| NAME | Strengths (mg) | Daily Dosing Schedule | | | | | name | Strengths (mg) | Daily Dosing Schedule | | | | |
| | | 1X | 2X | 3X | 4X | OTHER | | | 1x | 2x | 3x | 4x | OTHER |
| | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
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| **ALLERGIES** | | | | | |
|---|---|---|---|---|---|
| Medication | Reaction | Medication | Reaction | Medication | Reaction |
| | | | | | |
| | | | | | |

| **CURRENT FUNCTIONAL STATUS** | | | | | | | |
|---|---|---|---|---|---|---|---|
| Activities of Daily Living | Requires (>75%) assistance | Requires maximal (51-75%) assistance | Requires minimal (-25%) assistance | Requires supervision/standby assistance only | Requires of assistive device | Completely independent | Other |
| **Self-Care** | | | | | | | |
| -Eating | | | | | | | |
| -Swallowing | | | | | | | |
| -Grooming | | | | | | | |
| -Bathing/Showering | | | | | | | |
| -Dressing upper body | | | | | | | |
| -Dressing lower body | | | | | | | |
| -Toileting | | | | | | | |
| | | | | | | | |
| **Sphincters** | | | | | | | |
| -Bladder Management | | | | | | | |
| -Bowel Management | | | | | | | |
| | | | | | | | |
| **Mobility** | | | | | | | |
| -Transfer: bed/chair/wheel chair | | | | | | | |
| -Transfer: Toilet | | | | | | | |
| -Transfer: bathtub/shower | | | | | | | |
| -Transfer: car | | | | | | | |
| -Locomotion: Stairs | | | | | | | |
| -Community mobility | | | | | | | |

| **YOUR SURGICAL HISTORY** | | | | | |
|---|---|---|---|---|---|
| Surgery | Doctor | Month/year | Surgery | Doctor | Month/Year |
| | | | | | |
| | | | | | |
| | | | | | |

| **PAST MEDICAL HISTORY** | |
|---|---|
| | |
| | |
| | |
| | |
| | |

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| YOUR HISTORY | MEDICAL CONDITION | YOUR FAMILY HISTORY | | | |
|---|---|---|---|---|---|
| | | Mother | Father | Siblings | Grandparents |
| | COPD/Emphysema | | | | |
| | Coronary Artery Disease/Heart Diseases (CAD, MI) | | | | |
| | Deep Vein Thrombosis (DVT)/Pam Embolus | | | | |
| | Depression | | | | |
| | Diabetes | | | | |
| | Drug abuse | | | | |
| | Hypertension | | | | |
| | Kidney Diseases | | | | |
| | Liver Problems | | | | |
| | Neurogenic Bowel/bladder | | | | |
| | Peripheral Vascular Disease | | | | |
| | Psychiatric disorders | | | | |
| | Radiculopathy | | | | |
| | Rheumatoid disease | | | | |
| | Seizures | | | | |
| | Shingles | | | | |
| | Stroke | | | | |
| | TIA (Mini-Strokes) | | | | |
| | Cancer | | | | |
| | Thyroid Disease | | | | |
| | Other: | | | | |

**SOCIAL HISTORY**

| **PENDING LITIGATIONS/LAW SUITS** | | | | | |
|---|---|---|---|---|---|
| Worker's Comp | Employer | Auto Insurance | Medical Providers | SSI/State | Others: |

**HABITS**

| |
|---|
| Please **CIRCLE** all that apply and/or fill in the appropriate blanks. Tobacco<br>Smoking: _____ pack/day for _____ years Last smoked: _____ |
| Alcohol Consumption: Never, occasionally, socially, daily, ( _____ drinks/day), _____(#) drinks per week, alcoholism, Counseling |
| Illicit Drugs Use: Never, Marijuana, Cocaine, Crack, Crank, Ice, Heroin, Opium, Other: _____. Quit since _____ years ago. |

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS QUESTIONAIRE. WE LOOK FORWARD TO WORKING WITH YOU TO IMPROVE YOUR QUALITY OF LIFE!

