

**DESERT PAIN SPECIALISTS
79440 CORPORATE CENTER DRIVE, STE 110B
LA QUINTA, CA 92253**

WELCOME

I would like to welcome you to my pain medicine practice. I am committed to providing a professional, caring and personalized approach to treating your pain problems. There are many treatment options, and together we will control your pain and help you return to a full and productive life.

My office hours are Monday through Friday 9:00 am to 5:00 pm.
Phone: (760) 625-1960
Fax: (760) 625-1962

Enclosed is a medical history that you should complete before your first office visit. If you fax it to my office before your visit it will greatly decrease your wait time at the office.

Please bring your insurance card(s) and identification card with you. My practice may or may not be contracted with your insurance carrier. Federal insurance requires collection of all co-pay and deductibles regardless of whether or not I have contracted with your insurance carrier.

My website, www.desertpain.com is chock full of educational information about your pain problems. There are even video clips you can access on the 'Services' page to teach you about your pain and its treatment

I truly appreciate your business.

If you are unable to keep this appointment, please call to reschedule.

PLEASE BRING THE FOLLOWING ITEMS WITH YOU TO EACH VISIT

- 1. A LIST OF YOUR QUESTIONS AND CONCERNS**
- 2. YOUR INSURANCE CARD AND DRIVERS LICENSE**
- 3. REFERRAL FORMS**
- 4. PERTINENT MEDICAL RECORDS INCLUDING REPORTS OF
MRI, CT, OR X-RAY STUDIES**
- 5. ALL MEDICATIONS – EITHER A LIST OR THE BOTTLES
THEMSELVES**
- 6. YOUR COPAYMENT**
- 7. A NOTE PAD FOR TAKING NOTES DURING OUR VISIT**

I LOOK FORWARD TO OUR VISIT.

**SHOULD YOU HAVE ANY FURTHER QUESTIONS YOU CAN
CALL MY OFFICE AT (760)328-3729.**

RUTH K. ANDERSON, MD

DR. RUTH ANDERSON
PATIENT HISTORY FORM

DATE: _____

NAME: _____ PHONE: _____

DATE OF BIRTH: _____

WHO REFERRED YOU? _____

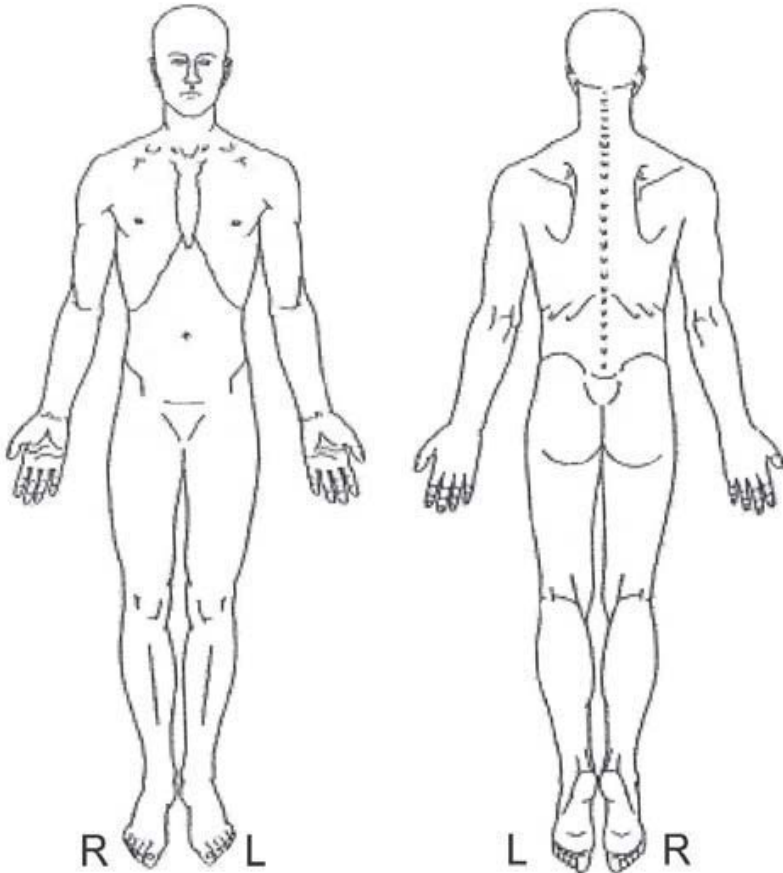
WHO IS YOUR PRIMARY CARE DOCTOR? _____

REASON FOR YOUR VISIT: _____

PLEASE HELP ME UNDERSTAND YOUR PAIN:

