CADUCEUS

PATIENT REGISTRATION INFORMATION

Insurance cards copied ☐	Account #:	Insurance:	Copayment: $
Eligibility verified ☐ online ☐ telephone call_____	Name of health plan representative _____ Office Personnel Verifying_____		
Is patient's condition a result of an auto accident? YES ☐ NO ☐ Date of Injury _____			

PATIENT'S PERSONAL INFORMATION

Name _____ (Last) _____ (First) _____ (MI) Age _____ Date of Birth_____

☐ M or ☐ F Language Spoken: ☐ English ☐ Spanish ☐ Other_____ Social Security # _____

Address _____ Apt# _____ City _____ Zip _____

Preferred method of contact: ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ E-mail

Cell Phone _____ Approval to text? ☐ Y ☐ N Approval to leave message? ☐ Y ☐ N

Home Phone _____ Approval to leave message? ☐ Y ☐ N

Work Phone _____ Approval to leave message? ☐ Y ☐ N

E-mail Address _____ Approval to leave message? ☐ Y ☐ N

Financially Responsible Party _____ Relationship to Patient: ☐ Mother ☐ Father Other _____

Date of Birth _____ CA Driver's License _____ Social Security # _____

Responsible Party's Home Phone _____ Work Phone _____ E-mail _____

Address _____ Apt# _____ City _____ Zip _____

Employer _____ Phone _____

Address _____ City _____ Zip _____

PATIENT'S INSURANCE INFORMATION AND ELIGIBILITY GUARANTEE

Primary Insurance Company Name _____ Subscriber (if other than patient) _____

Insured's Relation to Patient _____ Date of Birth _____ Subscriber I.D.# _____ Group # _____

Insurance Billing Address _____ City _____ Zip _____

Secondary Insurance Company Name _____ Subscriber (if other than patient) _____

Insurance ID #_____Group #_____Insured's Relation to Patient _____ Date of Birth _____

Insurance Billing Address _____ Suite# _____ City _____ Zip _____

HMO	PPO
Medical Group/IPA _____ PCP _____	Effective Date _____ Copayment _____
Effective Date _____ Copayment _____	Coinsurance amount _____ % Deductible_____

I understand that if the information provided above is incorrect or if the patient is not eligible under the stated insurance program or health plan, that I am liable for the charges incurred for services rendered. Additionally, I am liable for charges for services rendered which are considered not medically necessary; are considered cosmetic or not otherwise covered by the stated insurance program or health plan; and services which are not authorized in accordance with my health plan and/or medical group. In such instance, I agree to pay in full for all services rendered and shall do so within thirty days after receipt of invoice from the above-noted medical group or physician.

_____ Signature

_____ Date

CADUCEUS

PATIENT REGISTRATION INFORMATION

NAME

PATIENT'S REFERRAL INFORMATION

Referred by: _____ If referred by a friend, may we thank her or him? ☐ Yes ☐ No

Name(s) of other physician(s) who care for you: _____

_____

_____

EMERGENCY CONTACT INFORMATION

Name of person _____ Relationship _____

Address _____ City _____ Zip _____

Best number to contact this person _____ Alternate phone number _____

Name of person _____ Relationship _____

Address _____ City _____ Zip _____

Best number to contact this person _____ Alternate phone number _____

MEDICAL CONSENT

The undersigned consent to any x-ray examination, anesthesia, laboratory procedure, medical and surgical treatment or hospital service rendered under the general supervision of, or upon the advice of, a physician.

Assignment of Benefits • Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Caduceus Medical Group and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by my insurance carrier. In the event or default, I agree to pay all costs of collection and reasonably attorney's fees in conjunction with such collection efforts. I hereby authorize Caduceus Medical Group and it's agents to release all information necessary to secure the payment for services required. I further agree that a photocopy of this agreement shall be as vald as the original.

_____ _____

Signature Date

ETHNICITY:

☐ African-American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Other:_____

LANGUAGE SPOKEN:

_____

PREFERRED PHARMACY:

Name:_____ Address:_____ Phone:_____

PATIENT FINANCIAL POLICY

Caduceus Medical Group is dedicated to providing optimal care and service to our patients. This policy has been developed to address questions often asked by our patients.

Benefits and Coverage Limitations

It is the responsibility of the patient/guarantor to understand the terms and conditions of his/her insurance coverage including: in-network providers, co-payment and co-insurance responsibilities, and benefit maximums. Caduceus Medical Group will be held harmless from any fees resulting from the failure to understand any of the terms and conditions regarding the patient's coverage policy which results in non- payment by the health plan. Any such fees shall be the sole responsibility of the patient/guarantor.

Non-Covered Benefits

In the event that your health plan (insurance) determines a service to be a non-covered benefit or if the procedure is considered to be elective and not medically necessary, you will be responsible for payment of the total charges related to that visit. For services rendered to minors, the parent/guardian and/or policy holder accompanying the minor will be responsible for payment of all expenses incurred.

Payment

Payment for services is due at the time services are rendered. This would include co-payments, co-insurance, yearly deductible, and amounts for non-covered services. Outstanding balances are also due at the time other services are being provided. If a credit balance exists on an account, Caduceus is authorized to apply the credit balance to any unpaid or future balance.

Past Due Balances

For any past due balance in excess of 45 days, a monthly finance charge of 1.5% will be assessed and added to the balance due.

Collection of Unpaid Accounts

Statements for balances due are sent at 30, 60, and 90 days. The statement at 90 days is the final notice. Unpaid balances over 120 days will be referred to an outside collection agency and/or an attorney, which may result in legal action and reporting to credit bureaus. All legal expenses and costs incurred by Caduceus related to collection of any balance will be the responsibility of the undersigned.

Payment Plans

Payment plans for unpaid balances must be in writing and must be approved by the Management Services Officer or the Executive Board. Physicians/providers are not authorized to offer or create any payment plans.

Special Physical and Form Fees

For special physicals and/or forms that may require completion by a physician, e.g. DMV, school, sports, camp, etc., the patient/guarantor is responsible for any fees related to the service unless documented to be a covered benefit by third-party payer.

Returned Check or Insufficient Funds

In the event that a check is returned for any reason or if there are insufficient funds, a fee in the amount of $25 will be assessed and added to the account balance.

I have read and understand the Patient Financial Policy of Caduceus Medical Group and accept all of the terms stated herein.