Dr. Ky and Advanced Pain Solutions Staff

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# ADVANCED PAIN SOLUTIONS- SOAP & POC

| | Never | Rarely | Sometimes | Frequently | Very Frequently |
|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 |
| 1. How often do you become angry or unhappy? | | | | | |
| 2. How often have you felt you need to take a higher dose of medication to relieve your pain? | | | | | |
| 3. How often have you felt irritated with your doctors? | | | | | |
| 4. How often do you feel stressed at home? | | | | | |
| 5. How often do you take inventory of your pain medication to see how many you have left? | | | | | |
| 6. How often do you feel frustrated with everything around you and feel you can't handle it anymore | | | | | |
| 7. How often do you feel that people judge you for taking pain medication? | | | | | |
| 8. How often do you feel bored? | | | | | |
| 9. How often have you exceeded the amount of pain medications you were supposed to take? | | | | | |
| 10. How often do you worry about being left by yourself? | | | | | |
| 11. How often do you feel the urge to take pain medications? | | | | | |
| 12. How often have others told you they are concerned about your use of pain medication? | | | | | |
| 13. How often have others told you that you are very easily irritated? | | | | | |
| 14. How often have any of your close friends had a problem with drugs or alcohol? | | | | | |
| 15. How often have you felt obsessed with the need to take pain medication? | | | | | |
| 16. How often have you finished your pain medication early? | | | | | |
| 17. How often do you feel others get in the way of getting what you deserve? | | | | | |
| 18. How often, in your lifetime, have you been arrested or had trouble with the law? | | | | | |
| 19. How often have you attended an AA or N/A meeting? | | | | | |
| 20. How often have you been involved in an argument that got out of control and someone got hurt? | | | | | |
| 21. How often have you been sexually abused? | | | | | |
| 22. How often have you had to borrow pain medication from relatives or friends? | | | | | |
| 23. How often have others implied you have a drug or alcohol issue? | | | | | |
| 24. How often have you been treated for a drug or alcohol problem? | | | | | |

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## INFORMED CONSENT FOR OPIOID TREATMENT FOR NON-CANCER/CANCER PAIN

The purpose of this agreement is to give you information about the medications you will be taking for pain management and to assure that you and your physician/health care provider comply with all state and federal regulations concerning the prescribing of controlled substances. A trial of opioid therapy can be considered for moderate to severe pain with the intent of improving your quality of life by reducing pain and increasing function. The physician's goal is for you to have the best quality of life possible given the reality of your clinical condition. The source of treatment depends on mutual trust and honesty in the physician/patient relationship and full agreement and understanding of the risks and benefits of using opioids. I have agreed to use opioids (morphine-like drugs) as part of your treatment for chronic pain. I understand that these drugs can be very useful, but have a high potential for misuse; and, are therefore, closely controlled by the local, state, and federal government. Because my physician/ health care provider is prescribing such medication to help manage my pain, I agree to the following conditions:

**1. I AM RESPONSIBLE FOR MY PAIN MEDICINES. I agree to take the medication ONLY as prescribed.**

A. I understand **that increasing my dose without the close supervision of my physician could lead to drug overdose causing severe sedation and respiratory depression and death.**

**B.** I understand that decreasing or stopping my medication without the close supervision of my physician can lead to withdrawal, which include yawning, sweating, watery eyes, runny nose, anxiety, tremors, aching muscles, hot and cold flashes, "goose flesh", abdominal cramps, and diarrhea. These symptoms can occur 24-48 hours after the last dose and can last up to 3 weeks. **It can even lead to SEIZURES/convulsions, if uncontrolled, can lead to severe impairment and/or death.**

2. I will NOT request or accept controlled substance medication from ANY OTHER PHYSICIAN or individual while I am receiving medication from my physician/healthcare provider at Advanced Pain Solutions.

