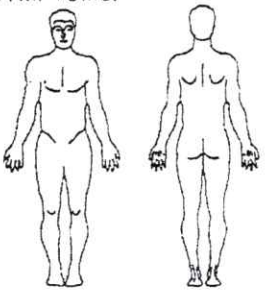
ERNESTO R PADRON, MD
Interventional Pain Management Specialists
3213 S 24th Street, Suite 101-B
Omaha, NE 68108
402-933-8375 / 847-696-7036

ERNESTO R PADRON, MD
Interventional Pain Management Specialists

NEW PATIENT INFORMATION

Patient Name _____ Birthdate _____ Sex: M / F
Address _____ City _____
State _____ Zip _____ Phone (____) _____ Patient Primary Language _____
Occupation _____ Employer _____ Work Phone _____
Address _____ City _____ State _____ Zip _____
Subscriber Name _____ Health Plan _____
Subscriber ID # _____ Group # _____ Spouse Name _____
Spouse Employer _____ City _____ State _____ Zip _____
Primary Care Physician Name _____ PCP Phone _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:
☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain
☐ Other _____
Is this? ☐ Work Related ☐ Auto Related ☐ N/A
Date Problem Began _____
How Problem Began

Current complaint (how you feel today):
0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often are your symptoms present?
(Occasional) ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100% (Constant)

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores?
No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

In general would you say your overall health right now is:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN FOR YOUR AREA(S) OF COMPLAINT? ☐ No ☐ Yes
Date(s) taken _____ What areas were taken? _____

Please check all of the following that apply to you:

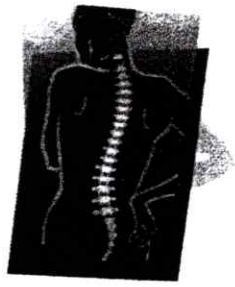
☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date) _____
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain) _____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other Health Problems (Explain) _____

☐ Prostate Problems
☐ Menstrual Problems
☐ Urinary Problems
☐ Currently Pregnant, # Weeks _____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Marked Morning Pain/Stiffness
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Visual Disturbances
☐ Surgeries _____
☐ Tobacco Use - Type _____
Frequency _____ /Day
☐ Medications _____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure
☐ Heart Problems/Stroke ☐ Rheumatoid Arthritis

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

Patient Signature _____ Date _____



Ernesto R. Padron, M.D.
Interventional Pain Management Specialists
3213 S. 24th Street, Suite 101-B
Omaha, Nebraska 68108
Office: 402-933-8375 / Fax: 402-933-9964

NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DICLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires all medical records and other individually identifiable health information use or disclosed by us in any form, whether electronically, paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new right to understand and control now much health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

We respect patient confidentiality and only release medical information about you in accordance with the Nebraska federal law. This notice describes our policies related to the use of the records or your care generated by ERNESTO R. PADRON, M.D., LLC.

We may use and disclose your medical records only for the following reasons:

1. **Treatment:** providing, coordinating, or managing health care and related services by one or more health care providers. For example: A physical exam
2. **Payment:** obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example: Sending a bill for your visit to insurance company for payment.
3. **Health Care Operations:** the business aspects of running a practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. For example: Internal quality assessment.

Information Disclosed Without your consent

Under Nebraska federal law, information about you may be disclosed without your consent for the following reasons:

1. **Emergency:** sufficient information may be shared to address the immediate emergency are facing.
2. **Follow-Up Appointments:** we will be contacting you to remind you of future appointments or Information about your treatment alternatives or other health -related benefits and services that may be interest to you.

3. **Required by Law:** includes situations where we have a subpoena, court order, or are mandated to provided public health information, such as communicable disease or suspected abuse and neglect such as child abuse, elder abuse or institutional abuse.
4. **Coroners, Funeral Director, and Organ Donation:** medical information is disclosed to coroner or medical examiner and funeral directors for the purpose of carrying out their duties. When organs are donated sufficient information will be provided to the program as necessary to facilitate the organ o tissue donation.
5. **Governmental Requirements:** information to health oversight for activities authorization by law: such as audits, investigation, or licensure, there may also to be need to share information with the Food and Drug Administration related to adverse events or product defects as well with the Department of Health and Human Services to determine our compliance with the federal laws related to health care upon request:
6. **Criminal activity or Danger to others:** if a crime is committed on our premises or against our personnel we may share the information wit the law enforcement to apprehend the criminal. We have the right to involve law enforcement when we believe an immediate danger may occur to someone.

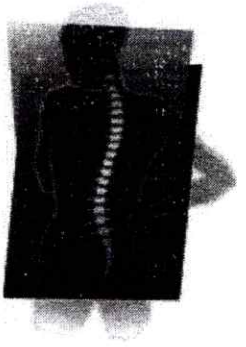
Any others use, or disclosure will e made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by the written request, except to extent that we have already taken actions relying on your authorization.