_____ _____

Print Name Signature

Date _____

CADUCEUS

Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided; and
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have the right to receive a copy of the *Notice of Information Practices* which provides a more complete description of information uses and disclosures prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and, prior to implementation, will post and make available, the revised notice at physical practice site(s). I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested.

○ I request the following restrictions to the use or disclosure of my health information:

_____

○ I also authorize the disclosure of my health information to the following family members or person(s):

○ I wish to be contacted regarding any test results or treatment plans by the methods indicated:

Please circle: **Home Phone** Yes/No **Cell Phone** Yes/No **Work Phone** Yes/No **Voice Mail** Yes/No
Fax Yes/No **E-Mail** Yes/No **US Mail** Yes/No

Patient Name	Birth Date	Signature of Patient or Legal Representative
Relationship to Patient (if patient is a minor)	Date	Witness

OFFICE USE ONLY:

○ Accepted

○ Denied

Signature	Title	Date

FP-009C

Formulary Benefits Data Consent Form

By signing below I give permission for **Caduceus Medical** to access my pharmacy benefits data electronically through **Surescripts Network**.

This consent will enable caduceus to obtain formulary information, and information about other prescriptions prescribed by other providers using Surescripts.

_____	_____
Patient Name (PRINTED)	Date of Birth
_____	_____
Patient/Guardian Signature	Date

CADUCEUS 4 KIDS

Date Form Completed:_____ Child's Name:_____

Age:_____ Date of Birth:_____

Birth History

Birthplace:_____ Birth weight:_____ Birth length:_____inches

Was pregnancy normal? Yes____ No____ If no, explain:_____

Was baby full-term? Yes____ No____ If no, at what gestational week was baby delivered?_____

Was delivery normal? Yes____ No____ If no, describe any complications:_____

Were there any nursery problems? Yes____ No____ If yes, explain:_____

Ethnic background of biological parents: (circle) White Hispanic Black American-Indian Asian Filipino Pacific Islander

Growth & Development

Do you use any special diets for your child? Yes____ No____ If yes, describe:_____

Is your child taking fluoride? Yes____ No____ Does your child drink bottled water or tap water?_____

Ages when your child first:

Rolled_____ Sat up unassisted_____ Crawled_____ Used first word:_____ Walked:_____

Received first teeth:_____ Put words together:_____ Discontinued bottle:_____ Became toilet-trained:____

School History

Current year in school:_____ Grade point average:_____ School name:_____

Attends special school or classes? Yes____ No____ If yes, describe:_____

Past Medical History

Does your child currently take any medications? Yes____ No____

If yes, please list:_____

Known allergies or allergic reactions (e.g., drugs, asthma, hives, hay fever)

_____

Hospitalizations: when, where, why?

_____

Date Hospital Reason

_____

Date Hospital Reason

_____

Date Hospital Reason

Serious injuries:

_____

Date Where treated? Cause

Any history or problem with: (circle all that apply)

Seizures	Yes	No	Rebellious behavior	Yes	No
Diabetes	Yes	No	Difficulty concentrating	Yes	No
Asthma	Yes	No	Cries easily	Yes	No
Hay Fever	Yes	No	Fearful	Yes	No
Heart disease	Yes	No	School Problems	Yes	No
Ulcers	Yes	No	Other:_____		
Cancer	Yes	No	_____		
Bed-wetting	Yes	No			
Speech/Hearing	Yes	No			
Eczema	Yes	No			

Contagious diseases (at what age) ?

Measles	Yes___ No___	Scarlet Fever	Yes____ No____
Chickenpox	Yes___ No___	Any other:_____	
Mumps	Yes___ No___		

General Survey

Has your child had any unusual problems with the following:

Eyes, Ears, Nose, Throat	Yes___ No___	If yes, explain:_____
Heart, Lungs	Yes___ No___	If yes, explain:_____
Stomach, Intestines	Yes___ No___	If yes, explain:_____
Kidney, Bladder	Yes___ No___	If yes, explain:_____
Blood	Yes___ No___	If yes, explain:_____
Immune System	Yes___ No___	If yes, explain:_____
Bones, Muscles	Yes___ No___	If yes, explain:_____
Tooth Decay	Yes___ No___	If yes, explain:_____

Family History

Child's father: Living?____ Age:____ Health:_____ If deceased, cause of death?_____
Child's mother: Living?____ Age:____ Health:_____ If deceased, cause of death?_____
Siblings: How many/gender?_____

Do the child's parents live together? Yes___ No___ Are there smokers in the child's home? Yes___ No___

Family History of:

Allergies	Yes___ No___	Who:_____
Cancer	Yes___ No___	Who:_____
Heart Disease	Yes___ No___	Who:_____
Asthma	Yes___ No___	Who:_____
Diabetes	Yes___ No___	Who:_____
Tuberculosis	Yes___ No___	Who:_____
Other	Yes___ No___	Who:_____

How long has your family lived in this area? _____ Any additional information you believe we should know about your child:_____
Where did you live prior to this area?_____

Your child's last/previous physician's name:_____

To the best of my knowledge, the information provided herein is true and accurate.

_____ _____
Name (print) Signature

HEALTH QUESTIONNAIRE

NAME _____ AGE _____ DATE _____

ADDRESS _____ PHONE _____

HISTORY OF PAST ILLNESS: Have you had

Childhood:

Measles	No	Yes
Mumps	No	Yes
Chickenpox	No	Yes
Diabetes	No	Yes
Strokes	No	Yes
Cancer	No	Yes

Rheumatic fever or heart disease	No	Yes
Tuberculosis	No	Yes
Venereal disease	No	Yes
Congenital Abnormalities	No	Yes
Other serious diseases: _____	No	Yes

Adult:

Have you had any serious illness?	No	Yes
Have you ever been hospitalized or been under medical care for very long?	No	Yes

If yes, for what reason? _____

Operations:

Have you had any surgery? No Yes

List _____

Injuries:

Have you had any broken bones?	No	Yes
Have you had any head concussions or injuries?	No	Yes
Have you ever been knocked unconscious?	No	Yes

FAMILY HISTORY:	If Living: Age	If Living: Health	If Deceased: Age (at death) & Cause		Has any blood relative ever had:		
Father					Cancer	No	Yes
Mother					Tuberculosis	No	Yes
Brother/Sister					Diabetes	No	Yes
					Heart Trouble	No	Yes
					High blood pressure	No	Yes
Husband/Wife					Stroke	No	Yes
Son/Daughter					Convulsions	No	Yes
					Suicide	No	Yes
					Insanity	No	Yes
					Bleeding tendency	No	Yes
					Gout or other arthritis	No	Yes

SOCIAL HISTORY:

Circle One: Single Married Separated Divorced Widowed

Are you living with your husband or wife?	No	Yes
Is your sex life satisfactory?	No	Yes
Do you have dependents at home?	No	Yes

Alcoholic Beverages: Never _____ Rarely _____ Moderately _____ Daily _____ Ever? _____ No Yes

Tobacco: Cigarettes _____ Packs a day _____ Don't Smoke _____ Ever smoked? _____ No Yes

Are you employed? Full Time _____ Part Time _____

What is your job? _____

Are you exposed to fumes, dusts or solvents? _____

Education: (Years)

- Grade School _____
- High School _____
- College _____
- Postgraduate _____

How much time have you lost from work because of your health during the past?