**3.** There are side effects with opioid therapy, which may include, but not exclusively, skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, edema, sedation, or the possibility of impaired cognitive (mental status) and/or motor ability, endocrinopathy. Overuse of opioids can cause decreased respiration (breathing). It is my responsibility to notify my physician/health care provider for any side effects that continue or are severe (i.e., sedation, confusion). I am also responsible for notifying my pain physician immediately if I need to visit another physician or need to visit an emergency room due to pain, or if I become pregnant.

**4.** I understand that the opioid medication is strictly for **my own use onl**y. The opioid(s) SHALL NOT be given or sold to others because it may endanger that person's health and is **against the law.**

**5.** I will inform my physician of all medications I am taking, including sedatives/muscle relaxants such as Soma, Xanax, Valium, Ativan, Fiorinal, Baclofen, Flexeril, Skelaxin; antihistamines like Benadryl; herbal remedies, alcohol, and cough syrup which can interact with other opioids and produce serious side effects **including death.**

6. During the time that my dose is being adjusted, I will be expected to return to the clinic as instructed by my clinical provider. After I have been placed on a stable dose(s), I may receive opioids from my primary care physician (if (s)he agrees); and, will return to the pain clinic for a medical evaluation at least once every six months.

7. I understand that opioid prescriptions will **NOT be mailed.** If I am unable to obtain my monthly prescriptions, I will be responsible for finding a local physician who can take over the writing of my prescriptions with consultations from my pain physician at **Advanced Pain Solutions.**

8. Any evidence of drug hoarding, acquisition of any opioid medication or adjunctive analgesia from other physicians (which includes emergency rooms and/or dentist), uncontrolled dose escalation, **loss of prescriptions,** or failure to follow the agreement may result in termination of the doctor/patient relationship.

9. I will communicate fully with my physician to the best of my ability at the initial and all follow-up visits my pain level and functional activities along with any side effects of the medications. This information allows my physician to adjust treatment plan(s) accordingly.

**10. I shall NOT use any illicit substances, such as cocaine, methamphetamines, marijuana, etc. while taking these medications because they are AGAINST the (Federal) law, and, most likely will interact with my opioids. As such, this may result in a change to my treatment plan, including safe discontinuation of opioid medications when applicable or complete termination of the doctor/patient relationship.**

11. The use of alcohol together with opioid medications is contra-indicated.

**12. I am responsible for my opioid prescriptions. I understand that:**

**a.** Refill prescriptions can be written for a maximum of one month supply and will be filled at the same pharmacy when due!

| Pharmacy: | Phone: |
|---|---|
| | |

**b. It is my responsibility to schedule appointments for the next opioid refill before I leave the clinic or within 3 days of the last clinic visit.**
c. I **am responsible for keeping my pain medications in a SAFE AND SECURE PLACE, such as a locked cabinet or a safe. I AM EXPECTED TO PROTECT MY MEDICATIONS FROM LOSS OR THEFT** (i.e., more important than my other prized possessions). I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. **If my medication is stolen,** I will report this to my local police department and obtain a stolen item report. I will then report the stolen medication to my physician. If my medications are lost, misplaced, or stolen, **my physician may choose NOT to replace** the medications or to taper and discontinue the medications. **I WILL NOT LEAVE A TRAIL OR A PATTERN OF LOST AND STOLEN PRESCRIPTIONS!!!!**

13. Prescriptions of controlled substances will only be done during an office visit—not during the evening or weekends. **Opioid refills will NOT be made on an "emergency basis", such as Friday afternoon.**

**14.** Refills can only be filled by a pharmacy in the **State of California,** even if I am a resident of another state.