You have the following rights with respect to protect health information:

1. The right request restrictions on certain uses and disclosures or protected health information, including those related to disclosure to family members, other relatives, close personal friends, or any other identified by you. We are not required to agree to a request restriction. If we agree to a restriction, we must abide by it unless you agree in writing to remove it.
2. The right to reasonable request to receive confidential communication of protected health information from us by alternative means or at alternative locations.
3. The right to inspect and copy your protected health information at the cost of a reasonable fee copying and mailing your records.
4. The right to amend your protected information.
5. The right to receive an accounting of disclosures of protected health information.
6. The right to obtain a paper copy of this notice form us upon request.
   This notice is effective as of April 14,2003 and we are required to abide by terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make new notice provisions effective for all protected health information that we maintain. We will post, and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, the Department of Health & Human Services, or Office of civil rights, about violations of the provision of this notice or the policies and procedures of our office.

   - If you have any questions or need more information, please contact our office

   Patient Signature: _____ Date: _____



DR. ERNESTO PADRON, M.D, LLC.
INTERVENTIONAL PAIN MANAGEMENT SPECIALISTS

3213 S. 24TH STREET, SUITE 101-B
OMAHA, NEBRASKA 68108
OFFICE: 402-933-8375 / FAX: 402-933-9964
www.painclinicschicago.com

ASSIGNMENT OF BENEFITS

Patient Name: _____ SSN: _____

In consideration of your undertaking to render care, I agree to the following:
En consideración por darme tratamiento médico yo acepto lo siguiente:

- **Release of Information:** I authorize the release of any information I deem appropriate concerning my medical condition to any insurance company, attorney, adjuster, or any other person necessary for me to process any claim for reimbursement of charges insured by me at Ernesto Padron M.D, LLC.

  Ud. está autorizado a proveer cualquier información Ud. considere propia y en referencia a mi condición médica a cualquier compañía de seguros, abogados, represéntate u otra persona necesaria para el proceso de cargos debido a mi tratamiento médico en Ernesto Padron M.D, LLC.

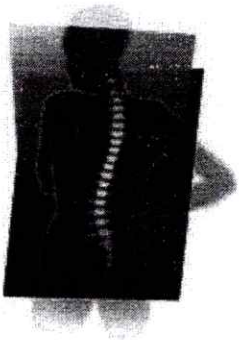
- **Right to Receive Payment:** I authorize and assign you, the medical provider and treating facility, Ernesto Padron M.D, LLC, the right to receive direct payment from my attorney, insurance company, or any other party who may become obligated to pay me any sums. I further authorize endorsement of my name to any draft which you are legally entitled.

  Yo autorizo y asigno, al médico en Ernesto Padron M.D, LLC, el derecho de recibir directamente pago de mi abogado, compañía de seguros, y otro médico, quien esta obligado a pagarme cierta cantidad. Yo además autorizo al centro que firme mi nombre a cualquier forma de pago que contenga mi nombre y por lo cual le pertenece legal mente.

- **Assignment of Right to Sue:** In the event any insurance company, attorney, or other person obligated to contractual agreement refuses to make a payment upon your demand for your services; I hereby assign and transfer Ernesto Padron M.D, LLC, the cause of action that exists in my favor against such parties and authorize you to prosecute said action either in my name or your name for you to resolve said claims as you see fit. I understand that I shall continue to remain responsible for any uncollected or unpaid balance on my account. I also understand that a 33% collection fee, in addition to attorney fees will be collected upon demand.

  En el caso que la compañía de seguros, o abogados, o otra persona encargada debido a un contrato no pagar a Ernesto Padron M.D, LLC, bajo la demanda, yo autorizo que se haga acción legal para procesar mi cuenta. Yo entiendo que seguiré responsable por todos los cargos por los servicios médicos. Yo también entiendo que en 33% será agregado por costos de colección y además de los gastos de abogados.

- **Attorney Direction:** I hereby direct my attorney not to interfere with my claim on any lien upon, any medical payment benefits to which I may be entitled for my health insurance, medical, workmen's compensation, or other payment sources. If there are any said medical payment checks which include my attorney's name, I



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direct my attorney to sign his/her name to these checks for the benefit of the medical provider and Ernesto Padron M.D, LLC.

Yo indicare a mi abogado que no interfiera con "líen" presentada y cualquier benefició por el cual a mi pertenece ya sea de mi seguro du salud, compensación de trabajo o otra forma. Y si alguno de esos pagos incluye el nombre de mi abogado, Yo indicare a mi abogado para que endorse su nombre y pague al médico y a Ernesto Padron M.D, LLC, que me proveyó de los servicios.

Patient Signature	Date	Witness

PAIN MANAGEMENT SPECIALISTS
ERNESTO PADRON, M.D., L.L.C.

SOUTH OMAHA SURGICAL CENTER
3201 S. 24TH ST.
OMAHA, NE 68108
P: 844-365-6766/F: 847 696 7040

PATIENT CONSENT FORM

CONSENT TO THE USE AND DISCLOSURE OF MEDICAL INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I understand, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information.

I, _____ consent to the use of disclosure of my medical information by Ernesto Padron M.D, LLC, for the purpose of diagnosing or providing treatment to me, obtain payment for my treatment, or to conduct healthcare operation of the practice. I understand treatment by the practice may be denied if I do not sign this consent.

