Dr. Rainier Guiang, M.D.
Dr. Gary Pang, M.D.
6900 Brockton Ave., Ste 103, Riverside, CA 92506
2083 Compton Ave., Ste. 104, Corona, CA 92881

Phone: 951-784-7111
Bus Fax: 951-823-0378
Referral/Medical Records: 866-287-0329

Financial Disclosure/ Assignment of Benefit

I understand that the physician's billing staff will file all claims for services rendered to my insurance carrier. I authorize and direct my insurer/payor to pay directly to University Pain Consultants, any and all applicable benefits that would otherwise be payable to me for reimbrusement of services rendered, up to the amount of my bill plus legal interest and penalties accruing as allowed.

Insurance Information: **No Insurance - I am a Cash Patient** ☐

Primary Ins:			Secondary Ins:		
HMO	PPO		HMO	PPO	
If HMO, Primary Care Physician:			If HMO, Primary Care Physician:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
ID#:	Grp#:		ID#:	Grp#:	

Leave Address blank if HMO enrollee

If you are not the named policyholder, please complete the following section:

Subscriber Name:			
Birthdate:	SSN:	Gender:	Phone:
Employer Name:		Employer Phone:	
Employer Address:	City:	State:	Zip:

***Is this due to a Motor Vehicle Accident? No Yes**

Litigation: Yes No	Med Pay Policy#:	Policy Amount:
Date of Accident:	State:	Adjuster's Name:
Auto Ins Carrier:	Policy#:	Adjuster's Phone:

***Is this a Worker's Comp Injury? No Yes**

Work Comp Carrier:		Adjuster's Name:
Claim Number:	Adjuster's Phone#:	Date of Injury:
Attorney: Yes No	Atty Name:	Atty Phone#:

I, however, acknowledge that I am responsible for any balances that may be due to the physician because of:

Co-Insurance or Co-Pay Amount	Exhausted Auto Benefits
Yearly Deductibles	Denied Worker's Comp Benefits
No Referral obtained from Primary	Failure to respond to Insurance Carrier Correspondence
Non Covered Services	Failure to respond to Coordination of Benefits Inquiry
Out of Network Services	Failure to provide current and/or insurance changes
Terminated Coverage	No Insurance Coverage or Inaccurate policy information
No Shows or Late Cancellations of Appointments = ******$50 per failure to show or cancel***	

Dr. Rainier Guiang, M.D.
Dr. Gary Pang, M.D.
6900 Brockton Ave., Ste 103, Riverside, CA 92506
2083 Compton Ave., Ste. 104, Corona, CA 92881

Phone: 951-784-7111
Bus Fax: 951-823-0378
Referral/Medical Records: 866-287-0329

Financial Disclosure/ Assignment of Benefit

I understand that I will receive a statement for any balance due, after the claim has been processed by my carrier. I understand and am agreeable that the balance of my statement will be paid in full to the physician within 30 days.

If I am unable to pay the entire amount (applies to amounts of $150.00 or more), I am responsible to immediately, on receipt of the statement, call the billing office 951-784-7111.

I understand that my failure to pay my balance or arrange payments and follow the payment agreement, may result in Collection Agency action.

In the event that payments are made to the providers and myself as joint payees or, directly to me as an individual payee, I agree to cooperate and to ensure that the provider receives all amounts due for services rendered.

I authorize the providers/billing department to pursue any means necessary to collect all charges on my account including follow up calls, appeals, arbitration and civil suit, if allowable under law. In the event such action is necessary against the carrier, this assignment shall allow an attorney of their choosing for any unpaid and underpaid claims.

I understand that my information, under certain circumstances may be released for one of the following reasons:

- Other health care professionals in order to coordinate my care or treatment
- Insurance adjuster - if my claim is a work or motor vehicle injury
- Employer - if my claim is related to a work injury
- Attorney - if my claim is in a litigation process
- Health insurance carrier for chart audit reason, and for claim payment

I understand that University Pain Consultants and/or their staff and the billing office will not release any information to myself or family members over the phone without verification of my identity in order to comply with privacy regulations.

This office is not responsible for any disclosure of your confidential medical information once we provide this information, AT YOUR request, to your insurer, employer, family member or otherwise.
With this full understanding, I indemnify and hold harmless this practice for any disclosure, which is out of my physicians, their staff and/or their billing office control.