**15. I am expected to BRING BACK ALL OPIOID MEDICATIONS AND ADJUNCTIVE MEDICATIONS (Xanax, Ativan, Valium, Klonopin, Soma, etc.) PRESCRIBED BY YOUR PHYSICIAN IN THE ORIGINAL CONTAINERS/BOTTLES AT EVERY VISIT.**

**16.** If an appointment for a prescription refill is missed, another appointment will be made as soon as possible. **NO** immediate or emergency appointments will be granted; so, **NO "WALK-IN" APPOINTMENTS.**

**17. If it appears to the health care provider that there is NO IMPROVEMENT in my quality of life from opioid treatment, my opioids may be weaned or discontinued.** If so, I will gradually taper my medication as prescribed (instructed) by the physician.

**18.** While physical dependence is to be expected after long-term use of opioids, **signs of addiction, abuse, or misuse shall prompt the need for substance dependence treatment as well as weaning and detoxification from the opioids.**

- **A.** **Physical dependence** is common to many drugs such as blood pressure medications, anti-seizure medications, and, especially, opioids. It results in biochemical changes such that abruptly stopping these drugs will cause a withdrawal response. Physical dependence does not equal addiction. One can be dependent on insulin to treat diabetes or dependent on prednisone (steroids) to treat asthma, but is not addicted to the substance.
- **B.** **Addiction** is a primary, chronic neurobiological disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the **drug decreases one's quality of life**. If I exhibit such behavior, I realize that I'm not a candidate for an opioid trial. I am expected to be referred to an addiction medicine specialist.
- **C.** Tolerance means a state of adaptation in which exposure to the drug induces changes that result in a lessening of one or more of the drug's effects over time. The dose of the opioid may have to be titrated up or down to a dose that produces maximal function and a **realistic** decrease of the patient's pain. **Total alleviation of pain from opioid therapy is UNREALISTIC!**

19. If I have a history of alcohol or drug misuse/addiction, I must notify the physician of such history since treatment with opioids for pain increases the possibility of relapse. A history of addiction does not, in most instances, disqualify one for opioid treatment of pain, but starting or continuing a program for recovery **is a necessity.**

20. I will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment, and sometimes two to three days extra if the prescription ends on a weekend or holiday. This extra medication is not to be used without the explicit permission of the prescribing physician.

21. I agree and understand that my physician reserves the right to perform random (unannounced) urine drug testing. If requested to provide a urine sample, **I AGREE TO COOPERATE.** If I decide NOT to provide a urine sample (including various and numerous excuses), I understand that my doctor may change my treatment plan, including safe discontinuation of my opioid medications when applicable or complete termination of the doctor/patient relationship. **The presence of a non-prescribed or illicit drug(s) in the urine can be grounds for termination of the doctor/patient relationship.** Urine drug testing is not forensic testing; rather, it is done for my benefit as a diagnostic tool and in accordance with certain legal and regulatory materials on the use of controlled substances to treat pain.

22. I agree to allow my physician/health care provider to contact ANY health care professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about my care or actions if my opioid physician or assistant feels it is necessary. I also agree to a family conference or a conference with a close friend or significant other if the physician feels it is necessary for my safety sake.

**23. I understand that NON-COMPLIANCE with the above conditions may result in re-evaluation of treatment plan, gradually weaned off these controlled medications, discontinuation of therapy, or even discharged from the clinic.**

**I, _____, have read the above information or it has been read to me and all my questions regarding the treatment of pain with opioids have been answered to my satisfaction. I hereby give my consent to participate in the opioid medication therapy acknowledge receipt of this document.**

Patient's Signature: _____ Date: _____

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**AUTHORIZATION TO RELASE HEALTHCARE INFORMATION**

Patient's Name: _____ Date of Birth: _____

Previous Names: _____ Social Security#: _____ - _____ - _____

I, _____, request and authorize to release healthcare Information on the patients named above to:

Advanced Pain Solutions
6169 N Thesta St.
Fresno, CA 93710

This request and authorization applies to:

☐ Healthcare Information relating to the following treatment, condition, or dates

_____

☐ All Healthcare Information

☐ Other:_____

Definitions: Sexually Transmitted Disease (STO) as defined by law, RCW 70.24 et. Includes herpes, herpes simplex. human papilloma virus (HPV), genital warts, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL., chancroid, lymphogranuloma venereum, Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and gonorrhea.

