



NOTICE OF PRIVACY PRACTICE

We Care About Your Privacy

OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

OUR LEGAL DUTY

Law requires us to:

- Keep your medical information private
- Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information
- Follow the terms of the current notice

We have the right to:

- Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law
- Make the changes in our privacy practices and the new terms of our notice effective for medical information that we keep, including information previously created or received before the changes

Notice of change to privacy practices:

- Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request

USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

For Treatment

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurse, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

For Payment

We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

For Health Care Operations

We may use and disclose your medical information for your health care operations. This might include measuring and improving quality, evaluating the performance of employees conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

Additional Uses and Disclosure

In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory

Unless you notify us that you object, the following medical information about you will be placed in our facility directories; your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification

We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We still share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information about you.

Disaster Relief

We may share medical information with public or private organization or person who can legally assist in disaster relief efforts.

Fundraising

We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances

We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner

To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions

Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings

We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials.

We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities

As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or condition.

Victims of Abuse, Neglect, or Domestic Violence

We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it's necessary to prevent a serious threat to your health or safety of the health and safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Worker's Compensation

We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities

We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement

Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders

We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services

We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

YOUR INDIVIDUAL RIGHTS

You have the right to:

- Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photo copies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may ask the receptionist for the form needed to request access. There may be charges for copying and for postage if you want the copies mailed to you. Ask the receptionist about fee structure.
- Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
- Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
- Request that we communicate with you about your medical information by different means or to different locations. This request must be made in writing to our Privacy Officer.
- Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
- To receive a copy of this privacy notice, please request a copy from receptionist.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice, please ask the receptionist to speak to our Privacy Officer. If you think we have violated your privacy rights, you may speak to our Privacy Officer and submit a written complaint. To take either action, please inform the receptionist that you wish to contact the Privacy Officer or request a complaint form. You may submit a written complaint to the U.S. Department of Health and Human Services; we will provide you with the address to file your complaint. We will not retaliate in any way if you choose to file a complaint.

This privacy practices are currently in effect and will remain in effect until further notice.

September, 2011

2452 Fenton Street Suite 101, Chula Vista, CA 91914
Phone (619) 600-5309 • Toll Free (866) 671-2871 • Fax (619)655-4700



Navarro Pain Control Group, Inc.

Rosa M. Navarro, MD

Board Certified Anesthesiology

Subspecialty Certification in Intervention Pain Management

ACGME Fellowship Trained

ABMS Boarded Anesthesiology/ABA Pain Medicine

navarropaincontrolgroup.com

NOTICE OF PATIENT PRIVACY

September, 2011

Navarro Pain Control Group, Inc. is committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION

We may require your written consent before we use or disclose to others your medical information for purpose of providing or arranging for your healthcare, the payment for or reimbursement of the care that we provide you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. The effective date at the top right hand side of this page indicated the date of the most current Notice in effect.

You have the right to receive a copy of our most current Notice in effect. If you have not yet reserve a copy of our current Notice, please ask at the front desk and we will provide you with a copy.

If you have any questions, concerns or complaints about the Notice or your medical information, please contact our Practice Manager or Dr. Rosa M. Navarro at (619)600-5309.

