Ketamine Clinics of California & Pain Therapy

1575 N. Lake Ave #100
Pasadena CA, 91104

Telephone: 626 345-9735
Fax: 626 628-0478

Patient Questionnaire

Patient Name:_____ Gender: M F Other: _____ **Age**:_____
Date of Birth:_____ SSN#:_____
Email:_____
Address: _____ City:_____ Zip Code:_____
Home Phone: _____ Cell Phone: _____

Marital Status: Single Married Divorced Widow
Children? Yes, ages _____

Emergency Care Information

Emergency Contacts
Name: _____ Relationship_____ Phone# _____

Name: _____ Relationship_____ Phone# _____

Personal Physician: Name_____ Phone: _____
Address: _____
May we contact your personal Physician to discuss medical or medication issues and/or coordinate your care?
NO_____ YES_____ if yes, please complete/sign release of information

Any Allergies? YES _____ NO _____
Allergic to:
_____
_____

Please list preferred **language**: English Spanish Armenian Other:_____
Race: White Black Hispanic Chinese Armenian Other:_____
Ethnicity: Not Hispanic/Latino Hispanic/Latino Decline to specify Other:_____
Occupation:_____

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Patient Questionnaire

Current Concerns:

Mental/Psychological symptoms: Anxiety Depression OCD PTSD Other_____

Please provide a brief description of the major concerns that led you to seek treatment/therapy now:

_____
_____
_____
_____

Previous Psychiatrist/Therapist

Name of clinician: Phone number, Address, Treatment, Dates

_____/_____/_____/_____

_____/_____/_____/_____

_____/_____/_____/_____

_____/_____/_____/_____

Describe the problems for which you sought therapy in the past: _____
_____
_____
_____

Your experience with previous therapy: Positive _____ Neutral _____ Limited _____ Negative _____

Have you been hospitalized for psychiatric or substance abuse problem? YES NO If yes, please list:
Facility: _____ Dates: _____ Reason:_____

Facility: _____ Dates: _____ Reason:_____

Please list any current medical problems:

_____
_____
_____

How is your quality of sleep? Poor Acceptable Good Other:_____

Social History

Do you smoke: YES NO; if so how often: Rarely Occasionally Often

Do you drink: YES NO; if so how often: Rarely Occasionally Often

Do you do illicit/recreational drug: YES NO

If so, please list: _____

Family History

Heart Disease: Mother Father Grandmother Grandfather

Lung Disease: Mother Father Grandmother Grandfather

Kidney Disease: Mother Father Grandmother Grandfather

Diabetes: Mother Father Grandmother Grandfather

High Blood Pressure: Mother Father Grandmother Grandfather

Do you have any allergies: YES NO; if so please list them below
(including medication)

_____
_____
_____

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Pain Management Treatment Program/Chronic Pain Medication Agreement

The following agreement relates to enrollment at the pain clinic and my use of medications prescribed for pain control. Pain medications are defined as controlled substances (narcotics) for which there are federal, state, institutional policies regarding dispensing and use.

1. I, _____ (DOB) _____Understand that I have enrolled in a Pain management program and I agree actively participate in the treatment as recommended by the pain management team/pain clinic. I recognize that my chronic pain is a complex problem and that my functioning level and coping skills can benefit from Physical Therapy, Psychotherapy, and Behavior Strategies in addition to pain management.
2. I agree to keep appointment as scheduled.
3. I agree to undergo psychological assessment and or psychiatric evaluation if needed. This can include but is not limited to psychometric testing to determine my suitability for chronic pain medications, invasive treatments, and other treatment modalities.
4. I understand that the continuous use of pain medication for more than a few days for the treatment pain (with the exception of cancer pain) is controversial, not routine, and can result in the development of a tolerance and/or mental and physical dependence.
5. I will fully inform the pain clinic of all details concerning my use of mood altering substances including alcohol, sedatives, tranquilizers, etc. I understand that taking pain medication improperly or combining it with other medications or substances can result in an interaction and /or overdose possibly causing death or brain damage.
6. I will **NOT** increase, decrease, stop, or alter my dose or use of pain medication without the prior approval of the pain clinic.
7. I will **NOT** obtain or seek pain medication from anyone other than Interventional Anesthesia & Pain Management Clinic, who is hereafter specified in my medical records as assigned to prescribe these medications to me, except in an emergency situation.
8. I will **NOT** ask the pharmacy, physician, or nurse to process prescriptions for pain medications before my scheduled refill.
   In order to prevent loss of my pain medication before the scheduled refill.
9. I will **NOT** give, sell, lend, or in any way provide my pain medication to any other person.
10. I understand that stopping some pain medications suddenly can result in uncomfortable or even painful withdrawal symptoms, heart attack, stroke, seizure, permanent damage, disability or death.
11. I will submit to unannounced observed drug testing if requested by the pain clinic. If drugs not prescribed to me or excessive levels of drugs prescribed to me are found in my blood or urine all pain medication will be discontinued and I will be discharged from the pain clinic. I will also be discharged from the pain clinic, if the pain medications prescribed to me are NOT found in my blood or urine.
12. I understand that some pain medications can cause a decrease in mental function. I accept responsibility for any decision to operate an automobile, other vehicle, machinery, or potentially hazardous device while taking any form of pain medication. I will not hold Interventional Anesthesia & Pain Management or its employees responsible for any accidents, injuries, damage or loss resulting from engaging in any activities while taking pain medication.
13. If my pain is not controlled with pain medications to the satisfaction of the pain management team/pain clinic I understand that the pain medications will be discontinue and alternate non-pharmacological interventions will be used.
14. I understand that the pain clinic has the right to discontinue my pain medications and discharge me from the pain clinic if I violate this agreement or at the discretion of the pain management team/pain clinic.
15. The complications and/or side effects of pain medications have been explained to me and I have fully understood the risks to my overall health.
16. The medications used to treat my pain are as follows:

