

Justin Paquette, M.D.
 8670 Wilshire Blvd Suite 206
 Beverly Hills, CA 90211
 (310) 855-0752

PATIENT INTAKE FORMS

PATIENT INFORMATION					
Name (Last, First, Middle):	Date of Birth:	SSN #:	Cell Phone No:	Home Phone No:	Sex:
Street Address	City, State, Zip		E-mail Address:	Marital Status:	
Date of Injury:	Claim #:	Employer:	Job Position:	Length of Time:	
Currently Working?:	Date Last worked:	**Referred by:	**Primary Care Provider / Phone No:		
EMPLOYER					
<u>Primary Employer:</u>	Street Address:		City, State, Zip:		
Phone No:	Contact Person / Ext. :		Fax No:		
<u>Current Employer:</u>	Street Address:		City, State, Zip:		
Phone No:	Contact Person / Ext. :		Fax No:		
APPLICANT ATTORNEY (WORKER'S COMP AND PERSONAL INJURY)					
Attorney / Law Firm:		Street Address, Suite No:		City, State, Zip:	
Office Phone No:	Fax No:	Cell Phone No:	E-Mail Address:		
DEFENSE ATTORNEY (WORKER'S COMP AND PERSONAL INJURY)					
Attorney / Law Firm:		Street Address, Suite No:		City, State, Zip:	
Office Phone No:	Fax No:	Cell Phone No:	E-Mail Address:		
INSURANCE					
Insurance Company:		Phone No:		Fax No:	
Adjuster (WC PATIENTS ONLY):		Phone No / Ext. (WC PATIENTS ONLY):		Fax No (WC PATIENTS ONLY):	
Street Address:		City, State, Zip:		E-mail Address:	
File No (WC PATIENTS ONLY):	Claim #/ID #:		WCAB #/Group #:		