Signature

Date

Witness

PLEASE LIST THOSE INDIVIDUALS WITH THEIR RELATIONSHIP TO YOU WITH WHOM WE MAY COMMUNICATE

Name

Relationship

Name

Relationship

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NEW PATIENT AGREEMENT AND CONSENT TO INDIVIDUAL TREATMENT PLAN

1. **INSURANCE**
 - a. Representation-The undersigned, hereafter referred to as "Patient," agrees that any information submitted with respect to insurance is accurate, valid, and covers the patient as described.
 - b. Assignment of Benefits-The patient agrees that any and all benefits provided for by such insurance is reassigned to Pain Control Associated of San Diego, Inc. and any of its' employees, nurses, medical providers, and physicians, hereafter collectively referred to as "provider," for services rendered.
 - c. Duty to inform-The patient agrees and promises to keep provider aware of any changes to, or cancellation of, relevant insurance, which is submitted as guarantee of payment.
2. **FINANCIAL RESPONSIBILITY**
 - a. Co-Payments-The patient agrees and understands that all co-payments specified by the insurance carrier are due and payable before the patient sees the provider.
 - b. Deductibles-The patient agrees and understands that they are responsible to inform provider of any annual deductibles on the insurance policy not yet met, and are responsible to remit the relevant amounts at the end of the visit.
 - c. Billing-The patient agrees and understands that billing is submitted to their insurance carrier as a courtesy. If such payment is revoked or refused because premiums are not paid or insurance is otherwise invalid, the patient will be responsible for the unpaid balance.
3. **APPOINTMENTS**
 - a. Making-The patient understands and agrees that all appointments are made in advance by calling the office. Further, the patient understands that there are no walk-in appointments. The patient understands the provider prefers that all patients are referred from a primary care provider who is responsible for implementation of recommendations as a result of the consultation.
 - b. First Visit-The patient understands and agrees that an initial visit does not constitute an agreement between patient and provider of ongoing, primary care and management. Rather, a first visit constitutes a consultation only, which may lead to an agreed individual treatment plan for the management of pain only. The patient understands further that an initial visit does not guarantee dispensing of prescriptions, in particular controlled substances (narcotics).
 - c. Keeping-The patient understands and agrees they are responsible for attending a scheduled appointment and that if it is necessary to cancel or reschedule they must do so at least 24 hours in advance of the scheduled appointment.
 - d. Missing-The patient understands and agrees that missing appointments may deprive other patients an opportunity to see the provider, and will be required to pay a fee of \$75.00 upon being a "no-show" a second time. If the patient is a "no-show" three times, the patient will be discharged from the practice and require a new consultation from the referring provider.
4. **INDIVIDUAL TREATMENT PLAN**
 - a. Compliance-The patient understand and agrees that the provider will make recommendations and outline a treatment plan that includes a combination of behavioral modification, interventional procedures, and possibly medication management, and that compliance with this plan is vital for the best possible chance of improvement. The patient promises to be compliant with this agreed treatment plan and that if circumstances arise or conditions change such that the patient cannot be compliant, the patient will inform the provider so that a mutual agreeable change, if deemed medically viable in the sole judgment of the provider, to the treatment plan can be effected.
 - b. Choice-The patient understands and agrees that they have a choice of whether or not to undergo procedures in terms of pain management. However, the patient also understands and agrees that the provider primarily specializes in interventional procedural pain management, and if the only choice of the patients is medical management, a consultation will be completed and the patient will be referred back to the primary provider for medical management implementation. If this is not acceptable to the patient, a list of physicians who provide primarily medical management in the treatment of chronic pain will be given to the patient and the patient then further agrees that all requirements of California Senate Bill 420 ("Pain Patient Bill of Rights") will have been met.
 - c. No Guarantee of Performance-The patient understands and agrees that pain is a symptom, not a diagnosis. Further, pain is an individual experience that impacts life psychologically, socially, and physically. As such, a pain treatment plan is individualized based and results may vary. These treatments may r may not be effective as perceived by the patient. The provider will endeavor to find a treatment plan that is mutually satisfactory; however, under no circumstances does this constitute a warranty of performance or guarantee. If the patient is dissatisfied with services rendered, the sole remedy will be governed by section 4b and 6b of this agreement.
 - d. Individual Treatment Plan Components
 - i. Medications-Defined as drugs taken or applied as directed by the provider as part of the individual treatment plan.
 1. On-label-patient understands and agrees that medications may be prescribed and that some of these may have a Federal Drug Administration (FDA) approved and studied indication for the treatment of pain.
 2. Off-Label-The patient also understands and agrees that research and development of medications is lengthy and expensive, and further that some medications which do not have an express FDA approved indication (Off-label), are known to be effective in the management of pain. Some of these medications may be part of the individual treatment plan. Some examples include anti-depressants, topical medications, and anti-epileptic drugs.
 3. Generic and choice- The patient understands and agrees that the provider may directly offer to sale to the patient medications that are part of the treatment plan. These medications meet FDA standards in labeling and meet requirements as generic alternatives. The patient understands they have no obligation to purchase these medications directly from the provider.
 4. Opioids- The patient understands and agrees that this class of medications, also known as narcotics, is controlled by the drug enforced agency (DEA) and appropriate local, state, and federal authorities. Drugs in this class include, but are not limited to, Vicodin, Percocet, Norco, Lortab, Fentanyl, Dilaudid, Demerol, Methadone, Morphine, and Oxycontin. These drugs are "scheduled" and under no circumstances will a prescription be given over the phone or on a walk-in basis. The patient understands and agrees that not all individual treatment plans will include opioids, and that the provider will have choice in deciding whether or not, based on medical judgment the patient is a candidate for these medications. If mutually agreed that these medications will be part of the individual treatment plan, then the "Opioid Informed Consent and Agreement" will exclusively govern their use.

- ii. Procedures- Defined as surgical interventions involving needles, injections, or minor surgical procedures, performed either in the office or in a surgical suite.
 - 1. On-Label and Off-Label- The patient understands that part of the treatment plan may include interventional procedures. Some of these procedures may be considered "experimental" or off-label. However, any decision to go forward with a procedure will be made mutually after discussion of informed consent, alternatives, risks, and benefits.
 - 2. Not covered by Insurance- Some recommended procedures might not be covered by insurance. The provider will endeavor to obtain pre-approval for any agreed procedure. This may delay scheduling of the procedure. In the event the insurance carrier declines coverage, the patient agrees they have the choice to undergo the NON-covered procedure, but agree to be financially responsible for the provider's usual and customary charge.
 - 3. No Guarantee of Performance- Response to procedures is as individual as the pain syndrome treated. As such, there is no guarantee of performance or warranty for any procedure performed.
- iii. Adjuncts- Defined as non-procedural or medical interventions for the treatment of pain.
 - 1. Behavioral therapy- The patient understands and agrees that psychological factors, such as depression, are caused or worsened by chronic pain. These conditions may actually cause more pain, and as such, the overall pain syndrome may not improve without behavioral therapy to lessen the impact of these factors. The patient understands and agrees that behavioral therapy may be prescribed as part of the individual treatment plan. Further, non-compliance with recommendations may be addressed by section 4a of this agreement. Also the patient understands that opioid "narcotic" therapy may require ongoing behavioral therapy and that non-compliance will be governed by the "Opioid Informed Consent and Agreement"
 - 2. Physical Therapy- The patient understands and agrees that physical therapy is a structured, individualized, physical conditioning program, which is particularly effective in managing many pain syndromes. This may be prescribed as part of the individualized treatment plan. The patient will endeavor to be compliant with referrals.
 - 3. Other consultations- The patient may also be interested in alternative therapies, such as acupuncture. These therapies may not be covered by insurance. The provider will make recommendations and referrals to licensed acupuncturists, however, the handling of payment and insurance will be strictly between the patient and the acupuncturist. Failure to follow alternative therapy recommendations does not constitute a breach of compliance by the patient.