- Six Months _____
- One Year _____
- Five Years _____

SYSTEMIC REVIEW: Do you have any of the following?

General:

Recent weight change?	No	Yes
Have you been in good general health most of your life?	No	Yes

Skin:

Skin Disease	No	Yes
Jaundice	No	Yes
Hives, eczema or rash	No	Yes
Frequent infection or boils	No	Yes
Abnormal pigmentation	No	Yes

Head-Eyes-Ears-Nose-Throat:

Eye disease or injury	No	Yes
Do you wear glasses?	No	Yes
Double vision	No	Yes
Headaches	No	Yes
Glaucoma	No	Yes
Itching eyes or nose	No	Yes

Head-Eyes-Ears-Nose-Throat (cont'd)

Sneezing or runny nose	No	Yes
Nosebleeds	No	Yes
Chronic sinus trouble	No	Yes
Ear disease	No	Yes
Impaired hearing	No	Yes
Dizziness or transient episodes of unconsciousness	No	Yes

Neck:

Stiffness	No	Yes
Thyroid trouble	No	Yes
Enlarged glands	No	Yes

Respiratory:

URI (cold) now	No	Yes
Spitting up blood	No	Yes
Chronic or frequent cough	No	Yes

SYSTEMIC REVIEW:

Respiratory (Cont'd)

Asthma or Wheezing	No	Yes
Difficulty breathing	No	Yes
Any trouble with lungs	No	Yes
Pleurisy or Pneumonia	No	Yes

Cardiovascular:

Chest pain or angina pectoris	No	Yes
Shortness of breath with walking or lying down	No	Yes
Difficulty walking two blocks	No	Yes
Heart trouble or heart attacks	No	Yes
High blood pressure	No	Yes
Swelling of hands, feet or ankles	No	Yes
Awakening in the night smothering	No	Yes
Heart murmur	No	Yes

Gastrointestinal:

Peptic ulcer (stomach or duodenal)	No	Yes
Vomiting blood or food	No	Yes
Gallbladder disease	No	Yes
Liver trouble	No	Yes
Hepatitis	No	Yes
Painful bowel movements	No	Yes
Bleeding with bowel movements	No	Yes
Black stools	No	Yes
Hemorrhoids or piles	No	Yes
Recent change in bowel habits	No	Yes
Frequent diarrhea	No	Yes
Heartburn or indigestion	No	Yes
Cramping or pain in the abdomen	No	Yes
Does food stick in throat	No	Yes

Genitourinary

Loss of urine	No	Yes
Frequent urination	No	Yes
Night time urinating	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Kidney trouble	No	Yes
Kidney stones	No	Yes
Bright's Disease	No	Yes

Gynecological

Age periods started _____

How long do periods last? _____ Days

Gynecological (cont'd)

Number of pregnancies _____

Number of miscarriages _____

Date of last cancer smear and results _____

_____

Frequency of periods, every _____ days.

Any pain with your periods	No	Yes

Number of children _____ Ages _____

Date of first day of last period _____

Locomotor-Musculoskeletal:

Varicose veins	No	Yes
Weakness of muscles or joints	No	Yes
Any difficulty in walking	No	Yes
Any pain in calves or buttocks on walking relieved by rest	No	Yes

Neuro-Psychiatric:

Have you ever had psychiatric care?	No	Yes
Have you been advised to see a psychiatrist?	No	Yes
Do you ever have, or have had, fainting spells?	No	Yes
Convulsions	No	Yes
Paralysis	No	Yes

Hematologic:

Are you slow to heal after cuts	No	Yes
Blood disease	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Have you had difficulty with bleeding excessively after tooth extraction or surgery?	No	Yes
Have you had abnormal bruising or bleeding?	No	Yes

Allergic:

Any allergies, including medication	No	Yes

Endocrine

Thyroid disease	No	Yes
Hormone therapy	No	Yes
Any change in hat or glove size	No	Yes
Any change in hair growth	No	Yes
Have you become colder than before - or skin become dryer	No	Yes

HEIGHT _____

WEIGHT _____

ALLERGIES AND SENSITIVITIES

1. Is there a history of skin reaction or other untoward reaction or sickness following injection or oral administration of:

	Circle One			What Drug or Food?
Penicillin or other antibiotics	Yes	No	Don't know	_____
Morphine, Codeine, Demerol or other narcotics	Yes	No	Don't know	_____
Novocain or other anesthetics	Yes	No	Don't know	_____
Aspirin, empirin or other pain remedies	Yes	No	Don't know	_____
Sulfa drugs	Yes	No	Don't know	_____
Tetanus antitoxin or other serums	Yes	No	Don't know	_____
Adhesive tape	Yes	No	Don't know	_____
Iodine or merthiolate	Yes	No	Don't know	_____
Any other drug or medication	Yes	No	Don't know	_____
Any foods, such as egg, milk or chocolate	Yes	No	Don't know	_____

2. Drugs Recently Taken: Within the past six months has patient taken:

Cortisone	Yes	No	Don't know
ACTH	Yes	No	Don't know
Anticoagulants	Yes	No	Don't know
Tranquilizers	Yes	No	Don't know
Hypotensives (high blood pressure medicines)	Yes	No	Don't know
Has the patient ever received treatment for: Asthma, rheumatism or rheumatic fever?	Yes	No	Don't know
Aspirin	Yes	No	Don't know

Source of information, if other than patient: _____

Signature of person acquiring this information: _____

Doctor _____ Date _____ Signature of patient _____

CADUCEUS
MEDICAL GROUP

Name: _____

D.O.B. _____

Who is your primary care physician/family doctor?

