Patient Intake Form

Patient Information

Full Name: _____ DOB: _____
First *M.I.* *Last*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Occupation: _____ Social Sec: _____

Female ☐ Male ☐

Emergency Contact

Please list in case of in emergency.

Full Name: _____ Phone: _____

Insurance

Please fill this information out if you are listed as spouse, child, or other on the insurance policy. Please provide the following information for the Subscriber. If you are the Subscriber just state self.

Insurance Carrier: _____

Full Name: _____ Relationship: _____

Address: _____ Phone: _____

Disclaimer and Signature

I, the undersigned certify that I (or dependent of Policy Holder) have insurance coverage with _____

and assign directly to Dr. Morris Jagodowicz all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance carrier. I hereby authorize the use of this signature on all insurance submissions. I also give consent to Dr. Morris Jagodowicz and billing staff as a dependent, spouse, or other relationship on my insurance company to contact the policy holder if necessary in regards to my billing account.

Signature: _____ Date: _____

MORRIS JAGODOWICZ, M.D.

AKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I hereby authorize Dr. Jagodowicz or his designees to bill my insurance carrier, medical group or other healthcare organization for services provided on my behalf. By placing my initials after the following paragraphs and placing my signature below, I understand that I (or guardian or designee) is financially responsible for my medical care regardless of insurance eligibility or enrollment status at the time services are rendered.

Initials of Patient or Responsible Party _____

I understand that I (or guardian or designee) is financially responsible for any and all services rendered to me on my behalf, by Dr. Jagodowicz. This includes any diagnostic services, office based procedures, and medical management provided to me in the course of my care.

Initials of Patient or Responsible Party _____

I understand that if it is determined after any and all medical services are rendered that my eligibility had been terminated by my health plan or medical group, or that the services provided did not have proper authorization, I am financially responsible for all outstanding balances that are accrued. I also acknowledge that I am financially responsible for any and all services rendered that are determined by my health plan or insurance carrier to be either a) a non-covered service: b) medical services that are excluded from my policy for whatever reason; or c) medical services considered by my health plan or insurance carrier to be "off label" in nature and not covered by my policy. I also acknowledge that any outstanding balances not paid within 120 days of services rendered may be turned over to a collection agency which could have an adverse effect on my credit rating.

Signature of Patient or Guardian _____ Date _____

Print Name _____

Morris Jagodowicz, M.D.
PAIN MANAGEMENT
Doctors Medical Plaza
10515 Balboa Blvd., Suite 390
Granada Hills, CA 91344
(818) 360-4949

CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I _____ authorize Morris Jagodowicz, M.D. at the above address to:
Patient Name (Print) Physician Name

MD check all that apply

☐ Receive my medical history information from the following physicians:
(name, address)_____

(name, address)_____

☐ Receive my treatment records from the following
Therapist/Other (name, address)_____

☐ Release my treatment information/records to the following healthcare professional
(name, address)*_____

☐ Release my treatment information and records to me (name, address)*_____

_____

This information is for the following purposes (any other use is prohibited): _____

_____

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken in reliance on it. This consent will expire in 365 days unless the physician specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to medical treatment, psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

_____ _____
Patient Signature Date

_____ _____ _____
Parent/Guardian Signature Parent/Guardian Name (Print) Date

_____ _____ _____
Witness Signature Witness Name (Print) Date

* A fee will be charged to copy, reproduce photographs, and for mailing costs

Confidentiality of Alcohol and Drug Dependence Patient Records

The confidentiality of alcohol and drug dependence patient records maintained by this practice/program is protected by federal law and regulations. Generally, the practice/program may not say to a person outside the practice/program that a patient attends the practice/program, or disclose any information identifying a patient as being alcohol or drug dependent unless:

1. The patient consents in writing;
2. The disclosure is allowed by a court order, or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or practice/program evaluation.

Violation of the federal law and regulations by a practice/program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the practice/program or against any person who works for the practice/program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

Morris Jagodowicz, M.D.

PAIN MANAGEMENT AGREEMENT

The purpose of this Agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

1. I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationshi and that my doctor undertakes to treat me based on this Agreement.
2. I understand that if I break this Agreement, my doctor will stop prescribing these pain-control medicines.
3. In this case, my doctor 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.
4. I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.
5. I will not use any illegal controlled substances.
6. I will not share, sell or trade my medication with anyone.
7. I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctor.
8. I will safeguard my pain medicine from loss or theft. Lost or stolen medicines will not be replaced.
9. I agree that refills of my prescriptions for pain medicine 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.
10. I authorize the doctor 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 medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
11. I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medicine.
12. I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.
13. I will bring all unused pain medicine to every office visit.
14. 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 on ___/____/____.

Patient signature:_____

Physician signature: _____

Print Name: _____

Morris Jagodowicz, M.D.

PAYMENT POLICY REGARDING OUT OF NETWORK CARRIERS

To Our Valued Patients:

We will file claims for patients covered by private or commercial plans in which our physicians are out of network. Since we are not providers for any insurance company, they may send you the payment and explanation of benefits. Therefore, you will need to write out a personal check to Dr. Jagodowicz for the amount given to you, and provide us with a copy of the *Explanation of Benefits* and send it to our office.