5. SEVERABILITY

- a. Treatment complete- The patient agrees and understands that the doctor/patient relationship is terminated when the patient or provider deems treatment complete. This may occur when the pain syndrome has either resolved (rarely), or when the pain is adequately managed to the satisfaction of the patient. However, treatment complete may also occur when all avenues, as governed by the provider's medical judgment, have been exhausted in the management of the patients' pain syndrome. Treatment complete may be designated as well if there are repeated instances of failure to comply with the individuals treatment plan.
- b. Return to Primary Care or Referring Physician- The patient understands and agrees that under no circumstances will provider function as a primary care provider, rather is performing as a specialist solely for the management of pain syndrome. The patient understands and agrees that any abnormality found on laboratory tests or imaging (MRI, CT scan, X-ray) not directly related to the pain syndrome may require a return to the primary care physician. As a result, the patient promises to maintain a relationship with a designated primary care provider and to follow-up exclusively with that individual for non-pain syndrome related conditions. Also, the primary care provider or referring provider will be the point of contact once treatment is deemed complete.
- c. Patient dissatisfaction with Provider and/or Individual Treatment Plan- The patient agrees and understands that any time should the patient become dissatisfied with their progress in management of their pain syndrome their sole remedy shall be to request a list of other pain management physicians in accordance with California Senate Bill 420, The Pain Patients' Bill of Rights.

6. LIABILITY

- a. Pain and Suffering- The patient agrees and understands that a pain syndrome by definition is a subjective state of pre-existing pain and suffering, and as such agrees not to hold provider responsible for any pain and suffering allegations related to this condition or make any allegations of causation through any treatment by the provider.
- b. Dissatisfaction with Individual Treatment Plan- The patient agrees and understands that the sole remedy for dissatisfaction with progress in management of their wholly subjective pain syndrome is requesting a list of other pain management specialist as kept by the local medical society in accordance with California Senate Bill 420.
- c. Agreement to Arbitrate- The patient agrees and understands that as a condition to develop an individual treatment plan following the first consultation, the patient agrees to waive any trial by jury for allegations of medical malpractice or patient abandonment. The patient further agrees that all medico-legal and legal disputes will instead be governed by binding arbitration in accordance with Cal. Civ. Proc. Code§ 1295 9West 1982).

7. SURVIVABILITY

- a. If any portion of this agreement is deemed invalid, the remaining portions of this agreement shall continue in full effect.

Signed and agreed by patient (printed name)

Signature

Date

Witness (printed name)

Signature

Date



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 - 5. Not covered by Insurance- Some recommended procedures might not be covered by insurance. The provider will endeavor to obtain pre-approval for any agreed procedure. This may delay scheduling of the procedure. In the event the insurance carrier declines coverage, the patient agrees they have the choice to undergo the NON-covered procedure, but agree to be financially responsible for the provider’s usual and customary charge.
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 - 5. Physical Therapy- The patient understands and agrees that physical therapy is a structured, individualized, physical conditioning program, which is particularly effective in managing many pain syndromes. This may be prescribed as part of the individualized treatment plan. The patient will endeavor to be compliant with referrals.
 - 6. Other consultations- The patient may also be interested in alternative therapies, such as acupuncture. These therapies may not be covered by insurance. The provider will make recommendations and referrals to licensed acupuncturists, however, the handling of payment and insurance will be strictly between the patient and the acupuncturist. Failure to follow alternative therapy recommendations does not constitute a breach of compliance by the patient.
5. SEVERABILITY
- a. Treatment complete- The patient agrees and understands that the doctor/patient relationship is terminated when the patient or provider deems treatment complete. This may occur when the pain syndrome has either resolved (rarely), or when the pain is adequately managed to the satisfaction of the patient. However, treatment complete may also occur when all avenues, as governed by the provider’s medical judgment, have been exhausted in the management of the patients’ pain syndrome. Treatment complete may be designated as well if there are repeated instances of failure to comply with the individuals treatment plan.
 - b. Return to Primary Care or Referring Physician- The patient understands and agrees that under no circumstances will provider function as a primary care provider, rather is performing as a specialist solely for the management of pain syndrome. The patient understands and agrees that any abnormality found on laboratory tests or imaging (MRI, CT scan, X-ray) not directly related to the pain syndrome may require a return to the primary care physician. As a result, the patient promises to maintain a relationship with a designated primary care provider and to follow-up exclusively with that individual for non-pain syndrome related conditions. Also, the primary care provider or referring provider will be the point of contact once treatment is deemed complete.
 - c. Patient dissatisfaction with Provider and/or Individual Treatment Plan- The patient agrees and understands that any time should the patient become dissatisfied with their progress in management of their pain syndrome their sole remedy shall be to request a list of other pain management physicians in accordance with California Senate Bill 420, The Pain Patients’ Bill of Rights.
6. LIABILITY
- a. Pain and Suffering- The patient agrees and understands that a pain syndrome by definition is a subjective state of pre-existing pain and suffering, and as such agrees not to hold provider responsible for any pain and suffering allegations related to this condition or make any allegations of causation through any treatment by the provider.
 - b. Dissatisfaction with Individual Treatment Plan- The patient agrees and understands that the sole remedy for dissatisfaction with progress in management of their wholly subjective pain syndrome is requesting a list of other pain management specialist as kept by the local medical society in accordance with California Senate Bill 420.
 - c. Agreement to Arbitrate- The patient agrees and understands that as a condition to develop an individual treatment plan following the first consultation, the patient agrees to waive any trial by jury for allegations of medical malpractice or patient abandonment. The patient further agrees that all medico-legal and legal disputes will instead be governed by binding arbitration in accordance with Cal. Civ. Proc. Code § 1295 9West 1982).
7. SURVIVABILITY
- a. If any portion of this agreement is deemed invalid, the remaining portions of this agreement shall continue in full effect.