_____

Office Use Only

Blood Pressure: _____
Heart Rate: _____
Temperature: _____
Weight: _____

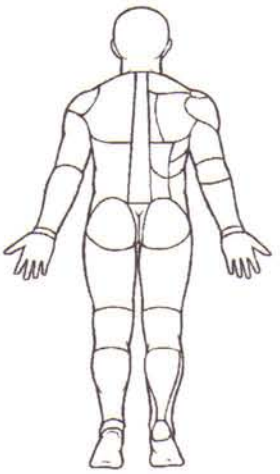
What is the major reason you are coming to see the doctor (chief complaint):

_____

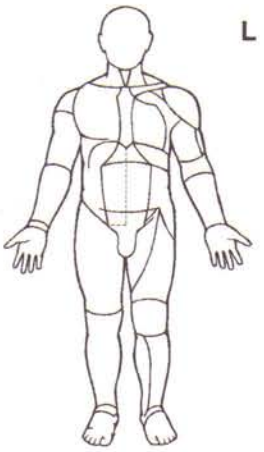
_____

_____

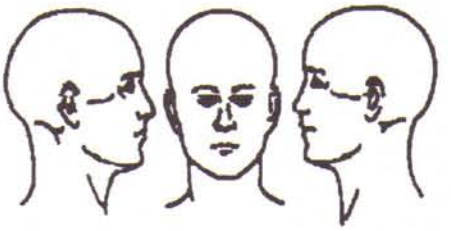
Mark an "X" on the figures below where your pain starts and show where it goes with an arrow.



R



L



How long does the pain last?

☐ Constant ☐ Intermittent

Quality Of Pain:

Please mark all that apply:

( ) Throbbing	( ) Cramping	( ) Gnawing	( ) Aching	( ) Shooting
( ) Stabbing	( ) Sharp	( ) Hot-burning	( ) Heavy	( ) Tender
( ) Splitting	( ) Sickening	( ) Tiring-Exhausting	( ) Fearful	
( ) Punishing-Cruel	( ) Other_____			

Intensity of Pain:
On a scale of 0-10, with 10 being the worst imaginable pain and 0 the absence of pain, how would you rate your pain?

At Worst:	0	1	2	3	4	5	6	7	8	9	10
At Best:	0	1	2	3	4	5	6	7	8	9	10
Average:	0	1	2	3	4	5	6	7	8	9	10

What makes your pain worse? Mark all that apply.
( ) Bending ( ) Lifting ( ) Coughing ( ) Sneezing
( ) Defecation ( ) Prolonged Sitting ( ) Walking ( ) Prolonged Standing
( ) Other, please explain _____

What makes your pain better? Mark all that apply.
( ) Rest ( ) Activity/physical therapy ( ) Massage ( ) Heat
( ) Cold ( ) Lying in a fetal position ( ) Lying on your back
( ) Lying on back w/ pillows under your legs ( ) Medication, please list _____
( ) Other, please explain _____

Which of the following tests have you undergone prior to your arrival here today?
( ) X-rays ( ) CAT scan ( ) MRI scan ( ) EMG test
( ) Discogram ( ) Myelogram

REVIEW OF SYSTEMS

Please place a checkmark if you currently have any of the following symptoms. (Disregard the bold headings)

• Constitutional
( ) No Problems ( ) Fever ( ) Weight Loss ( ) Fatigue

• Cardiovascular
( ) No Problems ( ) Chest Pain/Angina ( ) Irregular Heart Beat ( ) Fainting
( ) Limb Swelling ( ) Limb Pain on Walking

• Genitourinary
( ) No Problems ( ) Incontinence ( ) Pain on Urination ( ) Blood in Urine

• Musculoskeletal
( ) No Problems ( ) Muscle Pain ( ) Muscle Cramp ( ) Neck Pain ( ) Back Pain
( ) Joint Swelling ( ) Joint Pain ( ) Joint Stiffness ( ) Muscle Twitches

• Neurologic
( ) No Problems ( ) Headache ( ) Weakness ( ) Tremors ( ) Seizures
( ) Trouble with Memory/Concentration ( ) Blackouts ( ) Face Numbness/Pain

• Psychiatric
( ) No Problems ( ) Hallucinations ( ) Feeling Down ( ) Trouble Sleeping
( ) Suicidal Thoughts ( ) Inappropriate Crying/Laughing

• Hematologic/Lymphatic
( ) No Problems ( ) Abnormal Bleeding ( ) Anemia ( ) Lumps/Swellings

ADVANCED DIRECTIVES ACKNOWLEDGEMENT FORM

Patient Name: _____ Date:_____

_____ I ***do have*** an Advanced Directive / Living Will / Durable Power of Attorney for medical or health care decisions.

_____ I ***do not have*** an Advanced Directive / Living Will / Durable Power of Attorney for medical or health care decisions.

_____ Date: _____
Patient's Signature

FOR ADMINISTRATIVE USE ONLY:

_____ Written information regarding Advanced Directives ***was provided***.

If the patient has an Advanced Directive, has it been placed in the Medical Record?:

_____ Yes _____ No

Comments:

Staff Signature: _____ Date: _____

ADVANCED DIRECTIVES

Definition

Advanced Directives can protect your right to refuse or accept medical care if you ever become mentally or physically unable to choose or communicate your wishes due to an illness or injury.

Why have an "Advanced Directive"?

This protects your right to make medical choices that can affect your life. It helps your family by allowing them to avoid the responsibility and stress of making difficult decisions. It helps your physician by providing guidelines for your care.

What kind of situation might cause me to need an Advanced Directive?

IF YOU EVER:

1. Have irreversible brain damage or brain disease, which can affect your ability to think as well as communicate.
2. Have a permanent coma or other unconscious state which can leave you without hope of recovery.
3. Have a terminal illness in which you are expected to die within a short period of time.

What kinds of things can Advanced Directives Discuss?

1. **CPR** – A procedure is used to restore stopped breathing or heartbeat.
2. **IV Therapy (intravenous)** – This is used to provide food, water, and/or medication through a tube placed in a vein.
3. **Feeding Tubes** – Are inserted through the nose, throat or through a hole in the abdomen (stomach wall) to provide liquid food/nutrition when you cannot eat, chew or swallow yourself.
4. **Respirators** – machines used to keep a patient breathing when they are unable to breathe on their own. (Previously called "iron lungs").
5. **Dialysis** – a method of cleansing the blood by a machine when kidneys are no longer working properly.

