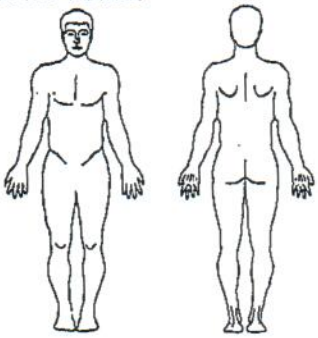
NEW PATIENT INFORMATION

PARK RIDGE PAIN SPECIALISTS
ERNESTO PADRON, M.D.

1300 W. TOUHY AVE
PARK RIDGE, IL 60068
847-696-7036/ FAX: 847-696-7040

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:

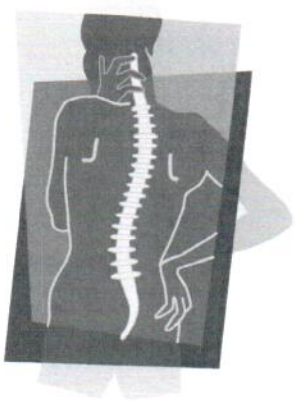
☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Stroke (Date)_____
☐ Corticosteroid Use (Cortisone, Prednisone, etc.)
☐ Taking Birth Control Pills
☐ Dizziness/Fainting
☐ Numbness in Groin/Buttocks
☐ Cancer/Tumor (Explain)_____
_____
☐ Osteoporosis
☐ Epilepsy/Seizures
☐ Other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



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

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Phone: 847-696-7036 Fax: 847-696-7040
www.painclinicschicago.com

NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED 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 used 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 how your 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 Illinois federal law. This notice describes our policies related to the use of the records of your care generated by Ernesto **Padron M.D, LLC.**

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

- **Treatment** - providing, coordinating, or managing health care and related services by one or more health care providers. For example: A physical examination
- **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
- **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 review

Information Disclosed Without Your Consent

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

- **Emergencies** – sufficient information may be shared to address the immediate emergency you are facing.
- **Follow-Up Appointments** – we will be contacting you to remind you of future appointments or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- **Required by Law** – includes situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases or suspected abuse and neglect such as child abuse, elder abuse, or institutional abuse.
- **Coroners, Funeral Directors, and Organ Donation** – medical information is disclosed to a 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 or tissue donation.

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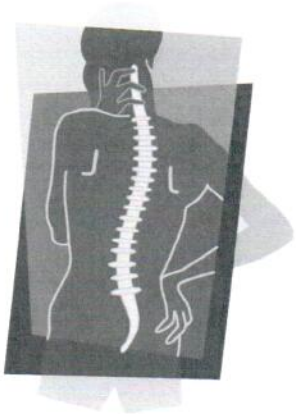

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- **Governmental Requirements** – information to a health oversight agency for activities authorized by law; such as audits, investigations, or licensure. There may also be a need to share information with the Food and Drug Administration related to adverse events or product defects as well as with the Department of Health and Human Services to determine our compliance with federal laws related to health care upon request.
- **Criminal Activity or Danger to Others** – If a crime is committed on our premises or against our personnel we may share information with the law enforcement to apprehend the criminal. We also have the right to involve law enforcement when we believe an immediate danger may occur to someone.

Any other uses or disclosures will be 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 the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relatives, close personal friends, or any other person identified by you. We are not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy you protected health information at the cost of a reasonable fee for copying and mailing your record.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures for protected health information.
- The right to obtain a paper copy of this notice from us upon request.

This notice is effective as of April 14, 2003 and we are required to abide by the 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 the 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 the Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

*If you have any questions or need more information please contact Ernesto Padron M.D, LLC.

Patient Signature: _____ **Date:** _____

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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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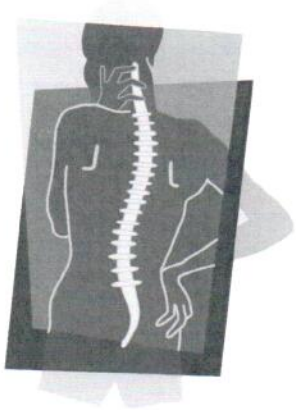

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direct my attorney to sign his/her name to these checks for the benefit of the medical provider and Ernesto Padron M.D, LLC.