By my signature, I state that I have read, understand, and agree to this Authorization and Release.

Patient:__________________________ Guardian Signature :________________________

Date: __________ Date: __________

UNIVERSITY
Pain Consultants

Phone: 951-784-7111
Bus Fax: 951-823-0378
Referral/Medical Records: 866-287-0329

Dr. Rainier Guiang, M.D.
Dr. Gary Pang, M.D.
6900 Brockton Ave., Ste 103, Riverside, CA 92506
2083 Compton Ave., Ste. 104, Corona, CA 92881

Medical Record Authorization of Release

Date of Request: ___________

Patient Name:	Date of Birth:
Primary Contact Number:	

Request Type:	**To be used for:**
Account Ledger	Personal
Claim Copies	Medical Evaluation/ Treatment
Medical Records	
Electronic Copy Paper Copy	

Request Information from: **Send Information to:**

Name of Entity or Provider:		
Address:		
City:	State:	Zip Code:
Phone Number:		Fax Number:

Request Information from: **Send Information to:**

Name of Entity or Provider:		
Address:		
City:	State:	Zip Code:
Phone Number:		Fax Number:

Scope of Records: Please send or retrieve

All information contained within my medical record regarding reason for referral or treatment including progress notes, operative reports, radiology reports (CT's, X-rays, MRI's), labs and insurance demographics.				
All information and care received between the dates of ________________and __________________.				
Other information: (please specify)				
Notes	Xrays	MRI	CT	Labs
Operative Reports				

Acknowledgement:

I have received a copy of my request, in hardcopy form, in person, dated, ___________________.

Name (print): ____________________________________Signature: ____________________________

Electronic Request Office Staff Initials:

Fax Copy	Email Copy	Date Sent:

UNIVERSITY
Pain Consultants

<u>Please bring the following to your appointment:</u>

1. **Valid Government I.D.**
2. **Insurance card**
3. **No checks accepted for co-pays**

New Patient Information

First:	Middle:	Last:	Date of Birth:	Age:
Home Phone:	Cell Phone:	Email address:	SSN:	
Address:	City:	State:	Zip Code:	

Emergency Contact Person:	DOB:	Address:	Telephone:

Race / Ethnicity (optional):	Preferred Language:

Referring Physician:	Address:	Telephone:
Primary Care Physician:	Address:	Telephone:

Reason For Your Visit (ex: back pain, neck pain):
How long ago did the pain start?
Was there an event that caused the pain? If so, explain:
Is there any type of litigation (law suit) involved with your pain? If so, explain:
How do you describe the pain? (circle all that apply)

sharp	dull	aching	burning	electrical
lancinating	stabbing	throbbing	deep	cramping
numb	tingling	pins & needles	swelling	shooting
other:				

How often do you experience the pain?

Rarely	Occasionally	Intermittently	Continuously

Please rate your average pain score from 0-10 (0 being no pain and 10 being excruciating pain):

Rating	1	2	3	4	5	6	7	8	9	10

Activities or factors that worsens your pain		Activities or factors that relieve your pain	
Sitting	Other:	Sitting	Other:
Standing		Standing	
Walking		Walking	
Driving		Driving	
Flexion/extension/twisting		Flexion/extension/twisting	
Lifting		Lifting	
Lying down		Lying down	
Changes in weather		Changes in weather	
Exercise		Exercise	

Previous Pain Physician (name, dates of treatment, and reason for not continuing treatment):

Previous Treatments:

Type of treatment:	Dates and effect of the treatment:
Acupuncture	
Chiropractic	
Physical therapy	
Psych / Behavioral therapy	
Cortisone by mouth	
Cortisone by injection	
Nerve blocks	
Epidural injections	
Facet injections	
Spinal cord stimulator / Morphine pump	
Discogram	
Surgery	
TENs Unit	
Other: (explain)	

Other Medical Problems: (examples: diabetes, heart disease, depression)

Please list all surgeries you have had:

Family medical history: (list any medical problems that run in your family)

Marital status: single / married / separated / divorced / widowed / other:________________________

With whom do you live with?