Advanced Directives allow you to state whether you choose any of these procedures or wish to refuse them.

How do I get an "Advanced Directive"?

You can make a **"Living Will"** or a **"Durable Power of Attorney"** for health care. You can contact an attorney to get one of these forms, or you can simply put your wishes in writing: be as specific as possible, then sign the document and have it witnessed and notarized.

Give a copy of your advanced directive to your physician's office as part of your medical record, and inform your family that you have done so. You can also make special requests or statements regarding organ donations, etc.

Where can I get more information or help in preparing Advanced Directives?

- Any family lawyer or attorney
- The State Attorney General's office
- The Internet
- Local hospitals
- Local hospice agencies
- Local home health agencies
- Long term care facilities, such a local nursing homes

NUTRITION RELATED HISTORY

Patient Name:_____ **Date:** _____/_____/_____

Age: _____ Date of Birth: _____/_____/_____ Sex: M ☐ F ☐ Ethnicity: _____

Phone Number: _____ Referring Clinician: _____

Reason for Visit: _____

Personal Goal(s) with Nutrition: _____

_____

Recent weight change (gain/loss in what time frame): _____

Possible Reason for Weight Change: _____

Current Exercise Schedule: _____

Disabilities: _____

Appetite: Excellent ☐ Good ☐ Fair ☐ Poor ☐ Dentures: Yes ☐ No ☐

Difficulty swallowing/chewing? (if yes, describe): _____

Recent nausea, vomiting, constipation, diarrhea: (if yes, describe): _____

Cultural or religious food preferences: _____

Motivation level for change: No motivation 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Very Motivated

Have you seen a dietitian before? If so for what?: _____

Past Medical History: (check off all current (C) or resolved (R) conditions)

C ☐ R ☐ High Cholesterol	C ☐ R ☐ Pre-Diabetes	C ☐ R ☐ Gastrointestinal Disorders (IBS, Celiac Disease, GERD, Gastric Bypass etc.)
C ☐ R ☐ High Triglycerides	C ☐ R ☐ Diabetes	If so, describe:_____
C ☐ R ☐ High Blood Pressure	C ☐ R ☐ Cancer	_____
C ☐ R ☐ Overweight/Obesity	C ☐ R ☐ Underweight	C ☐ R ☐ Other: _____

Lifestyle: Employed? Yes ☐ No ☐ Occupation: _____

Sources of stress: _____

Work schedule: _____

Barriers to eating healthy when at work: _____

_____

_____

Barriers to eating healthy when at home: _____

_____

_____

Barriers to eating healthy on the weekends: _____

_____

Please start thinking about how you eat on a regular basis before you come in for the consult. Thank you!

PATIENT FINANCIAL POLICY

Caduceus Medical Group is dedicated to providing optimal care and service to our patients. This policy has been developed to clarify matters that frequently arise between our patients and medical office(s). If you have any questions regarding the financial policy, please discuss them with our operations officer.

Benefits and Coverage Limitations – It is the responsibility of the patient/guarantor to understand the terms and conditions of their insurance coverage, including; in-network providers, co-payment and coinsurance responsibilities, and lifetime maximums. Caduceus Medical Group will be held harmless from any fees resulting from the failure to understand any of the terms and conditions regarding the patient's coverage policy which results in non-payment by the health plan, and is the sole responsibility of the patient/guarantor.

Non-covered Benefit – In the event that your health plan (insurance) determines a service to be a non-covered benefit, or if the procedure is considered to be elective and not medically necessary, you will be responsible for payment of the total charges related to that visit. For services rendered to minors, the parent/guardian, and/or policy holder accompanying the minor will be responsible for payment of all expenses incurred.

Time of Payment – Payment for services is due at the time services are rendered. This would include co-payments, co-insurance (patient responsibility), non-covered services, and deductibles. Outstanding balances are also due at the time of service.

Credit Balances – If a credit balance exists on an account, Caduceus is authorized to apply the credit balance to any unpaid or future balance.

Past Due Balance – For any past due balance in excess of 45 days, a monthly finance charge of 1.5% will be assessed and added to the balance due.

Collection of Unpaid Accounts – Statements requesting payment for balance due, when determined as patient responsibility, are sent at 30, 60, and 90 days. The statement at 90 days is the final notice. Unpaid balances over 120 days will be referred to an outside collection agency and/or an attorney which may result in legal action and reporting to credit bureaus. All legal expenses and costs incurred by Caduceus will be the responsibility of the undersigned.

Payment Plans – Payment plans for unpaid balances must be in writing and can only be approved by the Management Services Office or Executive Board. Physicians/providers are not authorized to offer or create any payment plans.

Special Physical and Form Fees – For special physicals and/or forms that may be required, e.g., DMV, Schools, Camps, Employers, and Sports Teams – the patient/guarantor is responsible for any fees related to the service, unless documented to be a covered benefit by the health plan.

Returned Check or Insufficient Funds – In the event that a check is returned, for any reason, or if there are insufficient funds, a fee in the amount of $25 will be assessed and added to the account.

I have read and understand the Patient Financial Policy of Caduceus Medical Group and accept all the terms maintained, herein.

Signature: _____ Date: _____

Name (Print): _____

PATIENT FINANCIAL POLICY

Caduceus Medical Group is dedicated to providing optimal care and service to our patients. This policy has been developed to address questions often asked by our patients.

Benefits and Coverage Limitations

It is the responsibility of the patient/guarantor to understand the terms and conditions of his/her insurance coverage including: in-network providers, co-payment and co-insurance responsibilities, and benefit maximums. Caduceus Medical Group will be held harmless from any fees resulting from the failure to understand any of the terms and conditions regarding the patient's coverage policy which results in non- payment by the health plan. Any such fees shall be the sole responsibility of the patient/guarantor.

Non-Covered Benefits

In the event that your health plan (insurance) determines a service to be a non-covered benefit or if the procedure is considered to be elective and not medically necessary, you will be responsible for payment of the total charges related to that visit. For services rendered to minors, the parent/guardian and/or policy holder accompanying the minor will be responsible for payment of all expenses incurred.

Payment

Payment for services is due at the time services are rendered. This would include co-payments, co-insurance, yearly deductible, and amounts for non-covered services. Outstanding balances are also due at the time other services are being provided. If a credit balance exists on an account, Caduceus is authorized to apply the credit balance to any unpaid or future balance.