Signed and agreed by patient (printed name)

Signature

Date

Witness (printed name)

Signature

Date

2452 Fenton Street Suite 101 • Chula Vista, CA 91914 • Phone (619)600-5309 Fax (619)655-4700



Navarro Pain Control Group, Inc.
Rosa M. Navarro, MD
Board Certified Anesthesiology
Subspecialty Certification in Intervention Pain Management
ACGME Fellowship Trained
ABMS Boarded Anesthesiology/ABA Pain Medicine

LONG TERM NARCOTIC THERAPY FOR THE TREATMENT OF NON-CANCER PAIN INFORMED CONSENT/AGREEMENT FORM

You have agreed to a trial of opioid (narcotic) treatment for your pain. Opioids include medications such as Percocet, Morphine, Methadone, etc. These include any medication classified as Schedule II or III by the DEA. The purpose of this treatment is to reduce your pain and to improve your level of function at work, at home and/or other valued activities. Alternative therapies have been explained and offered to you. You and Your doctor have elected a trial opioid therapy as only one component of treatment. It is important that you be aware of the potential risks and side effects of these medications. You need to understand that not all pain responds to narcotic medication, and that not all people react the same way to these medications. In some situations, at the discretion of your doctor, this trial may be deemed a failure and you will be discontinued from these medications.

Additionally, there are strict laws, which govern use of these controlled substances for medical conditions. As a condition of treatment with these medications, the governing agreement and its' provisions are attached and must be agreed to in their entirety.

Physical Side Effects

Possible side effects include mood changes, drowsiness, dizziness, constipation, nausea and/or confusion. Many of these side effects, if they occur, gradually resolve over days to weeks. Constipation often persists and may require management with medications. If other side effects persist, trials of alternative opioids may be necessary or opioids may need to be discontinued. You should not drive a car or other vehicle or operate machinery while your dose is being increased or if the medications make you drowsy. The sedating effects of alcohol and other sedatives are additive with the side effects of opioids. It is strongly advised that you avoid alcohol while receiving opioid therapy.

Physical Dependence

Physical dependence is an expected side effect of a long-term use of opioids if they are prescribed on a daily basis. This means that if you take opioids continuously and stop them abruptly for any reason, you will experience a withdrawal syndrome. This syndrome often includes sweating, diarrhea, irritability, sleeplessness, runny nose, tearing, muscle and bone aching, and dilated pupils. To prevent these symptoms, medications must be taken regularly if physical dependence is present. When opioids are discontinued, they should be tapered under the supervision of your physician. Do not abruptly stop taking your prescription without consulting your physician.

Addiction

Addiction is present when an individual experiences loss of control over the use of medications, is constantly seeking drugs, and/or experiences adverse consequences as a result of drug use, yet continues to take the medication. Most patients who use opioids are able to take medications as prescribed on a scheduled basis. They do not seek other drugs when their pain is controlled, and experience improvement in the quality of life as a result of the opioid medications; thus they are NOT addicted. Physical dependence does NOT indicate addiction. Individuals with a history of alcoholism, smoking and tobacco abuse, or other drug addiction may be at increased risk for the development of addiction while using opioids.

Tolerance to Medication

Tolerance to the pain-killing effects of opioids medications is possible with continuous use. This means that although there has been no physical change in the underlying condition, an increased dose of medication is required to achieve the same level of pain control experienced when the medications were initiated. We do not fully understand why, or understand what conditions, tolerance to the pain-killing effects of opioids occurs. When it does occur, it may require tapering and discontinuation of the medication. Sometimes tolerance can be handled by substituting a different opioid medication. Additionally, you should realize that if you have to undergo surgery for any reason, you will have a baseline opioid requirement and may experience more pain in your post-operative period than someone not taking these types of medication. You will need to inform your anesthetist and surgeon that you are taking these medications so that appropriate plans can be made.

Hyperalgesia

In rare cases, the opioid medications can cause pain themselves. A sign that may be happening if rapidly increases of medication (over a matter of weeks to months) to achieve the same relief. Unfortunately, there is no blood test or other examination that can reveal this. If your doctor believes this may be occurring then you will gradually tapered off ALL opioids.

Risk to Unborn Children

Children born to women who are regularly taking opioids will likely be physically dependent at birth, requiring expensive, long-term hospitalization. Women of childbearing age should maintain safe and effective birth control while on opioid therapy. Should you become pregnant, immediately contact your physician. The medication may be stopped.

I have read and understand all the above statements.

