PAUL H. CHIU, M.D.

707 S. Garfield Ave. Ste 304
Alhambra, CA 91801
(626) 281-PAIN (7246) (626) 281-9040 FAX

Name:_____
Last Name **First Name** **M.I.**

Date of Birth:_____ **Age:**_____ **Gender:Male/Female**

Home Address_____
Street **City** **State /Zip Code**

Home Phone:(___) _____ - _____ **Cell Phone (___) _____**

E-Mail:_____ **Social Security #: _____ - _____ - _____.**

Occupation: _____

Emergency Contact: _____ **(___) _____ - _____**
Name **Relationship** **Phone Number**

Referral Physician_____ **Physician's Office Phone (_____) _____.**

Health Insurance Carrier _____ **Member ID**_____

Medical Group _____

Subscriber's Name _____

Language Preference: □ English □ Spanish □ Mandarin □ Cantonese □ Vietnamese □ Other _____

How Did you hear about our office? **□ Newspaper** **□ Ad** **□ Yellowpages** **□ Other** _____

☐ ***I clearly understand that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my insurance benefits are denied.***

☐ ***I clearly understand that the initial consultation is only for pain assessment and does not imply any agreement of dispense of pain medications or injection therapies.***

☐ ***I understand that I will be charge for picking up prescriptions due to early refill, if approved by the doctor.***

Patient's Signature _____ **Date:** _____

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Patient Name:
D.O.B:
Age:
Date:

HIPPA Acknowledgement

I understand that I have the right to review **Paul H. Chiu, M.D., Inc**. Notice of Privacy prior to signing this consent. I understand **Paul H. Chiu, M.D., Inc** reserves the right to change their notice and practices, and I will be given new notification if this occurs. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations, and the organization is not required to agree to re restriction requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I understand that I am authorizing the release of all or any part of my medical record for the purposes of treatment, payment, or practice operations. This release may include records containing information regarding the diagnosis and/ or treatment of HIV/ AIDS, mental illness, and/ or drug and/ or alcohol addiction or abuse to any person or corporation which is or may be liable under a contract for all or part of the medical charges, including but not limited to: Medicare, MediCal, or other private or public health insurance programs, reviewing agencies, worker's compensation carriers, welfare agencies or patient's employer. The record may be needed in order to process a claim for medical services. I authorize **Paul H. Chiu, M.D., Inc** to release information needed for billing purposes to entities that may provide services pertinent to my physician visit, such as reference laboratories.

Signature of Patient or Legal Representative _____ Date _____

Printed Name of Patient _____ Witness _____

Release of Medical Information to Family Members
During the course of your treatment it may become necessary to discuss your condition with a family member or family friend. Below, please indicate to whom may we discuss your condition and/ or treatment with:

Spouse Name:

Family Member Name (s):

Friend(s) Name(s)

Restrictions
Please do not my treatment with:

Documentation of Failure to Obtain Signed Acknowledgement. I presented this acknowledgement to the patient. The patient refused to provide a signature when requested

Staff Member Signature _____ Date _____

707 S. Garfield Ave. #304
Alhambra, CA 91801
(626) 281-PAIN (7246)
(626) 656-1296 (Fax)

Paul H. Chiu, M.D., Inc.

Vanguard IPS 介入性疼痛治療中心

PATIENT – FACILITY
ARBITRATION AGREEMENT

1. It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

2. I voluntarily agree to submit to arbitration any and all claims involving persons bound by this agreement (as set forth in Article 3) whether those claims are brought in court, contract or otherwise. This includes but is not limited to, suits for personal injury, actions to collect debts, or any kind of civil action.

3. I understand and agree that this Patient-Facility Arbitration Agreement binds me, my heirs, assigns or personal representative and the undersigned facility, the professional corporation or partnership, if any, its employees, partners, heirs, assigns or personal representative and any consenting substitute physician. I also hereby consent to the intervention or joinder in the arbitration proceeding of all parties relevant to a full and complete settlement of any dispute arbitrated under this agreement.