AGE _____ RACE _____ SEX M F
WHO IS COMPLETING THE PAPERWORK? _____

PLEASE DRAW WHERE YOUR PAIN IS LOCATED:



PLEASE DESCRIBE YOUR PAIN:

CONSTANT INTERMITTENT

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> BURNING | <input type="checkbox"/> DEEP/DULL ACHE |
| <input type="checkbox"/> FIRE | <input type="checkbox"/> THROBBING/JABBING |
| <input type="checkbox"/> ELECTRIC | <input type="checkbox"/> SPASM |
| <input type="checkbox"/> SHOOTING | <input type="checkbox"/> TOOTHACHE |
| <input type="checkbox"/> KNIFE-LIKE | |

PLEASE LIST ASSOCIATED SYMPTOMS:

- MUSCLE SPASM
- NAUSEA/VOMITING
- RESTLESS LEGS
- FATIGUE
- PAIN WITH FIRST STEPS IN THE MORNING
- PAIN THAT WAKES YOU UP AT NIGHT

- LEG CRAMPS; RIGHT LEFT BOTH LEGS
- FOOT DROP; WHICH FOOT? _____
- NUMBNESS; WHERE IS IT? _____ TINGLING; WHERE IS IT? _____
- SWELLING
- LIGHTEADEDNESS SENSITIVITY TO LIGHT
- VISUAL DISTURBANCES PRIOR TO HEADACHE

STIFFNESS: () LOW BACK () LEGS () KNEES () HIPS () FEET () NECK () ARMS
() SHOULDERS () HANDS

TENDERNESS: () LOW BACK () LEGS () KNEES () HIPS () FEET () NECK () ARMS
() SHOULDERS () HANDS

WEAKNESS: () LOW BACK () LEGS () KNEES () HIPS () NECK () ARMS
() SHOULDERS () HANDS

PLEASE RATE YOUR PAIN :

0-10 SCALE, WHERE 0/10=NO PAIN AND 10/10 IS SO SEVERE YOU CAN'T EVEN SPEAK

CURRENT PAIN: ____/10 WORST PAIN: ____/10 'BEST DAY' PAIN: ____/10

WAS YOUR ONSET OF PAIN GRADUAL OR SUDDEN?

WHEN DID YOUR PAIN **FIRST** OCCUR (APPROXIMATE DATE): _____

WERE YOU INJURED OR IN AN ACCIDENT THAT CAUSED YOUR PAIN TO OCCUR? DESCRIBE:

WHAT MAKES YOUR PAIN BETTER?

- LYING DOWN SITTING GETTING OUT OF A CHAIR
- BENDING FORWARD STANDING
- WALKING REACHING TURNING MY HEAD
- EXERTION/EXERCISE
- TWISTING CHANGING POSITIONS
- LEANING ON A SHOPPING CART

OTHER, PLEASE EXPLAIN: _____

WHAT MAKES YOUR PAIN WORSE?

- LYING DOWN SITTING GETTING OUT OF A CHAIR
- BENDING FORWARD STANDING
- WALKING REACHING TURNING MY HEAD
- EXERTION/EXERCISE
- TWISTING CHANGING POSITIONS
- LEANING ON A SHOPPING CART

OTHER, PLEASE EXPLAIN: _____

MY PAIN IS WORSE IN THE: MORNING NOON EVENING DURING SLEEP

PLEASE CHECK ALL TREATMENTS YOU HAVE TRIED AND THEN INDICATE IF THEY WERE HELPFUL OR NOT

	Helpful	Not Helpful	Details
Ice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Biofeedback/ Relaxation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Home Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Massage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Accupuncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Chiropractic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Laser Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Nerve Blocks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
TENS/ MENS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Trigger Point Injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Epidurals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Pain Management Injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