I have been informed by Ernesto Padron M.D, LLC, of their Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand Ernesto Padron M.D, LLC has the right to change the Notice of Privacy Practices from time to time and I may contact Ernesto Padron M.D, LLC, at any time at above address to obtain a current copy of the Notice of Privacy Practices.

I understand I may request in writing Ernesto Padron M.D, LLC, restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand Ernesto Padron M.D, LLC, is not required to agree to my requested restrictions, but if agreed upon, Ernesto Padron M.D, LLC, must abide by such restrictions.

I understand I may revoke this consent in writing at any time, except where Ernesto Padron M.D, LLC, has already made disclosure in reliance on prior consent.

_____ _____ _____

Patient Signature Date Witness

PARK RIDGE PAIN SPECIALISTS
ERNESTO PADRON, M.D.
PAIN MANAGEMENT SPECIALISTS

Screener and Opioid Assessment for Patients with Pain Revised

SOAPP®-R

	Never	Seldom	Sometimes	Often	Very often
	0	1	2	3	4
1. How often you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication that you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○
13. How often have any of your close friend had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or be arrested?	○	○	○	○	○

Patient Name: _____ Date: _____

PARK RIDGE PAIN SPECIALISTS
ERNESTO PADRON, M.D.
PAIN MANAGEMENT SPECIALISTS

Screener and Opioid Assessment for Patients with Pain Revised SOAPP®-R

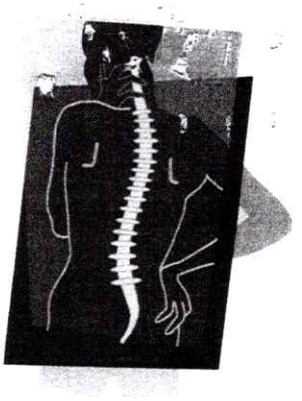
SOAPP®-R

	Never	Seldom	Sometimes	Often	Very often
	0	1	2	3	4
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medication form your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

Please include any additional information you wish about the above answers.
Thank You.

Patient Name: _____ Date: _____

PAIN MANAGEMENT SPECIALISTS
ERNESTO PADRON, M.D., L.L.C.



SOUTH OMAHA SURGICAL CENTER
3201 S. 24TH STREET
OMAHA, NE 68108
P: 844-365-6766/F: 847-696-7040

PATIENT NAME: _____

OPIATE /PAIN MANAGEMENT CONTRACT

The purpose of this Agreement is to prevent misunderstandings about certain medications you will be asking for pain management. This agreement is to help you and your provider to comply with the law regarding controlled pharmaceuticals.

____ I understand that there is a risk of psychological and /or physical dependence and addiction associated with chronic use of controlled substances.

____ I understand that this Agreement is essential to the trust and confidence necessary in a provider/ patient relationship and that my provider undertakes to treat me based on this agreement.

____ I understand that if I break this Agreement, my provider will stop prescribing these pain control medicines.

____ In case, my provider will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug – dependence treatment program may be recommended.

____ I would be also be amenable to seek psychiatric treatment, psychotherapy, and /or psychological treatment if my provider deems necessary.

____ I will communicate fully with my provider about the character and intensity of my pain, the effect of the pain of the pain on my daily life, and how well the medicine is helping to relieve the pain.

___ I will not use any illegal controlled substances, including marijuana, cocaine, etc., nor will I misuse or self-prescribe/ medicate with legal controlled substances. Use of alcohol will be limited to times when I am not driving or operating machinery and will be infrequent.

___ I not share my medications with anyone.

___ I will not attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medications from any other provider.

PAIN MANAGEMENT SPECIALISTS
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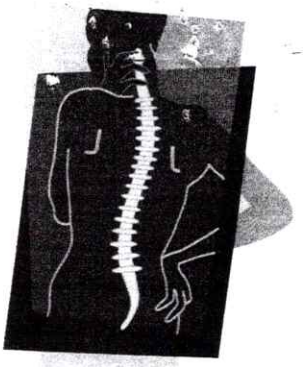

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___ **I will safeguard my pain medication from loss, theft, or unintentional use by others, including youth. Lost or stolen medications will not be replaced**.

___ I agree that refills of my prescriptions for pain medications will be made only at the time of an office visit or during regular office hours. **NO REFILLS WILL BE AVAILABLE DURING EVENINGS OR ON WEEKENDS.**

___ I agree to use this pharmacy _____ located at this address _____ with the telephone number of _____ For filling my prescriptions for all of my pain medicine.

___ I authorize the provider and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize my provider to provide a copy of this agreement to my pharmacy, primary care provider and local emergency room. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

___ I agree that I will submit to a blood or urine test if requested by my provider to determine my compliance with my program of pain control medications.

___ I understand that my provider will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program website periodically throughout my treatment period.

___ I agree that I will use my medicine at a rate no grater that the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for period time.

___ I will bring unused pain medicine to every office visit.

___ I agree to follow these guidelines that have been fully explained to me.

All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This Agreement is entered into on this _____ day of _____, 20: ___.

Patient Signature: _____
Patient Name (printed): _____
Provider signature: _____