Past Due Balances

For any past due balance in excess of 45 days, a monthly finance charge of 1.5% will be assessed and added to the balance due.

Collection of Unpaid Accounts

Statements for balances due are sent at 30, 60, and 90 days. The statement at 90 days is the final notice. Unpaid balances over 120 days will be referred to an outside collection agency and/or an attorney, which may result in legal action and reporting to credit bureaus. All legal expenses and costs incurred by Caduceus related to collection of any balance will be the responsibility of the undersigned.

Payment Plans

Payment plans for unpaid balances must be in writing and must be approved by the Management Services Officer or the Executive Board. Physicians/providers are not authorized to offer or create any payment plans.

Special Physical and Form Fees

For special physicals and/or forms that may require completion by a physician, e.g. DMV, school, sports, camp, etc., the patient/guarantor is responsible for any fees related to the service unless documented to be a covered benefit by third-party payer.

Returned Check or Insufficient Funds

In the event that a check is returned for any reason or if there are insufficient funds, a fee in the amount of $25 will be assessed and added to the account balance.

I have read and understand the Patient Financial Policy of Caduceus Medical Group and accept all of the terms stated herein.

_____ _____

Print Name Signature

Date _____

CADUCEUS
MEDICAL GROUP

Authorization to Use or Disclose Health Information

Patient Name:_____ Date of Birth:_____

1. I authorize the use or disclosure of the above named individual's health information as described below:

   _____ is authorized to make the disclosure, indicate office below:

   - ❑ Caduceus Imperial 18300 Yorba Linda Blvd, Suite 204, Yorba Linda, CA 92886
   - ❑ Caduceus Specialty 18200 Yorba Linda Blvd, Suite 104, Yorba Linda, CA 92886
   - ❑ Caduceus4Kids, 18200 Yorba Linda Blvd, Suite 108, Yorba Linda, CA 92886
   - ❑ Caduceus Jamboree, 19724 MacArthur Blvd, Suite 100, Irvine, CA 92612
   - ❑ Caduceus on Thalia, 333 Thalia, Laguna Beach, CA 92 xxx

2. The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated)

   - ❑ Problem list
   - ❑ Medication list
   - ❑ List of allergies
   - ❑ Immunization records
   - ❑ Most recent office notes
   - ❑ Most recent hospitalization
   - ❑ Lab/ Xray results (please describe the dates or types of lab tests you would like disclosed)_____
   - ❑ Consultation reports from (please supply doctors' names)_____ _____
   - ❑ Other (please describe)_____

3. I understand that the information in my health record may include information relating to sexually-transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. The information identified above may be used by or disclosed to the following individuals or organization(s) listed here.

   Name:_____

   Address:_____

5. This information for which I'm authorizing disclosure will be used for the following purpose:
   - ❑ My personal records
   - ❑ Changing doctors
   - ❑ Appointment with a specialist
   - ❑ Moving
   - ❑ Legal case
   - ❑ Other (please describe)_____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7. Unless I specify differently, this authorization will expire: Date:_____
If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.

8. I understand that once the above information is disclosed to the designated party, it may be re-disclosed by that party and the information may not be protected by federal privacy laws or regulations.

9. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment.

_____ _____
Signature of Patient or Legal Representative Date

If signed by legal representative, relationship to patient: _____

_____ _____
Signature of Witness Date

CADUCEUS
MEDICAL GROUP

Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided; and
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have the right to receive a copy of the *Notice of Information Practices* which provides a more complete description of information uses and disclosures prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and, prior to implementation, will post and make available, the revised notice at physical practice site(s). I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested.

○ I request the following restrictions to the use or disclosure of my health information:

_____
_____
_____

○ I also authorize the disclosure of my health information to the following family members or person(s):

_____
_____
_____

○ I wish to be contacted regarding any test results or treatment plans by the methods indicated:

Please circle: **Home Phone** Yes/No **Cell Phone** Yes/No **Work Phone** Yes/No **Voice Mail** Yes/No

Fax Yes/No **E-Mail** Yes/No **US Mail** Yes/No

_____	_____	_____
Patient Name	Birth Date	Signature of Patient or Legal Representative
_____	_____	_____
Relationship to Patient (if patient is a minor)	Date	Witness

OFFICE USE ONLY:

○ Accepted

○ Denied

_____	_____	_____
Signature	Title	Date

CADUCEUS
MEDICAL GROUP

Name: _____

D.O.B. _____

Who is your primary care physician/family doctor?

_____

Office Use Only

Blood Pressure: _____
Heart Rate: _____
Temperature: _____
Weight: _____

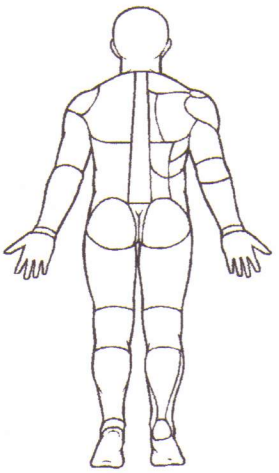
What is the major reason you are coming to see the doctor (chief complaint):

_____

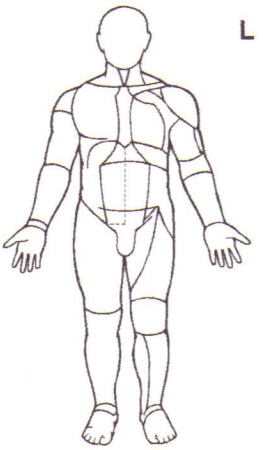
_____

_____

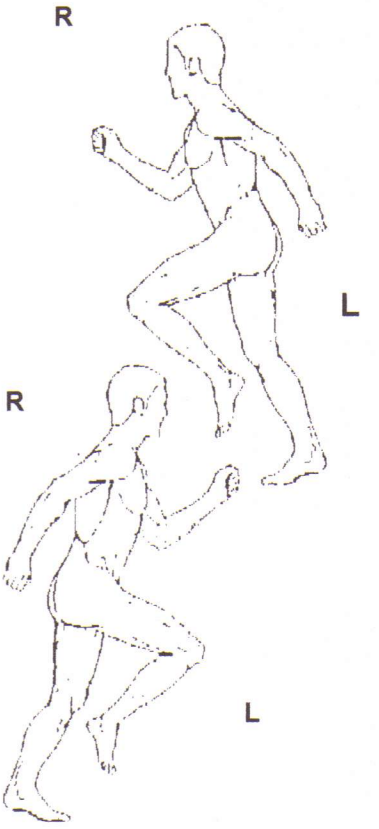
Mark an "X" on the figures below where your pain starts and show where it goes with an arrow.