PLEASE CHECK ALL MEDICATIONS THAT YOU HAVE TRIED AND WHETHER THEY WERE HELPFUL OR NOT

ANTI-INFLAMMATORY MEDICATION

NSAIDs	Helpful	Not Helpful	Details
Advil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Aleve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Celebrex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Diclofenac	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Mobic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Other (<i>list in details</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

MUSCLE RELAXANTS

Muscle Relaxants	Helpful	Not Helpful	Details
Flexeril	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Soma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Skelaxin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Zanaflex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Other (<i>list in details</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

NARCOTIC PAIN PILLS

Short Acting Narcotics	Helpful	Not Helpful	Details
Tramadol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Vicodin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Perocet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Darvocet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Actiq	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Dilaudid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Other (<i>list in details</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Long Acting Narcotics	Helpful	Not Helpful	Details
Duragesic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Morphine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
OxyContin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Methadone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Other (<i>list in details</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

NEUROPATHIC AGENTS

Neuropathic Agent	Helpful	Not Helpful	Details
Neurontin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Lyrica	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Topamax	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Cymbalta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Savella	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Other (<i>list in details</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

OTHER MEDICATIONS

Other	Helpful	Not Helpful	Details
Tylenol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Lidoderm Patch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Voltaren Gel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Flector Patch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Other (<i>list in details</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

<u>NAME</u>	<u>STRENGTH (MG)</u>	<u>HOW OFTEN YOU TAKE IT</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY

MARITAL STATUS: S M D W HOW MANY CHILDREN DO YOU HAVE? ____

WHAT IS YOUR LEVEL OF EDUCATION? _____

OCCUPATION: _____

DISABLED: _____ HOW LONG: _____

DO YOU SMOKE: Y N HOW MANY PACKS/DAY: _____ # YEARS: _____

DO YOU DRINK ALCOHOL: YES NO IF YES, NUMBER OF DRINKS/WEEK: ____
ARE YOU A REFORMED ALCOHOLIC ? YES NO; ARE YOU A LIFE TIME NON-DRINKER? YES NO

EXERCISE HISTORY: Do you exercise?
__ < 1TIME/WEEK; __ 1-2 TIMES/WEEK; __ 3-5 TIMES/WEEK; __ 6-7 TIMES/WEEK

TYPE OF EXERCISE: __ AEROBICS __ BIKING __ RUNNING __ HIKING __ SWIMMING
__ TREADMILL/ELLIPTICAL __ WEIGHT LIFTING __ OTHER

REVIEW OF SYSTEMS

PLEASE CIRCLE ALL SYMPTOMS YOU HAVE EXPERIENCED RECENTLY

- FEVER, CHILLS, FATIGUE, POOR APPETITE, POOR SLEEP, WEIGHT GAIN, WEIGHT LOSS
- HEARING LOSS, SORE THROAT, SWOLLEN GLANDS, BLURRY VISION, DECREASED VISION
- SHORTNESS OF BREATH, WHEEZING, COUGH
- CHEST PAIN, PALPITATIONS, SWELLING OF LEGS, RACING HEART
- RASH, ITCHING, NEW SKIN LESIONS, EASY BRUISING
- NEW JOINT PAIN, JOINT SWELLING, STIFFNESS, WEAKNESS
- ABDOMINAL PAIN, NAUSEA, VOMITING, DIARRHEA, CONSTIPATION, HEART BURN,
- HEADACHE, DIZZINESS, LOSS OF CONSCIOUSNESS, NUMBNESS, TINGLING
- DEPRESSED MOOD, ANXIOUS MOOD, ABNORMAL THINKING/INTELLECT

PATIENT'S MEDICARE AUTHORIZATION

I request that payment of authorized MEDICARE benefits be made on my behalf to for any services furnished to me by this supplier:

Desert Pain Specialists, Inc.
79440 Corporate Center Drive, Ste 110B
Phone: (760) 625-1960
Fax: (760) 625-1962

I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents. In addition, I authorize the release of any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If 'other health insurance' is indicated in Item 9 of the HCFA-15000 form, or elsewhere on other approved claim forms or other electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In MEDICARE assigned cases, the physician or supplier agrees to accept the charge determined by the MEDICARE carrier as full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the MEDICARE carrier.

