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

Board Certified Anesthesiology
Subspecialty Certification in Intervention in Pain Management

PATIENT REGISTRATION

Patient Last Name: _____ **First Name:** _____ **Middle Name:** _____

Gender: □Male □Female **DOB:** _____/_____/_____ **Age:** _____ **Marital Status:** □M □S □W □D

RACE: □American Indian □Asian □Black or African American □Hispanic □Hawaiian □White □Refuse to report □Other: _____

ETHNICITY: □Hispanic or Latina □Non-Hispanic or Latino □Refuse to report

NATIONALITY: □African-American □American □Arabian □Asian-Indian □Australian □Chinese □Filipino □French □German □Hispanic □Irish □Italian □Japanese □Korean □Mexican □Polish □Puerto Rican □Russian □Scotch-Irish □Spanish □Vietnamese

LANGUAGE: □English □French □German □Japanese □Mandarin □Russian □Spanish

Social Security#: _____-_____-_____ **Driver's License#:** _____ **Mother's Maiden Name:** _____

Home Address: _____
City State Zip Code

Home Phone #: (_____) _____ Cell/Message Phone: (_____) _____

PATIENT EMPLOYER: _____ Work Phone: (_____)_____

Work Address: _____
City State Zip Code

Occupation: _____ how were you referred to us? _____

Nearest friend or relative not living with you, in case of emergency▼ **EMAIL ADDRESS:** _____

Name: _____ Relationship: _____ Phone #: (_____)_____

INSURANCE-PRIMARY

Name of Insurance: _____ ID#: _____ Group: _____

Insured's Name: _____ Insured's Date of Birth: _____/_____/_____ Relationship: _____

Insured's Social Security #: _____-____-_____ Insurance Phone #: (_____)_____

Employer's Name: _____ Employer Address: _____
City State Zip Code

INSURANCE-SECONDARY

Name of Insurance: _____ ID#: _____ Group: _____

Insured's Name: _____ Insured's Date of Birth: _____/_____/_____ Relationship: _____

Insured's Social Security #: _____-____-_____ Insurance Phone #: (_____)_____

Employer's Name: _____ Employer Address: _____
City State Zip Code

WORKER'S COMPENSATION

Employer Name: _____ Date of Injury: _____ Claim#: _____

Insurance Company: _____ Insurance Company Phone #: (_____) _____

Claim Address: _____
City State Zip Code

Adjuster's Name: _____ Phone #: (_____)_____

ASSIGMENT & RELEASE: I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO NAVARRO PAIN CONTROL GROUP, INC. OR TO ROSA M. NAVARRO, MD. I AM FINANCIALLY RESPONSIBLE FOR ALL NON-COVERED SERVICES.

Patient Signature: _____ Date: _____

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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

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

2-PATIENT FILE

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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 ll 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" of 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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Signed and agreed by patient (printed name)	Signature	Date
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PATIENT COPY

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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, ad 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: _____ Patient's Signature: _____
Physician: Rosa M. Navarro, MD Date: _____/_____/_____

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

4-PATIENT FILE

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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: _____ Patient's Signature: _____
Physician: Rosa M. Navarro, MD Date: _____/_____/_____

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

PATIENT COPY

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

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.

Patient's Printed Name: _____ Patient's Signature: _____

Physician: Rosa M. Navarro, MD Date: _____/_____/_____

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

5-PATIENT FILE

Navarro Pain Control Group, Inc.
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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.
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POLICY ON BLOOD THINNERS AND SPINE PROCEDURES

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

- Blood thinners prescribed by a physician must be stopped temporarily prior to all procedures.
- **For Cervical Epidural Injection only**: Also stop 7 days prior to procedure all NSAID'S (i.e.Ibuprofen), Aspirin, Garlic, Fish Oil and Ginger.

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.

I have read and understand the above statements.

Patient Printed Name	Patient Signature	Date

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

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.

Patient Printed Name: _____ Patient Signature: _____

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Patient Printed Name: _____ Patient Signature: _____

Date: _____

PATIENT COPY

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

Board Certified Anesthesiology
Subspecialty Certification in Intervention in Pain Management

NEW PATIENT QUESTIONAIRE

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

	THROBING		ACHING		SHARP		DULL
	BURNING		NUMBNESS		STABBING		ELECTRIC
	PINS & NEEDLES		SHOOTING		THIGHNESS		

	CONSTANT	
	ON/OFF	
	DURATION	
	TIMING	
	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?		