I,_____, authorize the release of my records regarding drug, alcohol, or mental health treatment to the Person(s) listed above.

Patient Signature: _____

**CONSENT TO TREAT**

1. I, _____, (patient name) give permission for Advanced Pain Solutions to give me medical treatment.
2. I agree to allow Advanced Pain Solutions to file for insurance benefits to pay for the care I receive

I understand that:

- Advanced Pain Solutions will send my medical record information to my insurance company.
- I must pay for the cost of these services in the event that my insurance does not cover the cost.
- I have read and understand the patient financial responsibilities policy.
- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my provider.

Patient Signature: _____ Date: _____

Print Name: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Print Name: _____

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## HIPAA POLICY AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. This is an abbreviated version, however the complete text is available on the U.S. Department of Health and Human Services web site: www.hhs.gov

HIPAA states that there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office medical services. Your information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers if desired, laboratories and health insurance payers as is necessary and appropriate for your care.

Our Electronic Medical Record (EMR) has been certified by Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) to ensure that our system is secure, can maintain data confidentially, and can work with other systems to share information.

It is the policy of this office to remind clients of their appointment. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We agree to provide clients with access to their records in accordance with state and federal laws. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

We may change, add, delete or modify any of these provisions to better serve the needs of the practice and the client. You have the right to request restrictions in the use of your protected health information as the law permits. Your confidential information will not be sold for any reason.

Your signature will indicate that you have read the HIPAA information and consent to the guidelines set forth in the Act.

### NOTICE OF HEALTHCARE PRIVACY PRACTICES AT ADVANCED PAIN SOLUTIONS

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

1. **We Have A Legal Duty To Safeguard Your Protected Health Information (PHI)**

We are legally required to protect the privacy of health information that may reveal your identity. This information is commonly referred to as protected health information or "PHI" for short. It includes information that can be used to identify you that we have created or received about your past, present or future health or condition, the provision of health care to you, or the payment of this health care. We must provide you with this notice about our privacy practices that explains how, when and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure.

We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and post a new notice. You can also request a copy of this notice at any time from our office.

2. **How We May Use And Disclose Your Protected Health Information**

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your prior consent or specific authorization. Below we describe the different categories of our uses and disclosures and give you some examples of each category.

During your intake, prior to receiving any health care services, you will be asked to sign a statement permitting Advanced Pain Solutions and its medical staff to release your health information for purposes of Treatment, Payment and Health Care Operations. A description of each of these uses is described as follows:

**A. Uses and Disclosures Relating to Treatment, Payment or Health Care Operations.**

- **For treatment.** We may disclose your PHI to physicians, nurses, medical students, and other health care personnel who provide you with health care services or are involved in your care.
- **To obtain payment for treatment.** We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and your health plan to get paid for the health care services we provided to you. We may also provide your PHI to our business associates, such as billing companies, claims processing companies and others that process our health care claims or provide services on our behalf, or provide services directly to you.
- **For health care operations.** We may disclose your PHI in order to operate our health care delivery system. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants and others in order to make sure we're complying with the laws that affect us.

  To the extent we are required to disclose your PHI to contractors, agents and other business associates who need the information in order to assist us with obtaining payment or carrying out our business operations, we will have a written contract to ensure that our business associate also protects the privacy of your PHI.