Occupation:	Employer:	Highest Level of Education:

Do you do any of the following? Past or present			
Smoke?	Yes	No	How much and for how long?
Drink Alcohol?	Yes	No	What type and how often?
Ever used illegal drugs?	Yes	No	What type and how often?
Ever convicted of a Felony?	Yes	No	

Medication Allergies

Medication	Reaction:

Current Non-Pain Medications:

Name:	Dosage and how often taken:

Pain Medications:

Medication name:	Dose and how often taken:

Previously Tried Pain Medications

Name and dose	Reason for stopping

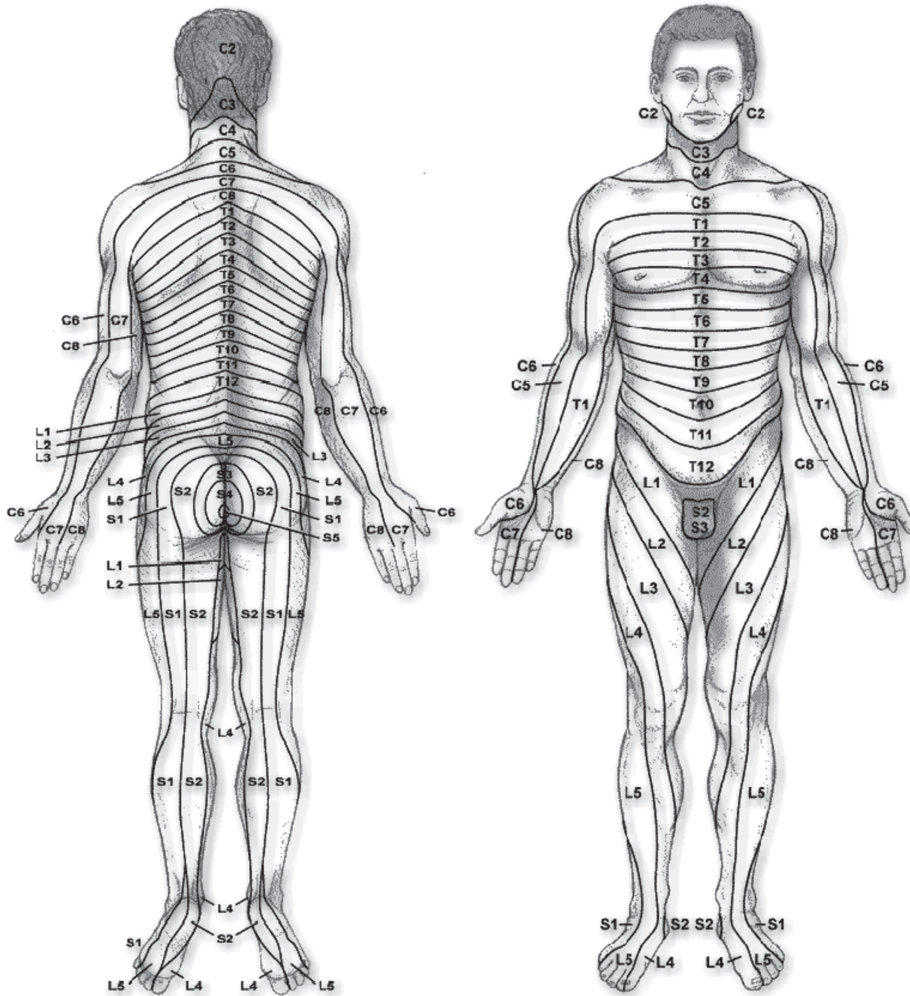
Do you take any blood thinning medications? Warfarin (Coumadin) Plavix Heparin

Review of systems:

Any problems with your breathing or respiratory system?	Yes / No	
Any chest pain or shortness of breath?	Yes / No	
Any problems with your digestive system?	Yes / No	
Any problems with your kidneys or urinary system?	Yes / No	

Any problems with your mood?	Yes / No	

Label the painful areas on the diagram below



Physicians Notes
Gen
HEENT
CVS
Resp
Abd
GU
Ext
Gait
ROM
Fl/Ex
Rotation
Palp
Facet
FABER
SI
Str
Sensory
SLR
Reflexes

Please list any of the following tests you have had for this pain:

Test	Date and location of report	Physicians notes:
MRI / CT Scan		
Xrays		
EMG / Nerve conduction study		
Discogram		
Bone Scan		
Blood tests		