4. I agree to accept medical services from the undersigned facility and to pay for those services in full the priced determined by the facility. I UNDERSTAND THAT IF I DO SIGN THE AGREEMENT AND CHANGE MY MIND WITHIN 30 DAYS OF TODAY, THEN I MAY REVOKE THIS AGREEMENT BY GIVING WRITTEN NOTICE TO THE UNDERSIGNED FACILITY WITHIN THAT TIME STATING THAT I WANT TO WITHDRAW FROM THIS ARBITRATION AGREEMENT. After those 30 days, this agreement may be changed or revoked only by a written revocation signed by both parties.

5. I have read and understood this Agreement, and this writing makes up the entire arbitration agreement between the undersigned facility and me.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_____ _____
(Patient or parents if patient is a minor) Date Time

_____ _____
Witness Date Time

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Fax: (626) 281-9040

Patient Name:
D.O.B:
Age:

Paul H. Chiu, M.D.
OPIOID THERAPY INFORMED CONSENT

Patient Name: _____ Date: _____

Opioid treatment for chronic pain can be used extremely effectively and successfully to reduce pain and improve what you are able to do each day. Along with opioid treatment, other medical care may be prescribed to help improve your ability to perform daily activities. This may include exercise, use of non-opioid analgesics, physical therapy, psychological counseling and/or other therapies or treatment.

I, _____, understand that compliance with the following guidelines is important in continuing pain treatment with

Dr. **Chiu .**

1) I understand that I have the following responsibilities:
   a) I will take medications only at the dose and frequency prescribed.
   b) I will not increase or change medications without the approval of this doctor or the designated clinician within this doctor's practice.
   c) I will actively participate in this doctor's efforts and programs designed to improve functionality (including social, physical, psychological and daily or work activities).
   d) I will not request opioids or any other pain medicine from physicians other than from this doctor. This doctor will be informed of, approve or prescribe all other mind and mood altering drugs.
   e) I will inform this doctor of all other medications that I am taking.
   f) I will obtain all medications from one pharmacy, with full consent for this clinical practice to talk with the pharmacist or other appropriated pharmacy personnel, given by signing this informed consent.
   g) I will protect my prescriptions and medications. No controlled substance prescriptions will be replaced by this office for any reason. I will keep all medications from children.
   h) I agree to participate in psychiatric or psychological assessments as deemed necessary by my medical provider.

   i) If I have an addiction problem, I will not use illegal or street drugs or alcohol. This doctor may ask me to follow through with a program to address this issue. Such programs may include, but are not limited to the following:
      i) 12-step program and securing a sponsor
      ii) Individual counseling
      iii) Inpatient or outpatient treatment
      iv) Other: _____

2) I am responsible for signing a consent to request record transfer to this doctor. No more than 3 days of medications may be prescribed by any emergency room or other medical provider without approval from this medical staff.

3) I understand that I will consent to random drug screens as deemed appropriate by this doctor or affiliated medical staff. A drug screen is a laboratory test in which a sample of my urine is checked to see what drugs I have been taking. I understand that my medical provider may require blood analysis specific to opioid levels and/or hormone levels, since testosterone and estrogen have been shown to significantly decrease during chronic opioid therapy.

4) I will keep my scheduled appointments and/or cancel my appointment a minimum of 24 hours prior to the appointment. I understand that this doctor may stop prescribing opioids or change the treatment plan if:
   a) I do not show any improvement in pain from opioids or my functionality has not improved or certain pre-established goals remain unmet.
   b) My behavior is inconsistent with the responsibilities outlined in #1 above.
   c) I give away, sell or misuse the opioid medications or other controlled substances.
   d) I develop rapid tolerance or loss of improvement from the treatment.
   e) I obtain opioids or other controlled substances from other than this doctor.
   f) I refuse to cooperate when asked to provide a urine or blood sample if requested.
   g) If an addiction problem is identified as a result of prescribed treatment or any other addictive substance.
   h) If I am unable to keep follow-up appointments.