**B. Other Uses and Disclosures That Do Not Require Your Consent**.

**We may use and disclose your PHI without your consent or authorization for the following reasons:**

- **When a disclosure is required by federal, state or local law, judicial or administrative proceedings or law enforcement.** For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect or domestic violence; when dealing with gunshot and other wounds; or when ordered in a judicial or administrative proceeding.
- **For public health activities.** For example, we may report information in regards to deaths and various diseases to governmental official in charge of collecting that information.
- **Victims of Abuse, Neglect or Domestic Violence.** We may release your PHI to a public health authority that is authorized to receive reports of abuse, neglect or domestic violence. For example, we may report your information to government officials if we reasonably believe that you have been a victim of abuse, neglect or domestic violence. We will make every effort to obtain your permission before releasing this information, but in some cases we may be required or authorized to act without your permission.
- **For health oversight activities**. For example, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
- **Emergency Situations.** We may use or disclose your PHI if you need emergency treatment, but we are unable to obtain your consent. If this happens, we will try to obtain your consent as soon as we reasonably can after we treat you.
- **Communication Barriers.** We may use or disclose your PHI if we are unable to obtain your consent because of substantial communication barriers, and we believe you would want us to treat you if we could communicate with you.
- **Product Monitoring.** Repair and Recall. We may disclose your information to a person or company that is required by law to: (1) report or track product defects or problems; (2) repair, replace or recall defective or dangerous products; or (3) monitor the performance of a product after it has been approved for use by the general public.
- **Lawsuits and Disputes**. We may disclose your PHI if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute.
- **Law Enforcement. We may disclose your PHI to law enforcement officials for any of the following reasons:**
    1. To comply with court orders or laws that we are required to follow;
    2. To assist law enforcement officers with identifying or locating a suspect, fugitive, witness or missing person;
    3. If you have been the victim of a crime and we determine that: (1) we have been unable to obtain your consent because of any emergency or your incapacity; (2) law enforcement officials need the information immediately to carry out their law enforcement duties; and (3) in our professional judgment disclosure to these officers is in your best interests;
    4. If we suspect a patient's death resulted from criminal conduct;
    5. If necessary to report a crime that occurred on our property; or
    6. If necessary to report a crime discovered during an offsite medical emergency (for example, by emergency medical technicians at the scene of a crime).
- **Military and Veterans.** If you are in the Armed Forces, we may disclose your PHI to appropriate military command authorities for activities they deem necessary to carry out their military mission. We may also release health information about foreign military personnel to the appropriate foreign military authority.
- **Inmates and Correctional Institutions.** If you are an inmate or you are detained by a law enforcement officer, we may disclose your PHI to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety, security and good order at the place where you are confined. This includes sharing information that is necessary to protect the health and safety of other inmates or persons involved in supervising or transporting inmates.
- **Coroners. Medical Examiners and Funeral Directors**. In the unfortunate event of your death, we may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties.
- **For purposes of organ donation**. We may notify organ procurement organizations to assist them in organ, eye or tissue donation and transplants.
- **To avoid harm.** In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
- **For specific government functions.** We may disclose PHI of military personnel and veterans in certain situations AND we may disclose PHI for national security purposes, such as protecting the president of the United States or conducting intelligence operations.
- **For workers' compensation purposes.** We may provide PHI in order to comply with workers' compensation laws.
- **Appointment reminders and health-related benefits or services.** We may use PHI to provide appointment reminders or give you information about treatment alternatives or other health care services or benefits we offer and/or provide.
- **Incidental Disclosures**. While we will take reasonable steps to safeguard the privacy of your PHI, certain disclosures of your PHI may occur during, or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your PHI.

**C. Uses and Disclosures Require Your Prior Written Authorization.**
In any situation, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we have not taken any actions relying on the authorization).

**3. What Rights You Have Regarding Your PHI**

**You have the following rights with respect to your PHI:**

**A. The Right to Request Limits on Uses and Disclosures of Your PHI.**

- You have the right to ask that we limit how we use and disclose your PHI. We will consider your request, but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

**B. The Right to Choose How We Send PHI to You.**

- You have the right to ask that we send information to you to an alternate address or by alternate means. We must agree to your request so long as we can easily provide it to the location and in the format you request.