PATIENT PAIN DRAWING

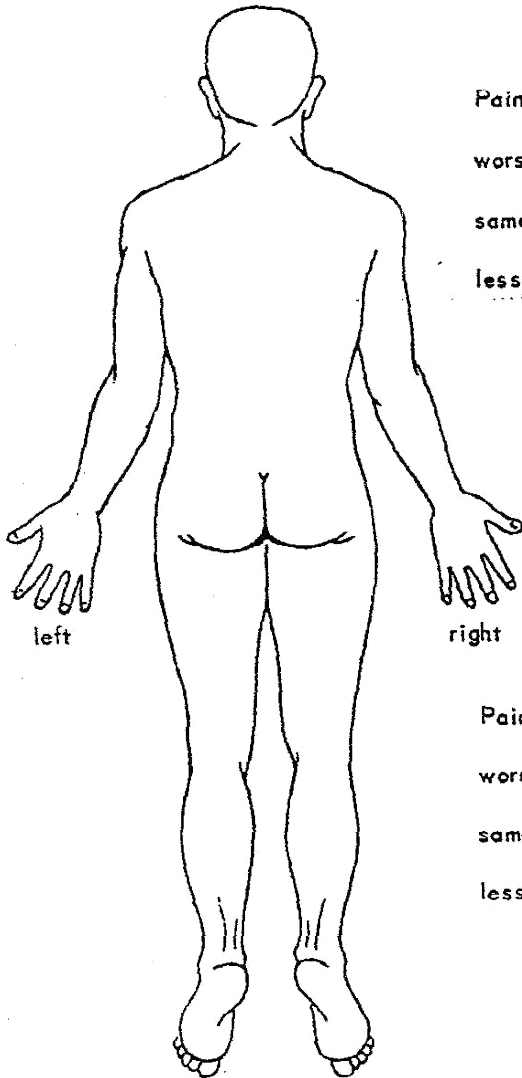
Patient: _____

Date: _____

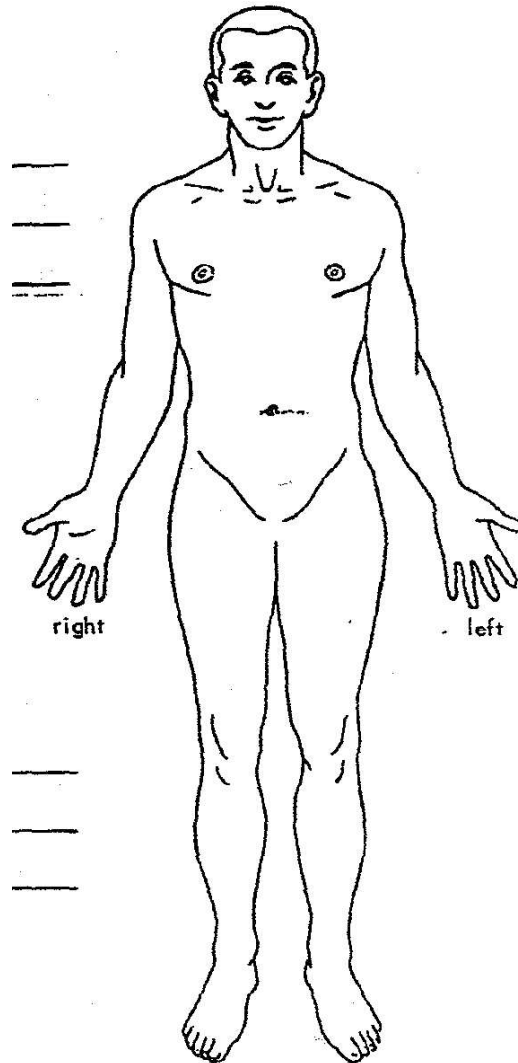
Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

ACHE	NUMBNESS	PINS & NEEDLES	BURNING	STABBING
^^^^^^^^^^^^^^^^^^	=====	OOOOOOOOOOOOOOOO	XXXXXXXXXXXXX	////////////////////

BACK



FRONT



What bothers you more (ie. pain, numbness, etc.)?

- Back _____ % vs. Neck _____ % = 100%
- Back _____ % vs. Leg(s) _____ % = 100%
- Neck _____ % vs. Arm(s) _____ % = 100%

OSWESTRY DISABILITY INDEX

Patient's name: _____ Date: _____

Please check the option that best applies to your back or leg pain at this time. Omit any section which does not apply to you.

Section 1: Pain Intensity

- I have no pain at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst manageable at the moment.

Section 2: Personal care (washing, dressing)

- I can look after myself normally but it's causing extra pain.
- I can look after myself normally but it's very painful.
- It is painful to look after myself and I am slow and careful
- I need some help to manage the most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed, wash without difficulty and stay in bed.

Section 3: Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floors but I can manage if they are conveniently positioned (e.g. on a table).
- I can lift only very light weights.
- I cannot lift or carry any thing at all.

Section 4: Walking

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than a mile
- Pain prevents me from walking $\frac{1}{4}$ of a mile.
- Pain prevents me from walking more than 100 yards.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

Section 5: Sitting

- I can sit in any chair as long as I like.
- I can sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than 1 hour.
- Pain prevents me from sitting more than $\frac{1}{2}$ hour.
- Pain prevents me from sitting more than 10 minutes.
- Pain prevents me from sitting at all.

Section 6: Standing

- I can stand as long as I want without extra pain
- I can stand as long as I want but it gives me extra pain.
- Pain prevents me from standing for more than 1 hour.
- Pain prevents me from standing for more than ½ hour
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

Section 7: Sleeping

- My sleep is never disturbed by pain.
- My sleep is occasionally disturbed by pain.
- Because of pain, I have less than 6 hours of sleep.
- Because of pain, I have less than 4 hours of sleep.
- Because of pain, I have less than 2 hours to sleep.
- Pain prevents me from sleeping at all.

Section 8: Sex life

- My sex life is normal and causes no extra pain
- My sex life is normal but causes some extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life nearly absent because of pain.
- Pain prevents any sex life at all.

Section 9: Social life

- My social life is normal and causes no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sports.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted social life to my home
- I have no social life because of pain.