_____ _____

Patient Signature Date

_____ _____

Physician Signature Date

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Patient Name:
D.O.B:
Age:
Date:

OPIOID TREATMENT INFORMED CONSENT (continued)

YOUR SAFETY RISKS WHILE UNDER THE INFLUENCE OF OPIOIDS:
You should be aware of potential side effects of opioids such as decreased reaction time, clouded judgment, drowsiness and tolerance. Also, you should know about the possible danger associated with the use of opioids while operating heavy equipment or a motor vehicle. Read and follow any warnings on your prescription bottles. If you have any questions, ask your doctor.

POSSIBLE SIDE EFFECTS OF OPIOIDS:

- Confusion or other change in thinking abilities
- Breathing too slowly – overdose can stop your breathing and lead to death
- Aggravation of depression
- Problems with coordination or balance that may make it unsafe to operate dangerous equipment or motor vehicles
- Sleepiness or drowsiness
- Nausea
- Dry mouth
- Vomiting
- Constipation

THESE POTENTIAL SIDE EFFECTS MAY BE MADE WORSE IF YOU MIX OPIOIDS WITH OTHER DRUGS, INCLUDING ALCOHOL

POSSIBLE RISKS OF OPIOIDS:

- Physical dependence. This means that abrupt stopping of the drug may lead to withdrawal symptoms characterized by one or more of the following:

Runny nose	Sweating
Difficulty sleeping for several days	'Goose bumps'
Diarrhea	Rapid heart rate
Abdominal cramping	Nervousness

- Psychological dependence/Addiction. A small percentage of patients may develop psychological dependence and addiction problems based on genetic or other factors. These conditions are characterized by compulsive opioid use despite potential or real harm.
- Tolerance. This means you may need more and more drug to get the same effect.
- Problems with pregnancy. If you are pregnant or contemplating pregnancy, discuss opioid use with your physician.

RECOMMENDATIONS TO MANAGE YOUR MEDICATIONS:

- Keep a diary of the pain medications you are taking, the medication dose, time of day you are taking them, their effectiveness and any side effects you may be having.
- Use a medication box that you can purchase at your pharmacy that is already divided in to the days of the week and times of the day so it is easier to remember when to take your medications.
- Take along only the amount of medicine you need when leaving home so there is less risk of losing all your medications at the same time. Ask your pharmacist to provide an extra, small bottle for your opioid medication(s) so that you may carry a only a small supply of medication that is properly labeled.

I have read this document, understand and have had all my questions answered satisfactorily. I consent to the use of opioids to help control my pain and I understand that my treatment with opioids will be carried out as described above.

Patient Signature Date Physician Signature Date

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Patient Name:
D.O.B:
Age:
Date

Patient Information Release Form

Patient's Name: _____ D.O.B.: _____

The above named patient has requested release of his/her personal records.

Attached are the items contained in his/her medical chart

1. Consultation note
2. Progress note
3. Operative reports
4. Laboratory reports
5. MRI/ X-ray reports
6. Procedure logs
7. Medication logs

Below you will find an authorization signed by the patient for the release of this information.

Thank you for your kind attention.

Sincerely,

Paul H. Chiu, M.D.

This is your authority to release any and all information pertaining to my medical care, including laboratory reports, imaging studies, procedure notes, medication list, etc.

