NEIL R. SONI, M.D.

PAIN MANAGEMENT & PHYSICAL REHABILITATION

9940 TALBERT AVENUE SUITE 101

FOUNTAIN VALLEY, CA 92708

TELEPHONE (714) 545-8700 FACSIMILE (714) 545-8084

PATIENT INFORMATION

Patient Name:_____ DOB:_____/_____/_____Age:_____ M F

Address: _____

City:_____ State:_____ Zip Code:_____

Home Phone (_____)_____Cell (_____)_____Work (_____)_____

Email Address:_____

SS#_____/_____/_____ Occupation:_____ Employer:_____

Emergency Contact:_____ Phone:_____

Whom may we thank for this referral:_____

ACCIDENT | INJURY INFORMATION

Is your condition job related? ☐ Yes ☐ No Is your condition auto accident related? ☐Yes ☐No

Name of Auto Insurance/Attorney_____ Phone #_____

Claim #_____ Date of Injury_____/_____/_____ Adjuster_____

INSURANCE AND PAYMENT INFORMATION

Primary Insurance Name:_____ ☐PPO ☐HMO ☐Self-Pay

ID#_____ Group #_____ Phone #_____

*****I am aware and understand that my insurance may send checks to me for payment of services for Kessler Family Wellness Center, Inc. and all associates, including Dr. Neil Soni, Dr. William Kessler, Dr. Andrew Hassen, Micah Clement, PA-C, and Dennis Bansil, PA-C. It is my responsibility to promptly deliver payments. If checks are not provided, I will be responsible for all charges in full. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account. I have read all the information above and certify that this information is true and correct to the best of my knowledge. I will notify the doctor's office of any changes to the above information.*

Patient or Guardian Signature: _____ **Date:** _____

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HEALTH HISTORY

Describe the purpose of your visit and the major problems needing help:

_____

_____

Describe the pain:

_____

Pain treatments tried: Did it help?

☐ Surgery ☐ Yes ☐ No ☐ Medications ☐ Yes ☐ No

☐ Physical Therapy ☐ Yes ☐ No ☐ Chiropractic ☐ Yes ☐ No

☐ Other_____ ☐ ☐

Have you had any tests for your problems?

X-Rays ☐Yes ☐No Date ____/____/____ Cat Scan ☐Yes ☐No Date ____/____/____

MRI ☐Yes ☐No Date ____/____/____ EMG/NCV ☐Yes ☐No Date ____/____/____

Other_____

Allergies to medications:

_____

Other allergies:

_____

Other healthcare providers you have seen or are currently seeing & their specialty:

_____

_____

Medications that you take <u>now</u> (including non-prescription or vitamins):

_____

_____

Sleep Hours per night? _____ Trouble falling / staying asleep? _____ Does pain awaken you? _____

Broken Bones/Surgeries:

Year	**Injury Suffered**	**Treatments**
_____	_____	_____
_____	_____	_____

Patient or Guardian Signature: _____ **Date:** _____

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HEALTH CARE PRIVACY POLICY

We are very concerned with protecting your privacy. While the law requires us to post this disclosure, please understand that we have, and always will, respect the privacy of your health information. It is our right to change our privacy practices provided law permits the changes. Before we make significant change, this notice will be amended to reflect the changes and we will make the new notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our notice effective for the health information maintained, created and/or received by us before the date changes were made. You may request a copy of our privacy notice at any time.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We may use or disclose protected health information without a written authorization, as permitted or required by Federal or State Law.

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons whom you chose to involve in your care. This information will only be provided with written consent that allows us to share this information. We will honor that notice until you send us written notification to either terminate or change it.

Payment: We may use and disclose your health information to seek payment for services we have provided. This disclosure involves our reception, billing department and may include insurance organizations or other businesses that may become involved in the process of mailing statements, reminders, claim forms and/or collecting unpaid balances such as third party collection services.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member of anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up x-rays, MRI's, or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. You will be asked questions at reception and when you schedule an appointment that are necessary to keep your personal information current in contact name and number. Questions you may be asked will be limited to your address, phone numbers, insurance carrier, and emergency contact name and number. You may also be asked for any balance due on your account. If you have a simple billing question, it will be answered at reception, however if your question requires specific medical information you may be moved to a private room for that discussion. In addition, your information may be shared with outside health or management reviewers, firms that provide practice management and prescription management services, and individuals performing similar activities. Also, we may share your information with any collection services we utilize to assist us with collection of any balance due from you as well as any outside laboratory we contract with to provide services to you in our office. Your insurance company may also have access to your records for disease state management, HEIDIS studies, and chart audits.

Required by Law: We may use or disclose your health information as required by law (court or administrative orders, subpoena, coroners, funeral directors, discovery request or other lawful process). We will use and disclose your information when requested by national security, intelligence and other State or Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medication, product recalls, disease / infections exposure and to prevent and control disease, injury and/or disability. Similarly, California law requires us to report certain infections and/or communicable diseases.