Patient's Printed Name: _____
Physician: Rosa M. Navarro, MD

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

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PATIENT COPY



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1. This agreement is a "one strike and out" agreement. Any subsequent violation of this agreement, FOR ANY REASON, will result in termination of opioid therapy. If the doctor feels there have been any violations of Federal, State, or Local laws, then these violations may be reported to law enforcement officials. You agree to hold Navarro Pain Control Group, Inc. harmless from any adverse outcome from this action.
2. You will obtain opioid pain medication prescriptions only from Navarro Pain Control Group, Inc., and agree to fill your opioid prescriptions only at a single, designated pharmacy of your choice.
3. Your opioid medication will be continued as long as there is demonstrated improvement in your pain level and function as determined by the prescribing physician (going to work, school, etc.).
4. Flare-ups or exacerbation of pain will occur from time to time and will be handled by therapies such as ice, heat, TENS, or relaxation rather than additional medications.
5. Dr. Rosa M. Navarro, MD, must see you at least once a month. It is your responsibility to make an appointment in advance. Walk-in visits for medication refills are not allowed. The schedule is generally open 2 weeks in advance. The Pain Clinic will not provide early refills, and will NOT phone in prescriptions for controlled substances under any circumstances. You will be provided a prescription only during normal clinic hours.
6. We encourage you to do your best to avoid pregnancy while on opioids. There are risks to unborn children, including, but not limited to birth defects, addiction, tolerance, and the suffering or withdrawal resulting in the need for costly and prolonged hospitalization. Women of childbearing age will undergo pregnancy screening prior to initiation of therapy and at each regularly scheduled refill visit. Should you become pregnant opioid medications may be tapered and stopped.
7. You will not receive other addictive medications such as sleeping pills (Ambien, Lunesta), tranquilizers (Valium, Xanax, etc.), or stimulants (Ritalin, etc.) from other physicians without authorization from the Pain Clinic.
8. You agree to a California Department of Justice CURES report upon signing this agreement, and regular, random occasions thereafter, which will be used by Navarro Pain Control Group, Inc. to measure your compliance with this agreement. You will allow your doctor to receive information from any health care provider or pharmacist about the use or possible misuse/abuse of opioids, alcohol and other drugs. You will submit a urine or blood specimen upon initiation of this agreement, and at random, regular intervals to measure compliance with this agreement.
9. You will take your medication exactly as prescribed. Any changes to your prescription must be discussed with your physician prior to changing. You will not share or sell your prescription, and will bring unused pain medication to each subsequent visit.
10. If you lose or misplace your prescription, you must report this to the police department and provide us with a copy of their report before a substitute prescription can be provided. If an emergency requiring opioid treatment occurs (an Emergency Room visit for example), you will contact this office the next working day and inform us of the circumstances.
11. You agree to be seen by any specialist including a psychiatrist or addictionologist at the discretion of the prescribing doctor. You will also submit to any standardized psychological assessments required by your prescribing physician, including those administered at Navarro Pain Control, Inc.
12. You must understand that your doctor will gradually take you off of your opioid medication if you do not follow the above plan, or if your doctor believes the opioids are not helping or are harming you. You expressly agree to hold Navarro Pain Control Group, Inc. harmless fro, any real or imagined consequence from tis discontinuation.
13. You agree to hold Navarro Pain Control Group, Inc. and your prescribing doctor totally and completely harmless from any claim arising out of use of these controlled substances including any event attributed to overdose, side effect, development of tolerance, dependence, addiction, failure to take the medication as ordered, or dissatisfaction with the level of pain control the medications afford you.
14. If opioid therapy is terminated, you will be provided with a de-escalating dose plan and you will be responsible to follow it. Failure to follow the de-escalating plan may result in experiencing intense, unpleasant physical withdrawal. Should this happen you expressly agree to hold the prescribing physician and Navarro Pain Control Group, Inc. harmless from this experience.
15. If opioid therapy is terminated, this does not necessarily mean you will not be able to return to Navarro Pain Control Group, Inc. for on-narcotic procedures, therapies, or medication management, it just means that your trial of opioids is considered a failure. However, if further treatment is determined to be unacceptable by either party, you will be provided the phone number to the San Diego County Medical Association, which maintains a list of other pain management doctors in your area, in accordance with California AB1120 (Pain Patients' Bill of Right). You will then be considered discharged from the practice and the treatment considered complete, and you expressly agree this cannot be construed as abandonment.

This consent has been read and understood by me, and I agree to all of the above.

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POLICY ON BLOOD THINNERS AND SPINE PROCEDURES

PRIOR TO PROCEDURES, ALL BLOOD THINNERS MUST BE STOPPED!!

Examples of blood thinners:

- To be stopped 10 days prior to scheduled procedure. Aspirin, Plavix, Aggrenox, Garlic, Fish Oil and Ginseng.
- To be stopped 7 days prior to scheduled procedure. Coumadin, Ibuprofen, Motrin, Advil, Naprosyn, Aleve or other Nonsteroidal Anti-Inflammatory.

If you have any questions about stopping blood thinners prescribed by your cardiologist, please contact their office and address your concerns. **DO NOT STOP BLOOD THINNERS** without clearance from cardiologist.

I have read and understand the above statements.

Patient Printed Name

Patient Signature

Date

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WELCOME!

NAVARRO PAIN CONTROL GROUP, INC. IS COMMITTED TO PARTNERING WITH YOU TO MAKE A DIFFERENCE.

We believe that the more you know about NAVARRO PAIN CONTROL GROUP, INC. the better we can partner with you to make a difference. So, please take a few minutes to read and become familiar with the following:

1. OFFICE HOURS: MONDAY-FRIDAY 8:00 AM-5:00 PM

2. TELEPHONE CALLS:

NAVARRO PAIN CONTROL GROUP, INC.'s Physician and clinical staff attempt to be thorough and complete during your visit, including answers to all of your questions. You will notice that the clinical staff will rarely be interrupted by the telephone during your visit (unless another doctor is calling.) This is because we ask our patients to respect one another's time by holding their questions until their scheduled visit. We encourage you to write down all of your questions so you will not forget.