Additionally, insofar as we have no contractual relationship with these carriers, we are unable to appeal any adverse claims decision. Any outstanding balance is the responsibility of the patient or guarantor and will be billed to the patient or guarantor 30 days after the claim is filed.

If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated.

Missed appointments: Our policy is to charge for missed appointments not canceled within 24 hours. There will be a $25.00 no show fee for office visits, a $50.00 no show fee for the surgery center and $50.00 no show fee for our psychological services. The psychological services for cash patients have an evaluation fee for $200.00 and follow up counseling sessions for $150.00. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

If you are a cash base patient with our practice by signing below you understand that there is a $300.00 initial consultation fee and $125.00 follow up fee.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**

_____

Print Name

Morris Jagodowicz, M.D.
PAIN MANAGEMENT-PRECISION INJECTION TECHNIQUES
Doctors Medical Plaza
10515 Balboa Blvd., Suite 390
Granada Hills, CA 91344
(818) 360-4949
FAX: (818) 366-6002

TO PATIENTS WITH BLUE-CROSS / BLUE-SHIELD POLICIES

It is Blue-Cross/Blue-Shield's practice to mail reimbursement checks for out-of-network physician services directly to the patient. In addition, these checks are written to the policyholder. Please be aware that these checks are reimbursement for physician services and are owed to the physician having provided the service.

WHAT TO DO?

If The Check Is For Services By Morris Jagodowicz, M.D.:

When you receive a check, please endorse the back of the check with your signature and then write "Payable to Dr. Morris Jagodowicz". It should be mailed to us with the attached form, also known as an "E.O.B." or "Explanation of Benefits". The E.O.B. helps our billing staff handle the payment correctly. Please feel free to make a copy of these materials before you send them. If you deposit or cash an insurance check, you will be responsible for writing a personal check for the exact amount you received within 30 days of the date on the "E.O.B." After 30 days you will be charged interest in the amount of 6% (six percent) monthly until payment is received by this office.

Blue-Cross/Blue-Shield does send us written notification that they have mailed you these checks. They also notify us when a check has been cashed or deposited by the policy holder. Failure to send these checks to the office, makes you immediately responsible for the outstanding balance on your account with us.

Please know that this is **as big an inconvenience for us as it is for you**. Hopefully the state of California will make this practice of sending reimbursement checks to the patient illegal in the future. This is a maneuver to force out-of -network physicians to be under contract with the insurance companies.

My signature below, means I understand what I have read and I agree to abide by all statements.

_____ _____

Patient Signature Date

MORRIS JAGODOWICZ, M.D.
Pain Management- Nerve Block Specialist

PAIN SELF-EVALUATION
Please fill in the entire form.

Name:_____ Age:_____

Date:_____ Referring Physician (If any)
_____

Describe in your own words, what your pain is like (where it is, how it feels, is it constant, does it come and go, does it radiate to other parts of your body):_____
_____
_____
_____

How long have you had this problem_____?
How did your pain problem first start (Accident, Etc?) Please describe:_____
_____
_____
_____

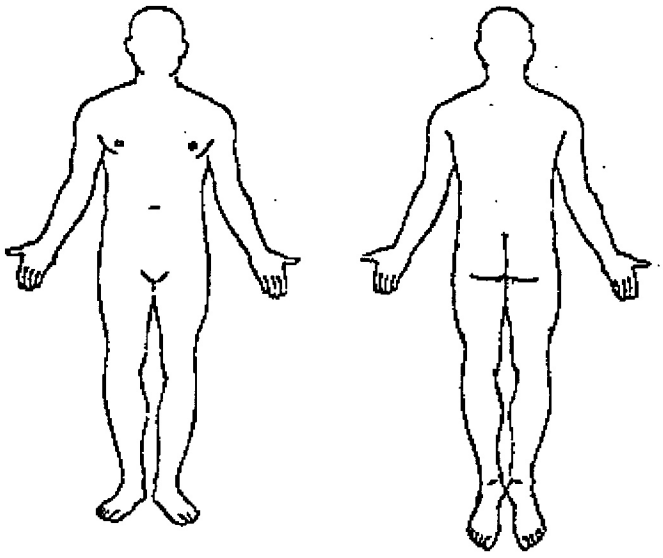
Have you had any previous treatments for this pain? (Surgeries, other blocks, medications) If so, please list below along with the date.

_____
_____
_____
_____
_____
_____
_____

In the figures below, indicate the following:

1. **Entire painful areas (XXX)**
2. **Single most painful area (***)**
3. **Areas of numbness and tingling (OOO)**

PAIN SELF-EVALUATION



Does the pain move from one area to another? (Yes/No). If yes describe

_____

_____

_____

With the following, indicate if the pain is increased (I) or decreased (D)

Walking_____ Sitting_____ Standing_____ Reclining_____ Sleeping_____
Fatigue_____ Tension_____ Exercise_____ Sexual Activities_____ Bending_____
Working_____ House Cleaning_____ Alcohol_____ Medication_____ Bowl Movement_____ Lifting_____

When did you last work your regular job (date)?

_____

Is your case Workman's Compensation?
(Yes/No)_____Are you involved in a lawsuit because of the pain (Yes/No)? _____

Additional
Comments:_____

_____

_____

_____