**C. The Right to See and Get Copies of Your PHI.**

- In most cases, you have the right to look at or get copies of your PHI that we have. If you request copies of your PHI, we will charge you a fee of $25.00.

**D. The Right to Get a List of the Disclosures We Have Made.**

- You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures that you have already been informed of, such as those made for treatment, payment or health care operations, directly to you, to your family, or in our facility directory. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel. Your request must state a time period for the disclosures you want us to include. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed and the reason for the disclosure.

**E. The Right to Correct or Update Your PHI.**

- If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We may deny your request in writing if the PHI is (I) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial.

**F. The Right to Get This Notice by E-Mail.**

- You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e- mail, you also have the right to request a paper copy of this notice.

**4. Effective Date of This Notice: January 1, 2020**

**ADVANCED PAIN SOLUTIONS**
6169 N. Thesta Street
Fresno, CA 93710


**PAUL KY D.O.**
PHONE (559) 435 1757
FAX (559) 435 1768

**PATIENT HIPAA CONSENT FORM**

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.
The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.
The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.
You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.
By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.
By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information; but, the practice does NOT have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO
May we leave a message on your answering machine at home or on your cell phone? YES NO
May we discuss your medical condition with any member of your family? YES NO
If YES, please name the members allowed:
_____
_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

LAST NAME: _____ DOB: _____

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Fresno, CA 93710

Advanced PAIN SOLUTIONS

**PAUL KY D.O.**
PHONE (559) 435 1757
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LAST NAME: _____ REVIEW OF SYSTEMS DOB: _____

| GENERAL: |
|---|
| □ Headaches □ Dizzy spells/Fainting |
| □ Lethargy/Weakness □ Fatigue |
| □ Fever/Chills |
| □ Chills/Night sweats |
| □ Weight loss/Weight gain |
| EYES: |
| □ Eye pain □ Redness □ Dryness |
| □ Cataracts □ Surgery—right—left—both |
| □ Loss of vision—right—left—both |
| □ Double vision □ Blurred vision |
| □ Change of vision |
| □ Glasses/contacts |
| EARS: |
| □ Ringing in ears/tinnitus—right—left |
| □ Loss of hearing—left—right |
| □ Hearing aids—right—left |
| NOSE/MOUTH/THROAT |
| □ Nose bleeds □ Loss of smell |
| □ Dry sinuses □ Sinusitis |
| □ Sore throat □ Mouth sores |
| □ Bleeding gums □ Tooth aches |
| □ Difficulty swallowing |
| □ Hoarseness □ Acid/bitter taste |
| □ Halitosis (smelly breath) |
| CARDIOVASCULAR: |
| □ High blood pressure |
| □ Chest pain □ Chest pain on exertion |
| □ Atrial fibrillations (Afib) □ Pacemaker? |
| □ Heart palpitation □ Heart murmurs |
| □ Heart valve surgery □ Bypass surgery |
| □ Heart attacks □ Heart stents |
| □ Carotid artery stenosis □ Surgery? |
| □ Cramping legs, especially on walking |
| □ Swollen legs □ Congestive heart failure |
| □ Difficulty catching breaths on walking |
| □ Varicose veins □ Varicose surgery |
| □ Blood clots: □ Anticoagulation? |
| Location: arm/leg: —left—right |
| RESPIRATORY: |
| □ Tobacco smoke, how much ___pack/day |
| □Plan to quit? □Have quitted |
| □ Marijuana smoke, how often? |
| □Plan to quit? □Have quitted |
| □ Dry coughs □ Coughs with mucus |
| □ Asthma □ Coughing up blood |
| □ COPD/Emphysema □ on ____liters O2 |
| □ Recent pneumonia |
| □ Night sweats |
| □ Wheezing □ Short of breath |
| □ Chest pain with breathing |