PATIENT'S SIGNATURE

DATE

**DESERT PAIN SPECIALISTS
RUTH K. ANDERSON, M.D.
79440 CORPORATE CENTER DRIVE, STE 110B
LA QUINTA, CA 92253**

**THIS FORM IS USED TO CONFIRM THAT _____
HAS RECEIVED DR. RUTH K. ANDERSON'S NOTICE OF PRIVACY
PRACTICES.**

**I, _____ ACKNOWLEDGE THAT I MAY RECEIVE DR.
RUTH K. ANDERSON'S NOTICE OF PRIVACY PRACTICES AT ANY TIME
UPON REQUEST. I HAVE HAD FULL OPPORTUNITY TO READ AND CONSIDER
THE CONTENTS OF THIS NOTICE OF PRIVACY PRACTICES.**

SIGNATURE _____ DATE _____

**IF THIS AUTHORIZATION IS SIGNED BY A PERSONAL REPRESENTATIVE ON
BEHALF OF THE INDIVIDUAL, COMPLETE THE FOLLOWING:**

**PERSONAL REPRESENTATIVE'S NAME: _____
RELATIONSHIP TO INDIVIDUAL: _____**

**PATIENT NAME (PRINTED): _____
ADDRESS: _____
TELEPHONE NUMBER: _____
PATIENT NUMBER: _____**

Agreement for Long Term Opioid Therapy
Desert Pain Specialists Inc.
79440 Corporate Center Drive, Ste 110B
La Quinta, CA 92253

The purpose of this agreement is to protect your access to controlled substances and to protect my ability to prescribe for you.

The long term use of opioids (narcotic analgesics) and benzodiazepine sedatives (like Valium) is controversial because of the uncertainty of their benefit with long term use. There is also the risk of addictive disorder developing or of relapse occurring in a person with a history of prior addiction. The extent of this risk is uncertain.

Because these drugs have the potential for abuse and diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient as a consideration for, and a condition of, the willingness of Dr. Anderson to initiate and continue to prescribe the controlled substances to treat your chronic pain.

1. All controlled substance prescriptions must come from Dr. Anderson. Obtaining prescriptions from multiple doctors, without Dr. Anderson's specific direction, is cause for immediate dismissal from her medical practice.
2. All controlled substances must be obtained from the same pharmacy, where possible. Should the need to change pharmacies arise, my office must be informed.
3. You are expected to inform my office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.
4. Dr. Anderson has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other health care providers for purposes of maintaining accountability.
5. You may not share, sell, or otherwise permit others to have access to these medications.
6. These drugs should not be stopped abruptly, as a withdrawal syndrome may likely develop.
7. Unannounced urine or serum toxicology screens may be requested and your cooperation is required.
8. It is expected that you will take the highest possible degree of care with your medications and prescriptions. I recommend locking up your medications to prevent theft.
9. Keep these medications out of reach of children, as they may be lethal to any one not tolerant of their effects.

10. Medications may not be replaced if they are lost, get wet, or are destroyed, left on an airplane etc. If your medication has been stolen, and you complete a police report regarding the theft, an exception may be made.
11. Early refills are generally not given.
12. You must give Dr. Anderson's office 2-3 day notice before your medication refill is due.
13. Changes in your narcotic prescription (ie increasing the drug dose) will only be made after an office consultation. No changes in narcotic prescriptions will be made over the phone.
14. Prescriptions may be issued early if Dr. Anderson or the patient will be out of town when the refill is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date.
15. If the responsible legal authorities have questions concerning your treatment, as might occur if you were obtaining medications from several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of narcotic administration.
16. Failure to adhere to these policies may result in the cessation of therapy with controlled substance prescribing by Dr. Anderson and possible dismissal from her medical practice.
17. Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.
18. There is a \$15 triplicate fee to cover administrative costs of filling these prescriptions.
19. The risks of long term controlled substance use are as follows:
 - a. Reflex and reaction times may be slowed. Do not drive or operate heavy machinery after initiating or adapting to a dose increase in your medication.
 - b. Addiction is a real but small risk of narcotic use in the chronic pain population. Addiction is the use of medicine even if it causes harm, the presence of cravings for the medicine, and feeling the need to use the drug even if it affects your quality of life. You must be completely honest with Dr. Anderson about your personal drug history and a history of addiction in your family.
 - c. Physical dependence is a normal reaction to these medications. It is not the same as addiction. It simply means that if you stop the drug(s) abruptly you will likely experience withdrawal symptoms. These symptoms include: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, body aches and a flu-like feeling. Opioid withdrawal is uncomfortable but not life threatening.