_____

_____

_____

_____ _____

Patient's Signature Provider's Signature

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Policy Statement

WE ARE NOT A NARCOTIC CLINIC. WE DO NOT PRESCRIBE NARCOTICS. WE ARE A PAIN MANAGEMENT CLINIC. WE TREAT PAIN!

Our policy is to treat chronic pain as a complex disease which requires a well concerted multi-modality approach for diagnosis and therapy.

Pain therapy may include Medical Management **(especially opioids and other controlled substances regulated by the DEA, state, and federal laws)** which we do not offer or provide, besides in the form of advice ailments and as the providers in our practice see best for you care.

Pain therapy may also include physical therapy, surgery, and/or interventional procedures and that is where our practice fits as a subspecialty of the American Board of Anesthesiology.

We provide the procedures and interventional options in their entirety as advanced and cutting edge as modern medical research and technology has to offer.

Our clinic is a specialty clinic that uses a unique anesthesiologist approach to pain through interventional options provided qualified chronic pain syndrome sufferers.

Our clinic is procedure based and injections are the foundation and bases for the most common procedures we use to target nerve roots and branches in order to block and/or modify the pain signal transmission. We also target other sources of pain such as muscles, tendons, joints, and the central nervous system, among other things.

Our clinic policy is to keep the patient for thirty minutes after the procedure is done because the patient receives a local anesthetic which paralyzes the movement to some extent and can result in lack of control. We ask the patient to wait for thirty minutes if they have a driver and an hour if they are driving themselves.

Patients already on opioids therapy under the care of another physician will be required to provide random Urine Drug Screening samples and undergo a State of California DEA regular report review as per state recommendations.

I acknowledge reading and understanding the policy statement and that my questions have been answered.

Patients Name: _____ DOB: _____

Signature: _____ Date: _____

Thank You for the opportunity to care for your health and well-being.

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Name:_____ Date:_____

1. CONSENT TO TREATMENT The undersigned consents to health care encompassing routine diagnostic procedures, including CHDP examinations. X-rays, blood tests, medical and dental treatment and other health services rendered to the patient by Ketamine Clinics of California (KCC) and its duty authorized agents and personnel.
2. NO GUARENTEES It is understood that the practice of medicine and surgery and the rendering of health care is not an exact science and that no guarantees have been made as to the results of treatments, examinations, or other health services rendered by KCC
3. RELEASE OF INFORMATION the undersigned agrees that, to the extent necessary to determine eligibility for payment and to obtain reimbursement, KCC may disclose portions of the patient's records, including his/her medical records to any person or entity which is or may be liable, for all or any portion of KCC charges. Special permission is needed to release this information where the patient is being treated for alcohol or drug abuse.
4. ASSIGNMENT OF INSURANCE BENEFITS The undersigned authorized, whether, he/she signs as agent or as patient, direct payment to KCC of any insurance benefits otherwise payable to or on behalf of the undersigned for treatment and health care services rendered by KCC, at a rate not exceed regular charges. It is agreed that company of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not covered y this assignment pursuant to paragraph 5 below.
5. FINANCIAL AGREEMENT If the patient is not a member of KCC at the time services are rendered, the undersigned agree, whether he/she signs as agent or as patient, that he/she hereby individually obligates himself/herself to pay the account of KCC in accordance with the regular rates and terms of KCC. Should the account be referred to an attorney or collection agency for collections, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.
6. CERTIFICATION The undersigned certifies that he/she read the foregoing. Received a copy thereof, and is the patient, the patient's legal representative, or is dully authorized by the patient as the patient's general agent to execute this Agreement and to accept its terms.
7. PRESCRIPTION REVIEW: The undersigned authorizes KCC to review my external prescription history.