Section 10: Traveling

- I can travel without pain.
- I can travel anywhere but it gives me extra pain.
- The pain is bad but I manage trips of over 2 hours.
- The pain restricts me short necessary journeys that are less than 30 minutes.
- Pain prevents me from traveling except to receive treatment.

Section 11: Previous treatment

Over the past three months have you received treatment, tablets, or medicines of any kind for your back or leg pain?

Please check the appropriate box.

- No. Yes (If yes state the type of treatment you received: _____)

CURRENT MEDICAL HISTORY SHEET

NAME: _____ **AGE:** _____ **DATE:** _____

GENERAL MEDICAL DR: NAME: _____

ADDRESS: _____

TELEPHONE: _____

CHIEF COMPLAINT: _____

HISTORY OF PRESENT ILLNESS

How long have you had this _____

Have you had any treatment for it: No Yes...Please list: _____

Do you have medication for this problem: _____ Does it help? Yes No

Please circle: Have you had: X-rays MRI CT Scan Bone Scan
Other: _____

Have you had: Physical Therapy Other Therapy: _____

PLEASE LIST ALL THE PRESCRIPTION MEDICATIONS YOU TAKE NOW:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

PLEASE LIST ANY OVER-THE-COUNTER MEDICATIONS: VITAMINS; HERBAL COMPOUNDS ETC. YOU TAKE:

ARE YOU ALLERGIC TO ANY MEDICATIONS: NONE KNOWN

YES
(LIST): _____

DO YOU HAVE ANY ALLERGIES TO FOODS OR OTHER SUBSTANCES: NONE KNOWN

YES (LIST):

PLEASE LIST THE NAMES AND TELEPHONE NUMBERS OF ALL YOUR TREATING PHYSICIAN'S:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

OTHER CONCERNS:

PAST MEDICAL HISTORY

PLEASE MARK THE CONDITIONS YOU HAVE: NONE
 ARTHRITIS CARDIOVASCULAR DISEASE DEPRESSION DIABETES
 EMPHYSEMA GASTRIC ULCER HIGH BLOOD PRESSURE KIDNEY DISEASE
LIST SIGNIFICANT ILLNESS YOU HAVE HAD IN THE PAST NONE LIST (strokes, seizures, etc.):

PAST SURGICAL HISTORY

NONE LIST (all surgeries with dates) HAVE YOU EVER HAD A BLOOD TRANSFUSION: YES NO

SOCIAL HISTORY:

DO YOU DRINK ALCOHOLIC BEVERAGES: SOCIALLY DAILY HOW MANY DRINKS: _____

DO YOU SMOKE: NEVER QUIT _____ YEARS AGO YES SINCE _____ PACKS DAILY _____

PLEASE NOTE ANY OTHER SIGNIFICANT FAMILY OR SOCIAL EVENT: _____

FAMILY HISTORY:

IS YOUR MOTHER LIVING: YES, AGE: _____ IN GOOD HEALTH NO, CAUSE OF DEATH _____

IS YOUR FATHER LIVING: YES, AGE: _____ IN GOOD HEALTH NO, CAUSE OF DEATH _____

SIBLINGS: BROTHER(S) _____ LIVING _____ DECEASED: CAUSE _____

SISTER(S) _____ LIVING _____ DECEASED: CAUSE: _____

ANY SIGNIFICANT FAMILY ILLNESSES: _____

PATIENT HISTORY

What is your occupation? What activities does your job involve (i.e. computing, driving, lifting)? List hobbies and sports that you enjoy. Does your current problem affect participation in these activities?

Please indicate your tolerance in regards to how your back and/or neck limits each activity:

Activity	←5 min.	15-30 min.	> 60 min.	> or = 2 h	unlimited	Other
Sitting						
Standing						
Walking						
Driving						

Note how the following activities are affected by your back or neck symptoms by checking the appropriate box.