Signed_____

Print Name _____

Date_____

PAUL H. CHIU, M.D.
Vanguard Interventional Pain Specialists

Patient Name:
DOB: **Sex: M / F**
Date:

Vitals	
BP	mmHg
Pulse	bpm
Weight	lbs.
Height	ft in

Initial Pain Evaluation

Please help us understand your pain by answering the following questions (circle all that apply):

Date of Injury:

_____

Cause of Injury:

☐ Motor Vehicle Accident ☐ Slip and Fall

☐ Work Related ☐ Other: _____

Details of motor vehicle accident:

Your position in car:
☐ Driver
☐ Passenger
☐ Right Back Seat
☐ Left Back Seat
☐ Pedestrian

Did you have restraints on?
☐ Wearing seatbelt
☐ Not wearing seatbelt

Where?
☐ Local street
☐ Freeway
☐ Parking lot

Did the airbags deploy?
☐ Yes ☐ No

Mechanism of injury:

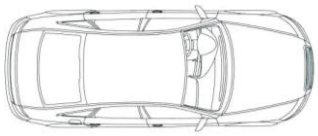
Were you?

☐ Tensed ☐ Unprepared

Was the vehicle?

☐ Moving ☐ Stopped

Mark where your car was impacted.



Where was your head facing?

☐ Left ☐ Forward

☐ Right ☐ Unknown

Hands positioned on steering wheel:

☐ Right hand ☐ Left hand

☐ Both hands

Did you feel pain immediately after the accident?

☐ Yes ☐ No

If no, when did the pain start? _____

Did you lose consciousness?

☐ Yes ☐ No

If yes, how long?_____

Was your head impacted during the collision?

☐ Yes ☐ No

Did any part of your body strike the vehicle?

☐ Yes ☐ No

If yes, explain: _____

Comments: _____

_____

Following the Accident:

Check all that apply:
☐ Ambulance/ Paramedics called
☐ Police arrived
☐ Treated at scene

Did you go to the hospital?
☐ Transported to Hospital
☐ Got medical attention on own

Where did you go?:

_____

When?:_____

What did they do at the hospital?
☐ Diagnostics preformed at hospital
☐ Medications prescribed
☐ Other treatment at hospital:

_____

Diagnostic tests performed:

☐ MRI ☐ CT scan
☐ X-Rays ☐ Discogram
☐ Myelogram ☐ EMG/NCV
☐ Other:_____

Translated by:_____

Transcribed by:_____

PAUL H. CHIU, M.D.

Vanguard Interventional Pain Specialists

Patient Name:

DOB: **Sex: M / F**

Date:

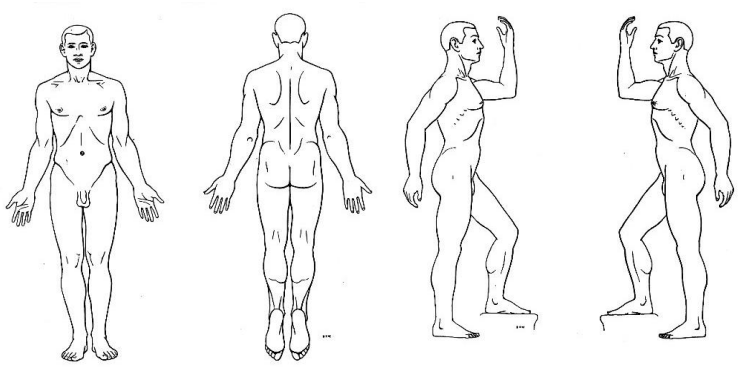
Where is your pain? Please indicate where is your pain located on the diagram.

Pain Scale:

0: No pain
1-3: Mild pain
4-5: Moderate pain
6-7: Moderate-severe pain
8-9: Severe pain
10: Worst possible pain

Frequency:

Constant: 24/7
Intermittent: On/off
Occasional: 5-25% of the time



Instruction: Please use the three boxes below to indicate your main areas of pain, check all the boxes that apply to that specific pain location. If you do not have three areas of pain, please leave the remaining box(es) blank. If you have any questions, please let us know, thank you.