In other words, NAVARRO PAIN CONTROL GROUP, INC.'s Physician, nurse or medical assistants do not accept phone calls except in very unusual circumstances. If you have a clinical question that you believe can NOT wait until your regularly scheduled visit, you may call the office at (619)600-5309. Please, follow the prompts. Your question will be assessed and triaged according to the clinical significance then responded to accordingly. Please do **NOT** leave duplicate messages.

3. CANCELLATIONS:

Cancellations not made within 24 hours will be subject to a \$25 fee. Please contact our office to cancel or re-schedule.

4. PRESCRIPTIONS:

All prescriptions must be picked up in person at a scheduled office visit, not on procedure appointment. For medications that can be called in, allow 4 working days to receive your prescription. Please call in your prescription request at (619)600-5309 x 104.

Patients who come in for pain management frequently must take medicines for a variety of ailments such as high blood pressure, diabetes, heart disease, etc. **You will need to fill these prescriptions through your Primary Care Provider.**

5. INSURANCE:

As a courtesy, NAVARRO PAIN CONTROL GROUP, INC. will file all claims to your insurance carriers for services provided. In order to extend this courtesy, we will need a picture ID and copy of insurance cards.

- Many procedures that are performed by NAVARRO PAIN CONTROL GROUP, INC. require preauthorization from your insurance carrier. It is not uncommon for authorization to require up to 10-14 days.
- Insurance coverage varies widely; we strongly recommend that you become familiar with your policy and the benefits or restrictions that are specific to your plan.
- If any changes in your insurance coverage or benefits occur while being treated at NAVARRO PAIN CONTROL GROUP, INC. you are responsible to notify us immediately.

6. FINANCIAL POLICY:

I understand that if I am not **ELIGIBLE** under the terms of my medical and hospital subscriber health insurance agreement, I am **LIABLE for all charges for services rendered**. I understand that I am responsible for any and all charges should any legal representative, court cost, and collection charges as a result of any collection activity. I further understand that lack of financial responsibility on my part may result in dismissal from the Practice.

7. CO PAY'S/DEDUCTIBLES:

If your insurance coverage requires co-pay, it will be collected when you check in, before you see the pain care provider. Deductibles are determined by your Insurance Company, NAVARRO PAIN CONTROL GROUP, INC. will notify you of your responsibility after explanation of benefits are received.

8. FORMS:

NAVARRO PAIN CONTROL GROUP, INC. requires that all types of forms be completed **during a scheduled office visit**. If you need a form filled out by the physician, please notify the scheduler of this fact. Fees are as follows:

1st page \$30.00 Each additional page \$15.00

9. OFFICE VISIT PRINTED RECORD: Same day office visit medical record will be available upon request, please ask physician

10. REFERRAL POLICY:

NAVARRO PAIN CONTROL GROUP, INC. is a specialty-based practice. Patients are scheduled upon referral only.

11. PRIMARY CARE PHYSICIAN:

If you are referred to NAVARRO PAIN CONTROL GROUP, INC. by another specialist, it is imperative that you have a relationship with a **primary care physician**. Our physician serves as consultants and cannot assume the role provided by a primary care doctor.

12. EMERGENCIES:

Fortunately, there are very few medical emergencies related to chronic pain. However, if you believe you are experiencing such an emergency, you should go immediately to the nearest urgent care facility or emergency room. The physician attending to your problem in the urgent care facility or emergency room should be the one to call and communicate with your pain care provider. You should request that physician to do so. Therefore, it is only in very unusual circumstances that an unscheduled or urgent visit is necessary.

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Patient Printed Name: _____

Patient Signature: _____

Date: _____



NEW PATIENT QUESTIONNAIRE

PATIENT NAME		DATE OF BIRTH	
DATE OF SERVICE		AGE	

Please tell us why you are here (CC): _____

Which words **BEST** describe your pain, please check all that apply

<input type="checkbox"/>	THROBING	<input type="checkbox"/>	ACHING	<input type="checkbox"/>	SHARP	<input type="checkbox"/>	DULL
<input type="checkbox"/>	BURNING	<input type="checkbox"/>	NUMBNESS	<input type="checkbox"/>	STABBING	<input type="checkbox"/>	ELECTRIC
<input type="checkbox"/>	PINS & NEEDLES	<input type="checkbox"/>	SHOOTING	<input type="checkbox"/>	THIGHNESS	<input type="checkbox"/>	

<input type="checkbox"/>	CONSTANT	
<input type="checkbox"/>	ON/OFF	
<input type="checkbox"/>	DURATION	
<input type="checkbox"/>	TIMING	
<input type="checkbox"/>	LOCATION	

PAIN	YES	NO
Did your PAIN start sudden?		
Did your PAIN start gradually?		
Where you in an accident?		
Where you injured at work?		
Is legal action pending?		