Back Issues	Never Disturbed	Rarely	Sometimes	Frequently	Always Disturbed
Sleeping					
Turning in bed					
Morning Stiffness					
Rising from a chair					
Leaning (over a sink, making a bed)					
Bending (putting on shoes & socks)					
Cough/sneeze					
Pain with bowel movements					
Incontinence					
Neck Issues	Never Disturbed	Rarely	Sometimes	Frequently	Always Disturbed
Reading					
Working at a desk					
Turning head right (i.e. backing up a car)					
Turning head left					
Looking up (i.e. rinsing hair)					

Justin Paquette, M.D.

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Tel: (310) 855 0752 • Fax: 310 272 7839

MEDICAL INFORMATION RELEASE ONLY

I hereby authorize Dr. Paquette to furnish information to insurance carriers concerning this injuries/illness.

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

If the patient is a minor or incompetent, the parent or guardian should sign below, and in addition, the minor or incompetent patient should sign above, if at all possible.

Parent's or Guardian 's signature: _____ Date: ____/____/____

**MEDICAL INFORMATION RELEASE
ASSIGNMENTS OR BENEFITS**

I hereby authorize Dr. Paquette to furnish information to insurance carriers concerning this injuries/illness, and I hereby irrevocably assign to the doctor all payments for medical services rendered and all major medical benefits.

I understand that I am financially responsible for charges not covered by this authorization, and/or the balance not paid by insurance.

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

If the patient is a minor or incompetent, the parent or guardian should sign below, and in addition, the minor or incompetent patient should sign above, if at all possible.

Parent's or Guardian's signature: _____ Date: ____/____/____

**MEDICAL INFORMATION RELEASE
RESEARCH AND PUBLICATION**

I hereby authorize Dr. Paquette to use my medical information (including photographs) for the purposes of research studies and possible publication. I understand that my identity will be kept anonymous.

→ I hereby give permission for my photograph to be used unaltered.

→ I hereby authorize that any photograph used be altered to conceal my facial identity.

I hereby authorize Dr. Paquette to use my medical information only (no photographs) for the purposes of research studies and possible publication. I understand that my identity will be kept anonymous.

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

If the patient is a minor or incompetent, the parent or guardian should sign below, and in addition, the minor or incompetent patient should sign above, if at all possible.

Parent's or Guardian's signature: _____ Date: ____/____/____

Name of the patient: _____ Date: ____/____/____

A copy of this authorization shall be as valid as the original

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NOTICE OF PRIVACY PRACTICES

To our patients

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Epic Medical Management is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use of disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care, such as family members and friends. We are not required to agree to your request. However, if you do agree, we are bound by our agreement except when otherwise required by law, emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Giovanni Ayala Office Manager/Privacy Officer** or you may call **310-855-0752** for further information.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Epic Medical Management at 8670 Wilshire Blvd. Ste. 206, Beverly Hills, CA 90211. You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, **contact Giovanni Ayala, Office Manager/Privacy Officer at 310-855-0752**. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Epic Medical Management will obtain your written authorization for uses or disclosures that are not identified by this notice or our health information privacy policies, please contact Epic Medical Management at 8670 Wilshire Blvd., Suite 206, Beverly Hills, CA, 90211

I hereby acknowledge that I have been presented with a copy of Epic Medical Management Notice of Privacy Practices.

Name of the patient: _____

Date: ____/____/____

Signature: _____

Epic Medical Management

Statement of Patient Financial Responsibility

Epic Medical Management is dedicated to providing the highest quality orthopaedic medical care for our patients. As a professional courtesy, our staff will bill your insurance carrier for you at no extra cost.

In the event the insurance carrier may not reimburse part or all of the professional and/or treatment claims of our patients, the patient will then become responsible for any remaining unpaid portion.

We will submit bills and attempt to obtain reimbursement from your insurance carrier for up to 90 days from the date of service. After 90 days, the patient will be required to remit payment for any remaining balance regarding services rendered but not yet paid.

When necessary, patients (the client) may also contact their insurance companies on their own behalf to urge compliance of payment and with the principles of general fairness and equity.

We will do our best to determine eligibility and coverage information from the insurance carriers but ultimately, it is the patient's responsibility to know what his/her benefits are.