PRIMARY pain location (choose one): ☐ neck ☐ lower back ☐ **R / L** shoulder ☐ **R / L** knee ☐ **Other:_____**

On a scale from 1-10 what is your pain level? Now:_____/10 Worse:_____/10

Frequency:	**Quality of pain:**		**What makes the pain worse:**		**What makes the pain better:**	
☐ Constant	☐ Dull	☐ Throbbing	☐ Heat	☐ Lying	☐ Heat	☐ Massage
☐ Intermittent	☐ Aching	☐ Radiating	☐ Cold	☐ Coughing	☐ Cold	☐ Resting
☐ Occasional	☐ Sharp	☐ Numb	☐ Walking	☐ Sneezing	☐ Walking	☐ Medication
	☐ Burning	☐ Tingling	☐ Sitting	☐ Lifting	☐ Sitting	☐ Other:
	☐ Penetrating	☐ Other:_____	☐ Standing	☐ Pushing	☐ Lying	_____
Does the pain radiate (pain, numbness, tingling)?			☐ Pulling	☐ Bending		
☐ Yes ☐ No			☐ Straining	☐ Being still		
Where?_____			☐ Turning	☐ Other: _____		

SECONDARY pain location (choose one): ☐ neck ☐ lower back ☐ **R / L** shoulder ☐ **R / L** knee ☐ **Other:_____**

On a scale from 1-10 what is your pain level? Now:_____/10 Worse:_____/10

Frequency:	**Quality of pain:**		**What makes the pain worse:**		**What makes the pain better:**	
☐ Constant	☐ Dull	☐ Throbbing	☐ Heat	☐ Lying	☐ Heat	☐ Massage
☐ Intermittent	☐ Aching	☐ Radiating	☐ Cold	☐ Coughing	☐ Cold	☐ Resting
☐ Occasional	☐ Sharp	☐ Numb	☐ Walking	☐ Sneezing	☐ Walking	☐ Medication
	☐ Burning	☐ Tingling	☐ Sitting	☐ Lifting	☐ Sitting	☐ Other:
	☐ Penetrating	☐ Other:_____	☐ Standing	☐ Pushing	☐ Lying	_____
Does the pain radiate (pain, numbness, tingling)?			☐ Pulling	☐ Bending		
☐ Yes ☐ No			☐ Straining	☐ Being still		
Where?_____			☐ Turning	☐ Other: _____		

Continued on next page…….

PAUL H. CHIU, M.D.

Vanguard Interventional Pain Specialists

Patient Name:

DOB: **Sex: M / F**

Date:

TERTIARY pain location (choose one): ☐ neck ☐ lower back ☐ **R / L** shoulder ☐ **R / L** knee ☐ **Other:_____**

On a scale from 1-10 what is your pain level? Now:_____/10 Worse:_____/10

Frequency:	**Quality of pain:**		**What makes the pain worse:**		**What makes the pain better:**	
☐ Constant	☐ Dull	☐ Throbbing	☐ Heat	☐ Lying	☐ Heat	☐ Massage
☐ Intermittent	☐ Aching	☐ Radiating	☐ Cold	☐ Coughing	☐ Cold	☐ Resting
☐ Occasional	☐ Sharp	☐ Numb	☐ Walking	☐ Sneezing	☐ Walking	☐ Medication
	☐ Burning	☐ Tingling	☐ Sitting	☐ Lifting	☐ Sitting	☐ Other:
	☐ Penetrating	☐ Other:_____	☐ Standing	☐ Pushing	☐ Lying	_____
			☐ Pulling	☐ Bending		
			☐ Straining	☐ Being still		
			☐ Turning	☐ Other: _____		

Does the pain radiate (pain, numbness, tingling)?

☐ Yes ☐ No

Where?_____

Do you have any weakness? ☐ Yes ☐ No **If yes, where? _____**

Do you have problem controlling your bowels or bladder? ☐ Yes ☐ No

Have you ever had pain or an injury in this/these area(s) BEFORE? ☐ Yes ☐ No

If yes, explain. _____

Did the pain resolve completely? ☐ Yes ☐ No

If no, what was your previous pain level (0-10) BEFORE this new injury. _____

Physicians seen for this complaint (name):