BLOOD THINNERS	
Aggrenox/Dipyridamole	Heparin/Heparin
ASA 325mg	Lovenox/Enoxaparin
Brilinta/Tricagrelor	Plavix/Clopidogrel
Cilostazol/Pletal	Prodaxa/Dabigatran
Coumadin/Warfarin	Savaysa/Edoxaban
Effient/Prasugel	Trental/Pentoxifylline
Eliquis/Apixaban	Ticlid/Ticlopidine
Fragmin/Dalteparum	Xarelto/Rivaroxaban
Ginko/Garlic/Vitamin E	

ALLERGIES	YES	NO
I have NO drug Allergies		
Do you have any Allergies		
If YES, please list Allergies		

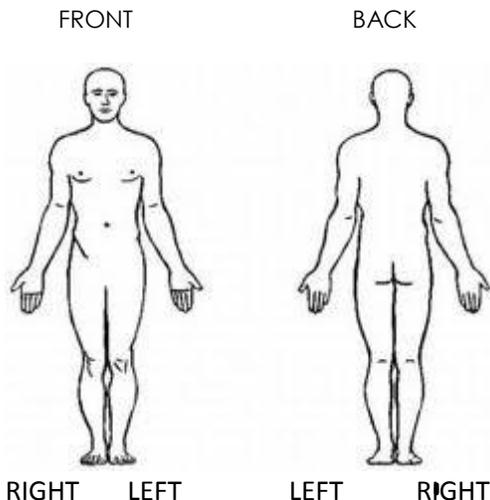
Please rate your pain on the following scale **ZERO** is **NO PAIN**, while **10** is the **WORST IMAGINABLE**

0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○

NO PAIN **WORST PAIN**

How severe is your pain: **MILD** **MODERATE** **SEVERE** **INTOLERABLE**

PLEASE MARK EVERYWHERE YOU EXPERIENCE PAIN



Have you had any	YES	NO	cervical	thoracic	lumbar	other
MRI'S						
X-Rays						
CT Scan						
CT Mylogram						



IN THE BOXES BELOW PLEASE TELL US IF YOUR PAIN LIMITS THE FOLLOWING ACTIVITIES

Does pain affect you appetite? YES/NO/Explain	How many hours per day you work? Type of work?
How many hours do you sleep?	How does the pain limit your activities? Type of activity:
What makes your pain worst?	**Is pain causing depression or anxiety? YES/NO Explain:
What makes your pain better?	**Do you smoke tobacco? If NO, <input type="checkbox"/> FORMER <input type="checkbox"/> NEVER If YES, <input type="checkbox"/> Since (date): <input type="checkbox"/> Frequency:
Urinary Problems? YES/NO/Explain	**Do you drink alcohol? If NO, <input type="checkbox"/> FORMER <input type="checkbox"/> NEVER If YES, <input type="checkbox"/> Since (date): <input type="checkbox"/> Frequency:
Bowel problems? YES/NO/Explain	**Do you do any recreational drugs? YES/NO (Cocaine, Heroin, or Marijuana)

PLEASE INDICATE IF YOU HAVE TRIED ANY OF THESE TREATMENTS AND IF THEY WERE EFFECTIVE

Treatment	Yes	No
Surgery		
Physical Therapy		
Chiropractor		
Acupuncture		
Massage		
Biofeedback		
TENS unit		
Steroid Injections/Nerve Blocks		

Onset of Pain was:	<input type="checkbox"/> Sudden
	<input type="checkbox"/> Gradual
My Pain is:	<input type="checkbox"/> Improving
	<input type="checkbox"/> Worsening
	<input type="checkbox"/> Unchanged

****PLEASE LIST ALL YOUR MEDICATIONS****

Name of Drug, and Supplements	Strength or Dosage	Number of tablets	Total number of tablets per day	Reason for taking medication

PHARMACY NAME	ADDRESS	PHONE & FAX



REVIEW OF SYSTEMS

CONSTITUTIONAL	Fever	YES	NO	Comments	URINE TOX-6	URINE TOX-12	P	N
	Weight Loss				COC	THC		
EYES	Vision Problems				OP	COC		
EARS/NOSE/MOUTH	Hearing Aids?				AMP	OPI		
CARDIOVASCULAR	Chest Pain				MET	AMP		
	Shortness of breath				BZO	MET		
	Palpitations				OXY	PCP		
	Pedal Edema				BY:	MDM		
RESPIRATORY	Cough					BAR		
	Wheezing					BZO		
GASTROINTESTINAL	Reflux					MTD		
GENITOURINARY	Urinary Tract Infection					TCA		
MUSCULOSKELETAL	Muscle Pain					OXY		
INTEGUEMENTARY	Skin					BY:		
NEUROLOGICAL	Syncope							
	Dizziness							
PSYCHIATRIC	Depression							
ENDOCRINE	Diabetes							
HEMATOLOGY/LYMPHATIC	Bleeding tendencies							
CANCER								

****PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS****

<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Insulin dep. diabetes	<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Easy Bruising
<input type="checkbox"/> Headaches	<input type="checkbox"/> Murmurs	<input type="checkbox"/> Muscle Disease	<input type="checkbox"/> Asthma
<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Broken Bones	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Pace Maker	<input type="checkbox"/> High Blood Pressure/Hypertension	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Peripheral Neuropathy	<input type="checkbox"/> Shingles
<input type="checkbox"/> Radiculopathy	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Migraine	<input type="checkbox"/> Low Back Pain
<input type="checkbox"/> Pregnancy Now	<input type="checkbox"/> Leg Pain	<input type="checkbox"/> Arm Pain	<input type="checkbox"/> Other

****PLEASE LIST ALL SURGERIES, INCLUDE ALL SPINE SURGERIES****

Surgery	Date

SOCIAL HISTORY

FAMILY HISTORY

MARITAL STATUS	LIVING STATUS	CHILDREN	FRATERNAL	MATERNAL
Married	Lives alone	YES	Alcohol	Alcohol
Single	Lives w/spouse	NO	Drug Use	Drug Use
Divorced	Lives w/family	How many?		
Widow	Other	Boy		
		Girl		