_____ Signature: _____

Date and time of signing Patient/Parent or Guardian/Conservator/Other

_____

If signed by other than patient, indicate relationship DOB:_____

Ketamine Clinics of California & Pain Therapy

SPINE. BACK PAIN. CANCER PAIN. PALLIATIVE CARE.

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH
Note: DO NOT USE THIS FORM IF INFORMATION CONTAINS HIV RELATED RESULTS

EXPLANATION: This authorization is necessary for us to comply with state and federal laws pertaining to the use and disclosure of protected health information (PHI) about the patient identified below. Please provide all requested information. Failure to provide all requested information may prevent Ketamine Clinics of California (KCC) from acting on this authorization.

Name:_____ DOB:_____

Address:_____ Telephone #:_____

I. Persons/Organizations Authorized to Disclose PHI	II. Persons/Organization Authorized to Receive PHI
	Ketamine Clinics of California 1575 N. Lake Ave St #100 Pasadena , CA 91104 Phone #626-345-9735 Fax# 626-628-0478

III. Description of PHI to be Used Or Disclosed

☐ Entire Medical Records	Medications
☐ Diagnostic Imaging Studies	History & Physical
☐ Electro diagnostic Studies	Labs
☐ Progress Notes	Pathology Report
☐ Consult Notes	Other

IV. PURPOSE: I hereby authorize the information checked above to be used and/or disclosed for following purposes:

- ☐ Requested by patient or personal representative
- ☐ For my Medical Care
- ☐ Other: (Specify)

V. Duration: This Authorization will expire on ___/____/____

My Authorization is given freely with the understanding that

1. RIGHT OF REVOCATION. I have the right to revoke this authorization at any time, provide that my revocation is submitted in writing to the Medical Record Officer of Los Angeles Interventional Pain Institute at 2693 E. Washington Blvd. Pasadena CA 91107
2. LIMIT TO REVOCATION. My revocation will be effective upon its receipt of by the person(s)/organization(s) I authorized in Section I but would not be effective to the extent that such persons have acted in accordance with the Authorization and in reliance thereon. With respect to the person(s)/organization(s) I authorize to receive and use health information described in Section II, if patient or personal representative requested this Authorization, any revocation will be effective only when I communicate my revocation to them directly.
3. REDISCLOSURE. If the recipient of my information in Section II above is not a health care provider, health plan or health clearing house or an entity required to comply with federal or state health privacy regulations, my health information may be further disclosed by such recipient and my information may no longer be protected under the state or federal laws. If this authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing it under federal substance abuse confidentiality requirements.
4. CALIFORNIA/ARIZONA RESTRICTION. A recipient of medical information in California or Arizona may not further disclose medical information about me (patient) unless a new authorization form is signed or the disclosure is specifically require or permitted by law.
5. RIGHT TO REFUSE TO SIGN. I do not have to sign this Authorization and that failure to do so will not affect my ability to obtain treatment payment or benefits.
6. COPY RECEIVED. A copy of this authorization will be given to me.

_____ _____

Signature of patient, Parent, Legal Guardian, or Representative Date

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Telephone: 626 345-9735 Fax: 626 628-0478 laipi.pasadena@gmail.com

Our goal is to provide quality medical care in a timely manner. In order to do so, we have to implement an appointment/cancellation policy. This policy enables us to better utilize available appointment for our patients in severe pain needing immediate care.

Cancellation of an Appointment:

In order to be respectful of the medical needs of other patients, please be courteous and call the office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Calling early in the day is appreciated. Appointments are in high demand, and your early cancellation will give another person the opportunity to have access to timely medical care.

How to Cancel your Appointment:

To cancel appointments, please call (626) 345-9735. If you do not reach the receptionist, you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please be sure to leave us your phone number and let us know the best time to return your call.