| GASTROINTESTINAL (GI): |
|---|
| □ Belching □ Excessive gas |
| □ Nausea □ Vomiting □ Yellow skin |
| □ Gallstones □ Gall bladder surgery? |
| □ Diverticulosis □ Colon surgery? |
| □ Regurgitation/heart burn |
| □ Bleeding ulcer □Surgery—banding/laser |
| □ Bowel incontinence |
| □ Constipation □ Diarrhea |
| □ Adhesion surgery □ Dehiscence surgery |
| □ Pancreatitis □ Pancreatic Sx |
| □ Blood in stool |
| □ Hemorrhoids □ Surgery? |
| GENITOURINARY: |
| □ Trouble urinating □ Pain with urinating |
| □ Urinary urgency □ Incontinence |
| □ Blood in urine □ Kidney stones |
| □ Cloudy urine □ Frequent urination |
| □ Rash in genitals □ Genital wards |
| □ Sexual problems |
| □ Sexually transmitted diseases |
| Women Only: |
| □ Vaginal discharge □ Abnormal period |
| □ Pregnant, how many wks/months? |
| □ Endometriosus □ Surgery |
| □ Hysterectomy □ Partial □ Complete |
| □ Interstitial cystitis □Stimulator implant |
| Men Only: |
| □ Painful ejaculations □ Penile discharge |
| □ Poor urinary stream □ enlarged prostate |
| □ Erectile dysfunction □ Penile implant |
| MUSCULOSKELETAL: |
| □ Muscle cramps location |
| □ Weak muscles location |
| □ Joint swelling |
| □ Neck pain □ Surgery |
| □ anterior (frontal) □posterior approach |
| □ Midback pain □ surgery |
| □ Low back pain □ Surgery |
| □ anterior (frontal) □posterior approach |
| □ Fracture location: |
| □ Joint pain location: |
| □ Shoulder surgery: □ right □ left |
| □ Wrist surgery: □ right □ left |
| □ Hip surgery: □ right □ left |
| □ Knee surgery: □ right □ left |
| □ Ankle surgery: □ right □ left |
| HEMATOLOGY/LYMPHATICS: |
| □ Anemia □ Easily bruising |
| □ Easily clotting |
| □ Enlarged lymph nodes |

| INTEGUMENTARY/BREASTS: |
|---|
| □ Change in skin texture □ Skin bruising |
| □ Hair distribution change in pattern |
| □ Changes in hair texture/thickness |
| □ Changes in moles □ Hives |
| □ Skin rash followed by burning sensation |
| Location: |
| □ Changes in nail texture □ Fungal nails |
| □ Color changes in hands/feet |
| □ Differences in skin temperature |
| □ Skin tightness |
| □ Persistent sores, how long? |
| Location: |
| □ Breast lumps □ Breast pain |
| □ Nipple discharges |
| NEUROLOGIC: |
| □ Seizures (epilepsy) |
| □ Burning pain location: |
| |
| □ Numbness location: |
| |
| □ Tingling location: |
| |
| □ Loss of consciousness (syncope) |
| □ Memory loss □ Alzheimer's? |
| □ Balance problems |
| ENDOCRINE: |
| □ Sensitive to cold □ Sensitive to heat |
| □ Increased thirst □ Decreased sex drive |
| □ Diabetes, what's your hemoglobin A1c? |
| |
| □ Low testosterone □ Low vitamin D25-OH |
| IMMUNOLOGY/ALLERGY: |
| □ Runny nose |
| □ Seasonal allergies |
| □ Latex allergy |
| □ Food allergy |
| □ Medication allergy |
| PSYCHIATRIC: |
| □ Irritability □ Anxiety |
| □ Bipolar □ Depression |
| □ Schizophrenia □ Hearing voices |
| □ Mood swings |
| □ Obsessive/compulsive habits |
| □ Problems concentrating |
| □ History of substance abuse |
| |
| □ History of being abused? |
| □ Verbal □ Physical □ Sexual |
| □ Suicidal thoughts |
| □ Do you a suicidal plan? |