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Workers' Compensation: California law may require us to disclose protected health information, without a separate authorization from you, for workers' compensation claims.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including but not limited to, phone calls, phone messages, voicemail messages, postcards and letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (or that of an individual for whom you are a legal guardian). There will be some limited exceptions. If you wish to examine your health information you will need to submit a written request to the address at the end of this notice. There is no charge for the first copy, but there will be a $25 charge for any subsequent copies provided to you.

Amendment: You will have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Please note that we have the right to disagree with your amendments. If there is a disagreement, you will be provided with the explanation of our denial of your amendments and how you may appeal the denial.

Non-Routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your healthcare information. (When we make routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures; therefore, these are not available). You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You can request nonroutine disclosures going back 7 years. Information prior to that date would not have to be released.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement, except for emergencies. Please contact our Office Manager if you want to further restrict access to your health care information. This request must be submitted in writing.

Questions and Complaints: You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Office Manager. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. We support your right to the privacy of your information and you will not be penalized or discriminated against for filing a complaint with us or with the U.S. Department of Health and Human Services.

How to Contact Us: Kessler Family Wellness, 1431 Warner Avenue, Suite D, Tustin, CA 92780 Phone: (714) 258-7116 Email: kesslerfamilywellness171@gmail.com

How to contact the U.S. Department of Health and Human Services: DHHS (Office of Civil Rights), 200 Independence Avenue, S.W.Room 509H HHH Building, Washington, D.C. 20201

_____ _____

Patient's Signature Date

_____

Signature of Policy Holder (If different from patient)

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Thank you for choosing us as your healthcare provider. At our Wellness Center we are committed to providing you with comprehensive, caring, and thorough treatment. We would like you to understand your financial commitment and our policies for all services rendered in this office. Please read and sign below.
We accept Cash, Check and Credit Cards. Please SIGN IN and CHECK OUT at the reception desk.

Copayments/Deductibles/Coinsurance
Depending on your insurance plan, you may have a deductible which must be paid before your insurance company will begin reimbursement for your treatment. All copayments and coinsurance are due at the time of service, no exceptions. Payment plans are an option; please discuss this with the front office staff. We are willing to work with you to accommodate your financial needs.

Insurance Claims
We accept most PPO insurance plans. As a courtesy, we will call your insurance to verify your coverage and benefits, and review the information with you. However, a description of benefits is not a guarantee of payment from your insurance, and your insurance coverage is an agreement between you and the insurance company. It is therefore your responsibility to be familiar with how your plan works and what services and supplies are covered. If your insurance company does not remit payment within 60 days, we will contact the carrier on your behalf to help expedite the reimbursement process. If your claims are rejected or deemed non-covered by the insurance company, you are responsible for payment. *Your insurance company may send payments directly to you, it is your responsibility to bring in those in payments and EOB's promptly.

Disclosure of Information and Privacy Policy
We may disclose information to other healthcare professionals and/or your insurance carrier for treatment, payment, or healthcare operations. Additional disclosures may be necessary to comply with workers' compensation and public health laws as well as judicial proceedings. We may contact a family member or other authorized person in the event of an emergency. Be assured that we will not disclose any information without your expressed written consent unless compelled to do so by legal authority. Further, you will be contacted by phone or mail in the event a request for information is made. A written copy of our full privacy policy is posted in our facilities and an additional copy will be provided to you for your review.

Appointment Reminder
We may call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we will leave a message on your answering machine or with the person whom answers the phone. We will not leave any message that discloses your confidential information. If you would like to use an alternate contact number, please inform us with the number you would prefer.

Please Be Respectful of the Doctors' Time
We understand that schedule conflicts occur, but we ask that you remember the doctors have a schedule to maintain. PLEASE be courteous and respectful of the doctors' time and if it is necessary for you to cancel or reschedule your appointment, please do so 24 hours in advance.

I have read, understand, and agree to the conditions set forth in Kessler Family Wellness's office, financial and privacy policies. My signature will serve as acknowledgement that I certify that the information I have provided to Kessler Family Wellness is true and correct, and I will notify the staff of any changes to my insurance coverage or financial status. I also acknowledge that I have been provided with a full copy of the office's privacy policy and understand my rights regarding my private health information.

_____
Printed Name

_____
Guardian Name if Minor

_____
Signature of Patient or Guardian

_____/_____/_____
Date

Opioid Risk Tool

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction.

Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk too. Pain Med. 2005; 6 (6) : 432

SOAPP® Version 1.0 - SF

Name: _____ Date: _____

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you have mood swings?	0 1 2 3 4
2. How often do you smoke a cigarette within an hour after you wake up?	0 1 2 3 4
3. How often have you taken medication other than the way that it was prescribed?	0 1 2 3 4
4. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0 1 2 3 4
5. How often, in your lifetime, have you had legal problems or been arrested?	0 1 2 3 4

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