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

	****BLOOD THINNERS****		
	Aggrenox/Dipyridamole		Heporin/Heporin
	Aritra/Foundaparinux		Lovenox/Enoxaparin
	Bevyxxa/Betrixaban		Plavix/Clopidogrel
	Brilinta/Tricagrelor		Prodaxa/Dabigatran
	Cilostazol/Pletal		Savaysa/Edoxaban
	Coumadin/Warfarin		Trental/Pentoxifylline
	Effient/Prasugel		Ticlid/Ticlopidine
	Eliquis/Apixaban		Xarelto/Rivaroxaban
	Fragmin/Dalteparum		

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

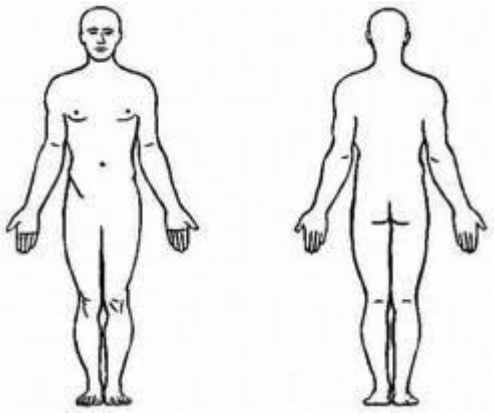
0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○

NO PAIN **WORST PAIN**

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

PLEASE MARK EVERYWHERE YOU EXPERIENCE PAIN

FRONT BACK



RIGHT LEFT LEFT RIGHT

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, ☐FORMER ☐NEVER If YES, ☐Since (date): ☐Frequency:
	Urinary Problems? YES/NO/Explain	**Do you drink alcohol? If NO, ☐FORMER ☐NEVER If YES, ☐Since (date): ☐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:		Sudden
		Gradual
My Pain is:		Improving
		Worsening
		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	Prior or Current									

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

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

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

Surgery	Date

SOCIAL HISTORY

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

FAMILY HISTORY

	FRATERNAL		MATERNAL
	Alcohol		Alcohol
	Drug Use		Drug Use

NPCG NEW PATIENT QUESTIONAIRE

LAST NAME, FIRST NAME: _____ DATE: _____

DOB: _____ AGE: _____ COMPLETED BY MA_____

REFERRED BY: _____ INSURANCE: _____

PAIN LOCATION: _____ VAS: _____

RADIATION (Where does it travel to?): _____

HOW DID IT START? _____

HOW LONG WITH THIS PAIN? _____

URINE PROBLEMS? **YES** **NO** _____

BOWEL PROBLEMS? **YES** **NO** _____

HAVE YOU SEEN A SURGEON? **YES** **NO** _____

SURGERY FOR THIS PAIN? **YES** **NO** _____

NEUROLOGIST FOR THIS PAIN? **YES** **NO** _____

RHEUMATOLOGIST FOR THIS PAIN? **YES** **NO** _____

NEUROMODULATORS? **YES** **NO** _____

CURRENT PAIN MEDICATIONS: _____

PHYSICAL THERAPY? **YES** **NO** _____

PAIN MEDICATIONS TRIED AND FAILED:

_____

IMAGES? **YES** **NO** (type of exam and dates)

_____ _____

_____ _____

OTHER: _____

_____

_____

Revised 09/09/20

Navarro Pain Control Group, Inc.
Anesthesiology
Subspecialty Certification in Intervention Pain Management
ACGME Fellowship Trained
American Board of Anesthesiology/Pain Medicine
Navarropaincontrolgroup.com

MISSED APPOINTMENT ACKNOLEDGEMENT

I acknowledge and agree that I must give at least a 24-hour notice if unable to keep an appointment. I will be responsible for a $25.00 fee for a missed appointment or same day cancelation. This fee must be paid on or before your next appointment.

If there are more than 4 missed appointments or same day cancelation, I will be discharged from NPCG care.

Thank you!

RECONOCIMIENTO DE CITA PERDIDA

Reconozco y acuerdo que tengo que dar por lo menos un aviso de 24 horas si no puede asistir a una cita. Yo seré responsable por una cuota de $25.00 por no asistir o cancelar la cita el mismo día. Esta cuota deberá pagarse en o antes de su próxima cita.

Si no asisto a mi cita o cancelo el mismo día más de 4 veces, mi tratamiento será descontinuado en NPCG.

¡Gracias!

PATIENT PRINTED NAME: _____

PATIENT SIGNATURE: _____

DATE: _____

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