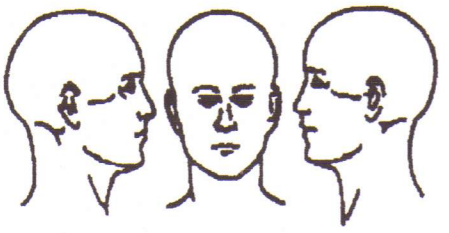


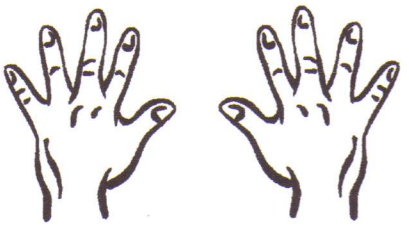
R

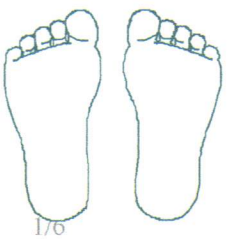


L









How long have you had this pain? _____
When did it start? _____
What were you doing when the pain first started? _____
_____

How long does the pain last?

- ☐ Constant
- ☐ Intermittent

QUALITY OF YOUR PAIN:

Please mark all that apply:

( ) Throbbing	( ) Cramping	( ) Gnawing	( ) Aching	( ) Shooting
( ) Stabbing	( ) Sharp	( ) Hot-burning	( ) Heavy	( ) Tender
( ) Splitting	( ) Sickening	( ) Tiring-Exhausting	( ) Fearful	
( ) Punishing-Cruel	( ) Other_____			

Intensity of Pain

On a scale of 0-10, with 10 being the worst imaginable pain and 0 the absence of pain, how would you rate your pain?

At Worst:	0	1	2	3	4	5	6	7	8	9	10
At Best:	0	1	2	3	4	5	6	7	8	9	10
Average:	0	1	2	3	4	5	6	7	8	9	10

What makes your pain worse? Mark all that apply.

( ) Bending	( ) Lifting	( ) Coughing	( ) Sneezing
( ) Defecation	( ) Prolonged Sitting	( ) Walking	( ) Prolonged Standing

( ) Other, please explain _____

What makes your pain better? Mark all that apply.

( ) Rest	( ) Activity/physical therapy	( ) Massage	( ) Heat
( ) Cold	( ) Lying in a fetal position	( ) Lying on your back	
( ) Lying on back w/ pillows under your legs		( ) Medication, please list _____	

( ) Other, please explain _____

Are there other symptoms/problems associated with the pain?

( ) Difficulty sleeping ( ) Feel "blue" all the time

( ) Other(s), please describe _____

In what time period is your pain worst?

( ) early morning ( ) late evening

TREATMENT HISTORY

How many times have you visited a professional caregiver (of any kind) for this *current* pain?

( ) 0-5 ( ) 6-10 ( ) Can't Remember ( ) Too many to count

Which of the following types of caregivers have you visited prior to your arrival here?

( ) Family Physician (includes general practitioner, internist, gynecologist, etc.)

( ) Sports Medicine	( ) Orthopedic/Spine Surgeon	( ) Neurologist
( ) Rheumatologist	( ) Occupational Medicine	( ) Anesthesiologist
( ) Rehabilitation Medicine	( ) Pain Management	( ) Chiropractor
( ) Osteopathic Physician	( ) Acupuncturist	( ) Biofeedback
( ) Alternative medicine	( ) Physical Therapist	

( ) Other, please list _____

Which of the following tests have you undergone prior to your arrival here today?

( ) X-rays ( ) CAT scan ( ) MRI scan ( ) EMG test

( ) Discogram/Discography ( ) Myelogram

Please check the medications that you have tried for your pain in the past and their effectiveness. (0=no help, 10=very helpful)

	Tried Medication		
Name of medication	Yes	No	**Effectiveness (0-10)**
Tylenol/acetaminophen			
NSAID's: Motrin/Advil/Ibuprofen, etc			
Opioids: Vicodin/Norco/Oxycodone, etc			
Oral Steroids/Medrol dose pack			
Amitriptyline(Elavil), Nortriptyline(Pamelor), etc			
Muscle relaxants/Flexaril			
Neurontin/Topamax/Tegretol, etc			
Marijuana/Cocaine/Heroine/Other illicit drugs			
Xanax/Ativan/Valium,etc			
Others, please list			

Have you had any of the following interventions done for your pain?

( ) TENS/nerve stimulator ( ) ultrasound ( ) Heat ( ) Cold

( ) Nerve block injections (not steroids)

If so, how many times? ☐1 ☐2 ☐3 ☐4 or more

( ) Trigger point injections

If so, how many times? ☐1 ☐2 ☐3 ☐4 or more

( ) Other, please list _____

PAST MEDICAL HISTORY

Drug and Food Allergies:

_____

Please list the medications you are currently taking:

Name	Dosage	How Often?

List all **MEDICAL** problems:

_____

_____

_____

_____

List all **SURGERIES** and their dates:

_____

_____

_____

_____

SOCIAL HISTORY

Any use of tobacco (type and for how long?)

_____

Any use of alcohol (type and for how long?)

_____

Any use of recreational drugs (type and for how long?)

_____

Any exposure to toxins/poisonous substances at work or with hobbies?

_____

What type of work do you do?