No-Show Policy:

A "no-show" is someone who misses an appointment without calling 24 hours in advance to cancel. "No-shows" inconvenience those individuals who need access to medical care in a timely manner, as well as the physician. A failure to show up at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show". The first time there is a no-show there will be no charge for the patient. Any additional "no-shows" will result in a fee of $25 for regular appointments and $50 for procedures. a credit card authorization form or $50 deposit will also be required prior to future appointments. If a patient accumulates 3 "no shows" he or she may be asked to leave the practice.

Cash Only:

If you are uncomfortable using a credit card, following your first "no-show" a $25 cash deposit will be required to schedule future appointments and a $50 cash deposit will be required prior to procedures. This amount will be applied to your bill on the day of the appointment and any remaining balance will be refunded at this time. No checks will be accepted.

Late Cancellations:

Late cancellation will be considered as a "no-show". Exceptions will only be made in extraordinary circumstances. Cancellations made more than 24 hours in advance of your scheduled appointment time will not be assessed a cancellation fee.

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Patient Name: _____

NOTICE OF PRIVACY PRACTICES

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

Our practice is dedicated to maintaining the privacy of your health information, we are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you the following important information.
Use and disclosure of your health information in certain special circumstances.

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

A: To public health authorities and health oversight agencies that are authorized by law to collect information.

B. Lawsuits and similar proceedings in response to a court or administrative order

C. If required to do by a law enforcement official.

D. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.

E. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

F. To federal officials for intelligence and national security activities authorized by law.

G. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement officials.

H. For Workers Compensation and similar programs.

Your rights regarding your health information communications.
You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than work. We will accommodate reasonable.
You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right request that we restrict our disclosure of your health information to only certain individuals involved in your case or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law in emergencies or when the information is necessary to treat you.
You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to:
You may ask to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice, to request an amendment, your request must be made in writing and submitted to Interventional Anesthesia & Pain Management Clinic, attention to "Soraya Malek", Office Manager. You must provide us with a reason that supports your request for amendment.
Right to a copy of this notice. You are entitled to receive a copy of this Notice of Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, contact our front desk receptionist.
Right to file a complaint if you believe your privacy rights have been violated, you may file a complaint with our practice or with the secretary of the department of Health and Human Services. To file a complaint with our practice, contact Interventional Anesthesia & Pain Management Clinic. All complaints must be submitted in writing, you will not be penalized for filing a complaint.
Right to provide an authorization for other uses and disclosure. Our practice will obtain your written authorization for uses and disclosure that are not identified by this notice or permitted by applicable law.

Special Permissions and Restrictions: _____
(Please sign your initials)

If you have any questions regarding this notice or our health information privacy policies, please contact KCC, or Soraya Malek, Office Manager at 626-345-9735. I hereby acknowledge that I have been presented with copy of KCC Notice of privacy Practices. This consent is valid from the date indicated below until I revoke it in writing.

Signature: _____ Date/Time: _____

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Initial Depression Survey

Name: _____ Date: _____

1. Chief Complaints

___Depression ___Anxiety ___Bipolar Disorder ___Agitation ___OCD

Comments:
_____
_____
_____

2. Duration

Comments:
_____
_____
_____

3. Causation

___Family History ___Spouse ___Increased stress ___Job ___Accident ___Unknown

Comments:
_____
_____
_____

4. Context

___ETOH use ___Tobacco use ___Drug use ___Marital problems ___Children ___Job Problem

___Legal problems

Comments:
_____
_____
_____

5. Severity

___Mild ___Moderate ___Severe

Comments:

6. Major life Stress

___None ___Spouse ___Children ___Job ___Legal problems

Comments:

7. Past evaluation/managements

___None ___Psychiatric Evaluation ___ECT/Medications

Comments:

8. Current Evaluation / Management

___None ___Psychotherapy ___Medication

Comments:

9. Number of previous episodes

Comments:

10. Hospitalized

___Yes ___No

Comments:

11. Suicide attempt

___Yes ___No

Comments:

_____
_____
_____

12. Interference with activities

___Sleep ___Work ___School ___Social Activity ___Appetite ___Household activities

Comments:

_____
_____
_____

13. Current/associated symptoms

___Depression ___Anger ___Frustration ___Agitation ___Hostility ___Paranoia

___Hallucinations ___Loss of interest ___Fatigue ___Insomnia ___Loss of Concentration

Comments:

_____
_____
_____

14. Comorbid disease

___HTN ___Dementia ___CVD ___Diabetes ___Thyroid Disease ___CAD___HIV_____

Comments:

_____
_____
_____

15. Comments:

_____
_____
_____