Chiropractor: _____ ☐ Ongoing ☐ Completed

Physical Therapist: _____ ☐ Ongoing ☐ Completed

- **Does/did it help?** ☐ Yes ☐ No

Physician: _____

Orthopedist: _____

Neurologist: _____

Other: _____

Have you received any of the following treatments?:

☐ Massage	☐ Bed rest
☐ Therapeutic exercises	☐ Heat/Ice
☐ Acupuncture	☐ Electrical Stimulation
☐ Ultrasound	☐ Topical pain relievers
☐ Injections	☐ Adjustments
☐ Medications	☐ Other:_____

Pain medications/NSAID tried: **Did it help?** ☐ Yes ☐ No

☐ Over-the-Counter pain relievers/NSAID: _____	☐ Muscle Relaxants: _____
☐ Prescription pain relievers/NSAID:_____	☐ Corticosteroids: _____

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DOB: **Sex: M / F**
Date:

Additional concerns (check any that apply after the accident):

☐ Headaches	☐ Difficulty concentrating	☐ Hearing Loss	☐ Irritability/Anger
☐ Dizziness	☐ Ringing in ears	☐ Nervousness	☐ Unhappiness
☐ Loss of balance	☐ Trouble sleeping	☐ Nausea	☐ Demoralization and Apathy
☐ Vision disturbance	☐ Fatigue	☐ Anxiety	☐ Other: _____
☐ Forgetfulness	☐ Weight gain	☐ Depression	_____

Duties under Duress - Living or work duties that are difficult for you to perform.

☐ Work	☐ Driving
☐ Yardwork	☐ Taking care of children
☐ Laundry	☐ Using the computer
☐ Cleaning	☐ Other: _____
☐ Studying	

Activities of Daily Living - Activities that are difficult for you to perform.

☐ Dressing	☐ Writing	☐ Traveling
☐ Self-care	☐ Household	☐ Climbing stairs
☐ Eating	☐ Sports activities	☐ Getting in/out bed
☐ Sexual activity	☐ Social activities	☐ Other: _____
☐ Reading	☐ Hobbies	_____

Medical History

Medical Problems:

☐ Heart Disease	☐ Abnormal Heart Rhythm	☐ High Cholesterol	☐ Kidney Disease
☐ Shortness of Breath	☐ Hepatitis	☐ High Blood Pressure	☐ Shingle
☐ Diabetes-Type___	☐ Arthritis	☐ Chest Pain	☐ Others:_____
☐ Bleeding Disorder	☐ Asthma:	☐ Bladder/ Bowel Dysfunction	

List any previous surgeries/dates:

_____
_____
_____
_____
_____
_____

List ALL current medications:

_____
_____
_____
_____
_____

List ANY allergies to medications:

☐ Penicillin
☐ Sulfa drugs
☐ Aspirin, Ibuprofen or other non-steroidal anti-inflammatory agents
☐ Other:_____
☐ **No known drug allergies**

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Vanguard Interventional Pain Specialists

Patient Name:

DOB: **Sex: M / F**

Date:

Social History

Status:	**Occupation:**	**Check all that apply:**
☐ Married ☐ Divorced	**Job title:_____**	**Do you smoke?** ☐ Yes ☐ No
☐ Single ☐ Widow	☐ Retired ☐ Temporary disability	**Do you drink alcohol (how much)?**
☐ Separated	☐ Unemployed ☐ Permanent disability	☐ Yes_____ ☐ No
	Is your work physically demanding? ☐ Yes ☐ No	**Do you take any other drugs?** ☐ Yes ☐ No

Notes: _____

_____

_____

Certification

I certify that I have answered truthfully all the questions, and have not knowingly withheld any information concerning any of the above problems, either past or present.

_____ _____

Please print your name and signature Date

_____

Physician's Signature

*****WE DO NOT REFILL MEDICATIONS BY TELEPHONE. ALL MEDICATION REFILLS MUST BE DONE IN PERSON DURING REGULAR OFFICE HOURS. Please make sure you are given sufficient medications or enough refills to last until your next appointment.**