- d. Tolerance to these medications is another normal reaction to their long term use. It means that it takes more medication to get the same amount of pain relief. Tolerance or failure to respond to opioids may cause Dr. Anderson to choose another form of treatment.
- e. Males only. Chronic opioid use is associated with low testosterone levels in males. This may affect mood, stamina, sexual desire and physical performance.
- f. Females only. If you plan to become pregnant or believe you are pregnant while taking this medication (or any that Dr. Anderson has prescribed), you must call your obstetric doctor and this office to inform them. Opioids are not generally associated with the risk of birth defects but there is that possibility.

I affirm that I have the full right and power to sign and be bound by this agreement. I have read and understand all the risks of long term controlled substance use and will abide by the terms of their use as described above.

Patient Signature

Date

Patient Name (Printed)

FINANCIAL POLICY
Desert Pain Specialists, Inc
79440 Corporate Center Drive, Ste 110B
La Quinta, CA 92253

I know that choosing a physician is a very important decision and I thank you for choosing our office. Please take a minute to review some of our financial policies.

Information regarding your insurance coverage:

You must understand the details of your health insurance coverage and fulfill any requirements such as pre-certification and providing information on pre-existing conditions of your policy. It is also your responsibility to provide our office with all required information regarding your health insurance policy. You must notify my office if there are any changes to your insurance coverage. If any complications arise during the billing process, you have an obligation to provide assistance and information to our billing office. You can reach Professional Health Care Billing at 1-866-978-6028 with questions.

Uninsured Patients:

If you do not have current health insurance, you are responsible for the fee for service. Payment will be collected in full at the time of service.

Non-participating provider or non covered benefits:

I am a participating provider with Medicare, Blue Cross, Blue Shield and Tricare. If you have insurance coverage with another carrier or if the services provided are not covered under your specific health care plan, then you are responsible for paying for all services performed. My office will bill your insurance carrier directly as an out-of-network provider in lieu of accepting payment directly from you. If we do so, you agree to assign your payment rights to my office and forward any checks you receive relative to the services provided to the office of Dr. Ruth Anderson. Upon your request and full payment, I will be glad to provide a statement of services for your records and/or reimbursement.

Participating provider and covered benefits

If you have Medicare, Blue Cross, Blue Shield or Tricare insurance and the services sought are covered services under your health care plan then my office will directly bill your insurance carrier. Under your plan you may be responsible for paying certain

amounts (e.g. co-payments, deductibles, and fees for non-covered services), which are due at the time of service.

Types of payment: Dishonored Checks:

Desert Pain Specialists accepts cash, personal checks, Master Card, Visa and American Express. If your check is dishonored (returned for insufficient funds) you will be required to pay an additional fee of \$35.00 which shall be due and owing immediately.

Collection of outstanding balances:

All outstanding balances are due within 30 days. Unless we have agreed to other payment arrangements in writing, you are expected to pay all past due balances, in their entirety, prior to or at the time of your visit. Balances that remain outstanding for a period of 90 days or more will be referred to a collections agency. If you are referred to a collection agency, you will be responsible for paying a collection charge equal to 35% of your outstanding balance, which is in addition to your outstanding balance.

Missed Appointments:

It is important that you appear for all scheduled appointments. By way of courtesy, you will usually be called to confirm your appointment 2 days before your scheduled appointment. Your failure to cancel an appointment at least 24 hours prior to the visit deprives other patients in severe pain an opportunity for prompt treatment at my office. You will be responsible for paying a missed appointment fee of \$50.00 if you do not provide 24 hours notice of cancellation. This policy is aimed at minimizing your wait time and ensuring prompt medical care. There are rare circumstances which may not permit you to provide 24 hours prior notice, but such circumstances are exceptional and extremely infrequent. They will be considered on a case by case basis.

By signing below, the patient or responsible party acknowledges that he/she has read and understood the foregoing Financial Policy and agrees to be bound by the terms and conditions set forth therein.

Signature of Patient or Responsible Party

Date

Print Name of Patient or Responsible Party