_____

Are you currently on disability: **( ) Yes** **( ) No**

Education:
Grade School High School College Post-Graduate Vocational Training

Marital Status:
Single Married Divorced Separated Widowed

FAMILY HISTORY

Mother: ☐ Living ☐ Deceased Age(s) _____ Health issues: _____

Father: ☐ Living ☐ Deceased Age(s) _____ Health issues: _____

Brother(s):
#_____ ☐ Living ☐ Deceased Age(s) _____ Health issues: _____
Sister(s):
#_____ ☐ Living ☐ Deceased Age(s) _____ Health issues: _____

REVIEW OF SYSTEMS

Please place a checkmark if you currently have any of the following symptoms. (Disregard the bold headings)

- **Constitutional**

( ) No Problems ( ) Fever ( ) Weight Loss ( ) Fatigue

- **Eyes**

( ) No Problems ( ) Blurred Vision ( ) Eye Redness ( ) Double Vision
( ) Vision Loss ( ) Eye Dryness ( ) Eye Pain

- **Ear/Nose/Throat**

( ) No Problems ( ) Trouble Hearing ( ) Ringing in the ear ( ) Loss of Balance
( ) Dizziness/Vertigo ( ) Ear Discharge ( ) Ear Pain

- **Cardiovascular**

( ) No Problems ( ) Chest Pain/Angina ( ) Irregular Heart Beat ( ) Fainting
( ) Limb Swelling ( ) Limb Pain on Walking

- **Respiratory**

( ) No Problems ( ) Trouble Breathing ( ) Chronic Cough ( ) Coughing Blood

- **Gastointestinal**

( ) No Problems ( ) Indigestion ( ) Nausea ( ) Vomiting ( ) Diarrhea
( ) Heart Burn ( ) Constipation ( ) Bloody Stools ( ) Abdominal Pain

- **Genitourinary**

( ) No Problems ( ) Incontinence ( ) Pain on Urination ( ) Blood in Urine

- **Musculoskeletal**

( ) No Problems ( ) Muscle Pain ( ) Muscle Cramp ( ) Neck Pain ( ) Back Pain
( ) Joint Swelling ( ) Joint Pain ( ) Joint Stiffness ( ) Muscle Twitches

- **Skin & Breast**

( ) No Problems ( ) Numbness ( ) Hair Loss ( ) Discoloration ( ) Tingling
( ) Sweating Change ( ) Nail Change

- **Neurologic**

( ) No Problems ( ) Headache ( ) Weakness ( ) Tremors ( ) Seizures
( ) Trouble with Memory/Concentration ( ) Blackouts ( ) Face Numbness/Pain

- **Psychiatric**

( ) No Problems ( ) Hallucinations ( ) Feeling Down ( ) Trouble Sleeping
( ) Suicidal Thoughts ( ) Inappropriate Crying/Laughing

- **Hematologic/Lymphatic**

( ) No Problems ( ) Abnormal Bleeding ( ) Anemia ( ) Lumps/Swellings

- **Allergic/Immunologic**

( ) No Problems ( ) Rash ( ) Joint Pain ( ) Dry Eyes +/- Mouth

- **Endocrinologic**

( ) No Problems ( ) Excessive Thirst ( ) Excessive Urination ( ) Heat/Cold Intolerance

Person completing this questionnaire_____

Relationship to Patient_____

For office use: This questionnaire may be completed by the patient, relatives or ancillary staff provided that it is signed and dated by the treating physician. Reference may later be made to this information by a signed and dated statement by the treating physician, designating location of the information, date obtained and any subsequent changes.

Physician's Signature_____Date_____

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have the right to receive a copy of the *Notice of Information Practices* that provides a more complete description of information uses and disclosures prior to signing this consent. I understand that the organization reserves the right to change their notice and practices, and prior to implementation will post and make available, the revised notice at physical practice site(s). I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested.

○ I request the following restrictions to the use or disclosure of my health information.

_____

_____

_____

○ I also authorize the disclosure of my health information to the following family members or person(s):

_____

_____

_____

○ I wish to be contacted regarding any test results or treatment plans by the methods indicated:

Please circle: **Home Phone** Yes/No **Cell Phone** Yes/No **Work Phone** Yes/No **Voice Mail** Yes/No

Fax Yes/No **E-Mail** Yes/No **US Mail** Yes/No **None of the above** Yes/No

_____ _____

Patient Name Birth Date

_____ _____ _____

Signature of Patient or Legal Representative Date Witness

_____

Relationship to Patient (if patient is a minor)

OFFICE USE ONLY:

○ Accepted

○ Denied

_____ _____ _____

Signature Title Date

CADUCEUS
MEDICAL GROUP

Return Patient Visit Form

Office Use Only
Blood Pressure: _____
Heart Rate: _____
Temperature: _____
Weight: _____

A. Reason for your visit today:
( ) Medication refill
( ) Follow up after a procedure
( ) Routine follow-up
( ) Other, please explain _____

B. Has your pain changed since the last visit: ( ) Yes ( ) No

C. ***Nature of Pain:*** ( ) Constant ( ) Intermittent

Intensity of Pain: On a scale of 0-10, with 10 being the worst imaginable pain and 0 the absence of pain; how would you rate your pain?

At Worst:	0	1	2	3	4	5	6	7	8	9	10
At Best:	0	1	2	3	4	5	6	7	8	9	10
Average:	0	1	2	3	4	5	6	7	8	9	10

What makes your pain worse?
( ) Bending ( ) Lifting ( ) Coughing ( ) Sneezing ( ) Defecation
( ) Prolonged Sitting ( ) Prolonged Standing ( ) Walking
( ) Other, please explain _____

What makes your pain better?
( ) Rest ( ) Activity/physical therapy ( ) Massage ( ) Heat ( ) Cold
( ) Lying in a fetal position ( ) Lying on your back ( ) Medication
( ) Other, please explain _____

D. Have you had any new medical problems or hospitalizations since your last clinic visit?
( ) Yes ( ) No
If yes, please explain: _____

E. Have you started any new medication(s) not prescribed by my office since the last clinic visit?
( ) Yes ( ) No
If yes, please list the name(s) and dose(s) of the medication(s):
_____

F. Have you noticed any side effects from medications: ( ) Yes ( ) No
If yes, please explain: _____

CADUCEUS
MEDICAL GROUP

G. Have you had any of the following since the last visit:

1.	Nausea/Vomiting	( ) Yes	( ) No
2.	Fever	( ) Yes	( ) No
3.	Constipation	( ) Yes	( ) No
4.	Urinary retention	( ) Yes	( ) No
5.	Flu-like symptoms	( ) Yes	( ) No

H. Who is your primary care doctor/family doctor? _____

CADUCEUS
MEDICAL GROUP

Appointment Materials

Please remember to bring the following information, if applicable, with you to your appointment:

- ☐ MRI and x-ray images along with the official reports
- ☐ The names and addresses of your primary care physician and the referring physician
- ☐ List of all the medications you are taking including herbal medications
- ☐ Complete the initial patient questionnaire we have sent you
- ☐ If you are transferring your care to us, please bring a copy of your old medical records

Failure to follow these guidelines may result in **delay** or rescheduling of your appointment. Once again, thank you for selecting us as your provider of choice. We look forward to taking care of all your pain care needs.