3. RIGHT UPPER EXTREMITIES

4. LEFT UPPER EXTREMITIES

- (a) Inspection and/or palpitation with notation of any misalignment, asymmetry, crepitation, defects, tenderness, masses or effusion
- (b) Assessment of range of motion with notation of any pain crepitation or contracture
- (c) Assessment of stability with notation of any dislocation (luxation), subluxation or laxity
- (d) Assessment of muscle strength and tone (e.g., flaccid, cogwheel, spastic) with notation of any atrophy or abnormal movement
- (e) Temperature, color
- (f) ROM: finger abduction/adduction: _____ shoulder abduction/adduction: _____
Scapular elevation: _____ elbow flexion: _____ wrist flexion/extension: _____
- (g) Stability, dislocation
- (h) Motor strength is: R ____/5 L ____/5 biceps flexion R ____/5 L ____/5 biceps extension
R ____/5 L ____/5 triceps flexion R ____/5 L ____/5 triceps extension
R ____/5 L ____/5 deltoid function (cogwheel, spastic)

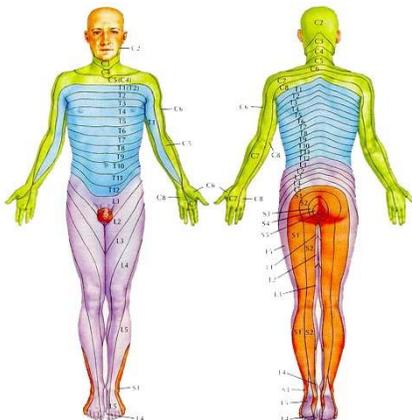
5. RIGHT LOWER EXTREMITIES

6. LEFT LOWER EXTREMITIES

- (a) Inspection, percussion and/or palpitation with notation of any misalignment, asymmetry, crepitation, defects, tenderness, masses or effusion
- (b) Assessment of range of motion with notation of any pain (e.g., straight leg raising), crepitation or contracture
- (c) Assessment of stability with notation of any dislocation (luxation), subluxation or laxity
- (d) Assessment of muscle strength and tone (e.g., flaccid, cogwheel, spastic) with notation of any atrophy or abnormal movement
- (e) Temperature, color
- (f) ROM: hips: _____, knee: _____, ankle: _____, straight leg raise test: _____R _____L
- (g) Stability, dislocation
- (h) Motor function of quadriceps femoris muscle and hamstrings muscle

	RIGHT	LEFT		
Hip Extension	____/5	____/5	Foot Inversion	____/5 _____/5
Hip Flexion	____/5	____/5	Foot Eversion	____/5 _____/5
Knee Extension	____/5	____/5	Plantar Flexion	____/5 _____/5
Knee Flexion	____/5	____/5	Dorsi Flexion	____/5 _____/5
EHL	____/5	____/5		

- VI. SKIN Inspection and/or palpitation of the skin and subcutaneous tissue (e.g., scars, rashes, lesions, Café-au-lait spots, ulcers) in 4 of the following 6 areas: (1) Head and neck (2)Trunk (3)Right upper extremities (4)Left upper extremities (5)Right lower extremities (6)Left lower extremities
- VII. ABDOMEN Soft NT/ND BS or _____
- VIII. PSYCHIATRIC Brief assessment of mental status including:
 - Orientation to time, place and person
 - Mood and affect (e.g., depression, anxiety, agitation)
- IX. NEUROLOGICAL Test coordination (e.g., finger/hose, heel/knee/shin, rapid alternating movements in the upper and Lower extremities, evaluation of fine motor coordination in young children) heel and toe walking
 - Examination of deep tendon reflexes and/or nerve stretch test with notation of pathological reflexes (e.g., Babinski)
 - Examination of sensation (e.g., by touch, pin, vibration, proprioception)



	RIGHT		LEFT
	B		C5
	BR		C6
	T		C7
	P		L4
	A		S1
	RIGHT		LEFT
	BABINSKI		BABINSKI
	CLONUS		CLONUS

MODERATE MEDICAL DECISION MAKING

- 1) Multiple diagnoses/management options
- 2) Moderate amount/complexity of data
- 3) Moderate risk of complications/morbidity/mortal

DIAGNOSIS/ASSESSMENT

MANAGEMENT OPTIONS & PLAN OF CARE

Impression (Multiple Diagnosis), (Moderate Data)

Procedures

Medications

Physical Therapy, (TENS), Psych

OTHER COMMENTS

Discussed complications of bleeding, infection, nerve damage, paralysis anaphlaxix. (PUMPS/SCS-dislodgement, disconnection, malfunction, CSF leak). Patient understands and will sign an informed consent prior to procedure. I spent more than 50 percent of my time discussing the diagnosis and treatment plan.

Smoking Cessation: Smoking Dangers (tobacco use):

Smoking and second hand smoke are harmful to your health. If you smoke, STOP! If you are around others who smoke, encourage them to stop. Smoking leads to chronic obstructive pulmonary disease, and increases risk of heart disease, cancer, and stroke. There are many medications and aids available to help you stop smoking. For additional help and/or information, call 1-800-NO-BUTTS (1-800-662-8887) or 1-800-LUNG-USA (1-800-586-4872). (99406)

Mr. /Mrs. _____ was evaluated upon request from _____, MD for consultation for _____ (diagnosis). I am basing my consultation/evaluation on records sent by _____, MD, the pain questionnaire completed by the patient, review of the diagnostic studies, and history and physical done on the patient. The patient was seen and evaluated by: _____.

Rosa M. Navarro, MD
Navarro Pain Control Group, Inc.

Date: _____