Should you have any further questions or concerns, our finance department would be happy to speak with you.

I have read and understand, and will agree to comply with, the above stated financial policy.

I understand that I am financially responsible for the balance of any professional or treatment sessions for which payment has for any reason been denied by my insurance carrier. This includes treatment sessions not covered by my insurance company upon medical review, or treatments that may no longer be covered by insurance as a result of denied status.

(Patient's Signature)

(Date)

(Please Print Name)

HEALTHCARE LIEN

Justin Paquette, M.D.

8670 Wilshire Blvd. Suite 206, Beverly Hills, California 90211

Patient Name: _____ **DOB:** ____/____/____

Patient SSN: _____ - _____ - _____

Date of Injury: ____/____/____

Patient authorizes Provider(s) to furnish his/her Attorney and insurance carrier with a full report of examination, diagnosis, course of treatment, prognosis, and any other relevant information concerning his/her care and treatment for the aforementioned injury. Patient further authorizes his/her Attorney and insurance company to furnish Provider(s) with information concerning the merits, viability and status of Patient's injury claim.

Patient hereby gives this Lien to Provider against all proceeds (whether by settlement, judgment or award, including all Med-Pay advances), derived from Patient's injury claim to secure payment of all fees owed Provider(s) by Patient for treatment furnished Patient for the aforementioned injury. This Lien, regardless of when executed, shall apply retroactively to all care and treatment furnished Patient by Provider(s) arising out of aforementioned injury.

Patient understands and agrees that this Lien attaches against all proceeds derived from Patient's injury claim as soon as the proceeds are received, by either Patient or his/her Attorney. Patient authorizes and directs his/her Attorney and insurance carrier to withhold from any settlement, judgment or award all funds necessary to fully and completely satisfy this Lien.

Patient further authorizes and directs his/her Attorney to honor this Lien and make full payment thereon as soon as possible and prior to and in advance of distributing any of the proceeds derived from Patient's injury claim to Attorney or Patient. It is understood and agreed that payment shall be tendered without regard to setoff, unresolved claims against other third parties, or apportionment or pro-rata distributions to other healthcare providers.

Patient and Attorney understand that this Lien is offered for the protection of Provider and in consideration for Provider agreeing to await payment for services rendered to Patient. Patient understands and agrees that payment of Provider's fees is not contingent on Patient's receipt of a favorable settlement, judgment or award and that he/she remains directly and fully responsible to Provider for all services rendered him/her. Patient agrees that if no suit on the injury claim is filed by Attorney within the statutory period provided therefore, that all Providers' fees shall become due and payable immediately upon expiration of the statutory period.

Attorney and Patient hereby agree to immediately notify Provider(s) in the event Patient retains new or different legal counsel. Patient directs his/her new counsel to execute a new copy of this Lien and otherwise honor the terms thereof.

Attorney agrees that his/her status as trustee for those funds recovered on Patient's behalf will change from trustee to debtor if Attorney: (1) does not directly and fully and completely pay Provider for services furnished Patient that is subject to this Lien (absent a written agreement signed by Provider accepting a compromised amount in lieu of full payment; (2) releases/forwards the funds from Patient's settlement, judgment or award from his/her trust account prior to satisfaction of this Lien; or (3) refuses to withhold that amount owed Provider from the funds obtained on Patient's behalf by way of settlement, judgment or award.

Patient, Attorney and Provider agree that if enforcement of this Lien, or any portion thereof, is required, all disputes for less than \$5,000 will be submitted to Small Claims Court for resolution while all disputes in amount in excess thereof will be submitted to binding arbitration with any award therefrom confirmed by a court of competent jurisdiction. Patient, Attorney and Provider further agree that if enforcement of this Lien, or any portion thereof, is required, that the prevailing party shall be entitled to recover Attorney's fees, arbitration fees and costs, jointly and severally, from the non-prevailing part(ies).

I/we have read and fully understand this lien and agree to be bound by its terms.

Dated: _____

(Patient Signature)

Dated: _____

(Attorney Name)

(Attorney Signature)