Physicians Notes (do not write in this area)

Assessment:

Plan:

Follow up: _____ days _____ weeks ______ months _______ PRN

ESI C/T/L	MBB C/T/L	Blk	MRI C/T/L	CT	Xray	EMG	UDS	PT	OC
SCS	ITP								

Dr. Rainier Guiang, M.D.
Dr. Gary Pang, M.D.
6900 Brockton Ave., Ste 103, Riverside, CA 92506
2083 Compton Ave., Ste. 104, Corona, CA 92881

Phone: 951-784-7111
Bus Fax: 951-823-0378
Referral/Medical Records: 866-287-0329

Authorization for Release of Health Information

Your health information is protected and to maintain those privacy practices, please read and complete.

How May We Communicate With You? **Date:**

Patient Name:	Date of Birth:
Primary Contact Number:	Email Address:

For Personal Messages: (appointment reminders are automated)

Home Ph:	Voicemail: Yes No	Msg w/ others: Yes No
Cell Ph:	Voicemail: Yes No	Msg w/ others: Yes No

Information Sharing:

None at this time:	I would like my account password protected	Password:

If you would like us to personally communicate with someone other than yourself (including spouses, partners and children), on your behalf regarding appointments, medical conditions, treatments and financials, please complete this section.

Alternate Patient Representative Name:	
Relationship to Patient:	Telephone Number:
Formal Power of Attorney on file: Yes No	(if yes, please provide copy to office for legal purposes)

Exclusions: You may release to the above named person all information EXCEPT

Appointments Info:	Medication List:	Conditions/ Diagnoses:
Treatment/ Procedures:	Financials:	Drug, alcohol use/abuse or behavioral health treatment:

Commencement: Authorization is valid

Single Use Only:	One year from today:	Until Revoked in Writing:

Other medical record information: Please note when requesting information, we will release that which has been created by and pertains to your interaction with our providers. All other records must be obtained directly from those treating entities. There may be a fee associated with printing of your records. You are entitled to free copies in electronic format. Additional formats, or releases to providers, persons and attorneys are subject to fees.

Acknowledgement: I, hereby acknowledge that I have received and understand the Notice of Privacy Practices for University Pain Consultants and have completed the above of my own accord.

Name (print):______________________________________Signature: __________________________________

Office Use Only: Picture ID Verified Employees Initials:

Individual Refused to Sign	Communication barrier prohibited obtaining release
Emergency prevented obtaining release	Patient seen at alternate facility

Dr. Rainier Guiang, M.D.
Dr. Gary Pang, M.D.
6900 Brockton Ave., Ste 103, Riverside, CA 92506
2083 Compton Ave., Ste. 104, Corona, CA 92881

Phone: 951-784-7111
Bus Fax: 951-823-0378
Referral/Medical Records: 866-287-0329

OPIOID Medication Policy

University Pain Consultants is a comprehensive pain management clinic. We utilize many different avenues of treatment in addressing our patient's pain complaints. If you are currently taking a medication that is an opioid based medication such as morphine, oxycodone, hydrocodone, methadone, hydromorphone, fentanyl, or any other such drug, you will be assessed by our physicians and a determination will be made regarding whether or not the continuation of such medications is, in their opinion, appropriate or not.

Having an appointment with one of our doctors **does not** in any way obligate them to continue the prescribing of these medications.

Policy regarding marijuana use:
Our physicians do not prescribe opiate medications to patients using marijuana in any form even if the patient has a valid medical marijuana card.

Polity regarding criminal history:
Our physicians do not prescribe opiate medications to patients with a history of illicit drug use (past or present), misdemeanor or felony convictions pertaining to narcotics including driving while under the influence, or history of violence in any form.

In the event your physician determines that prescribing an opioid based medication for your condition is appropriate, the following conditions may apply prior to obtaining a prescription for the medication:

1) Agreeing to the conditions of our opioid contract (to be discussed later)
2) Obtaining the results of a blood or urine drug screen if necessary
3) Allowing our physician(s) to discuss your case with any of your previous health care providers
4) Obtaining a psychological or psychiatric evaluation (if necessary)

By signing below, I am agreeing to and understand the terms and conditions as state above:

Signature: ______________________________ Dated: ________________

Name (print): ____