Yo indicare a mi abogado que no interfiera con "lien" 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

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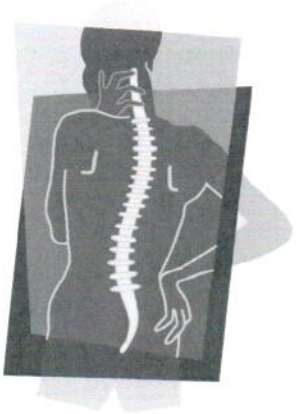

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PATIENT CONSENT FORM

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

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Ernesto R. Padron, M.D

Treatment Agreement

This is an agreement between (patient name):_____

and ERNESTO PADRON,MD: regarding the diagnosis of:

_____

for which the following medication(s) have been prescribed

narcotics:_____

I understand that there are alternative treatments which include:

_____

_____

The goal of my therapy is to reduce my pain to a level that is tolerable and will allow me to improve my ability to perform daily activities. I understand that daily use of narcotic increases certain risks, which include but are not limited to:

- Addiction
- Allergic reaction, overdose, and/or fatal complications
- Breathing problem
- Drowsiness, dizziness and/ or confusion
- Impaired judgment and inability to operate machines or drive motor vehicles
- Nausea, vomiting, and / or constipation
- Development of tolerance

I agree to the following guidelines:

1. I will take this medication only as prescribed and I will not change the amount or frequency without authorization from my physician. Unauthorized changes may result in my running out of medication early, and early refills will not be allowed. (see #2)
2. I understand that due to the high potential for abuse of these medications, the following rules apply: I will NOT be allowed to obtain early refills or receive replacement of lost or stolen medication. Refills will only be provided during regular offices hours.
3. I will obtain ALL of my prescriptions through ERNESTO R. PADRON, MD.
   And will fill ALL of my prescriptions at (pharmacy name) _____

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Ernesto R. Padron, M.D

In an acute emergency, another provider may prescribe medication for me. If this occurs, I will notify my primary ERNESTO R. PADRON, M.D as soon as possible.

4. I will submit to random urine or blood tests if requested by my physician or nurse practitioner to assess my compliance. If I do not have insurance I understand I will have to pay out of pocket.
5. I agreed to see ERNESTO R. PADRON, MD for ongoing case management and will keep regularly scheduled appointments as long as I am taking this narcotic medication.
6. If I do not follow these guidelines, I understand that my treatment may be terminated.

I have discussed the risks, benefits, and alternatives to narcotics treatment with my provider. I have had an opportunity to ask questions and receive answers to those questions to my satisfaction.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

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APPOITMENT & CANCELLATION POLICY

DEAR PATIENT:

Our appointment cancellation policy is necessary to maintain the high professional standards of our practice. Missed or cancelled appointment spaces deprive other patients of treatments, disrupt our efficiency, and cause financial difficulty for office. Our policy is as follows:

If you cancel your appointment at least 24 hours prior to your appointment time ..... No charge
If you cancel your appointment within 24 hours of your appointment time ..... $25.00 charge to Your account
If you fail to show up or call to cancel your .....$50.00 charge to your account

You will be personally responsible for this charge because it cannot be billed to your insurance company (WC/ MVA). Future appointments will not be made until the cancellation fee is paid. If a patient accumulates a total of 3 missed appointments, future appointments will not be scheduled.

Unavoidable circumstances may warrant special consideration, but please note that above charges will apply to most cancellations. You will receive a courtesy call and text message to remind you of your visits 24-48 hours prior your appointment, but it is your responsibility to know when your appointment is scheduled. If we have less than 24 hours notice that you cannot attend your appointment, we will not have sufficient time to offer that time slot to another patient in need. Thank you for understanding the importance of keeping your appointment.

To cancel or rescheduled an appointment, please call (847-696-7036). Messages left on the answering machine will be log at the time they were recorded.

These policies have been enacted to improve your experience in our office. Please let us know if you have any questions regarding this appointment policy so that our staff may clarify for you. Thank you for entrusting us with your Pain Management Care.

My signature below indicates that I understand the appointment cancellation policy information set forth herein by Park Ridge Pain Specialists. I also understand and agree that such terms may be amended occasionally by the practice.

Print Name: _____ Witness: _____

Signature: _____ Date: _____