HUGH BEATTY, M.D. PAIN MANAGEMENT REGISTRATION FORM

PAIN MANAGEMENT PATIENT REGISTRATION

Patient Name_____

Referring Physician_____

DOB_____ AGE_____ Sex: M F

Social Security No._____
Marital Status: Single Married Divorced Widowed
(Circle One)
Name of Spouse or Parent_____
Home Phone(____)_____

Home Address: _____
City, State, Zip _____

If patient is a minor, please provide the following information about the responsible party:

Full Name of Responsible Party

_____

Relationship to Patient_____

Driver's License No.: _____State_____
Occupation_____
Employer_____

Work Phone(____)_____

Work Address_____

Primary Insurance:_____
Subscriber Name:_____
ID#_____Group No:_____
Address _____
Phone Number (____)_____

Secondary Insurance:_____
Subscriber Name: _____
ID#_____Group No:_____
Address _____
Phone Number(_____)_____

HEALTH HISTORY

(Please check any condition you have now or have had in the past and give a brief description.)

____ Lung problems_____
____ Cancer_____
____ Diabetes_____
____ Frequent Infections_____
____ Heart problems _____
____ High Blood Pressure_____
____ Stroke _____
____ Kidney problems_____
____ Memory Loss_____
____ Confusion _____
____ Suicidal thoughts_____
____ Other _____

If female, are you currently pregnant? Yes No
(Circle One)
Past Surgeries:_____
_____

Have you ever had a blood transfusion? Yes No
(Circle One)

FAMILY HISTORY

(Please mark and state who in your family has had any of the following:

Stroke_____ Diabetes_____
Heart
disease_____
Breast
cancer_____
Prostate Cancer
_____
Other
cancers_____

MEDICATIONS AND DOSAGES

1. _____
2. _____
3. _____
4. _____
5. _____

Hugh Beatty, M.D.

6001 Truxtun Avenue, Suite 240, Bakersfield, CA 93309 Phone: (661)395-0315 Fax: (661) 395-0277

PAIN MANAGEMENT AGREEMENT

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

I, _____, understand that this Pain Management Agreement (here after referred to as "Agreement") is essential to the trust and confidence necessary in a doctor/patient relationship, and that Dr. Beatty undertakes to treat me based on this Agreement.

I understand that if I do not comply with this Agreement, or fail to keep appointments and/or comply with therapeutic treatments, Dr. Beatty will stop prescribing pain-control medicines and will terminate my care .In the event care is terminated, Dr. Beatty will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.

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

I will not use any illegal controlled substances, including, but not limited to, methamphetamines, cocaine, and designer drugs. I will not share, sell, or trade medications.

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

I will safeguard my pain medications from loss or theft. *Lost or stolen medications will not be replaced.*

I agree that refills of my prescriptions for pain medications will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.

I agree to use exclusively _____Pharmacy located at _____, telephone number_____, for filling prescriptions for all of my pain medications.

I authorize Dr. Beatty 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 Dr. Beatty 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.

Patient Signature_____ Date_____

HUGH BEATTY, M.D.

6001 Truxtun Avenue, Suite 240, Bakersfield, CA 93309 Phone: (661)395-0315 (661) 395-0277

Patient Care Policies

_____ Initial **Follow-up treatment**: Test results will not be discussed over the phone. Therefore, any patient requiring blood work or other diagnostic testing will be scheduled for a follow-up appointment. The exception to this policy will be those results that are critically abnormal, or results which indicate immediate changes in your present treatment. In the event of such exceptions, you will be contacted by phone and given further instructions. This policy is necessary in order to document your progress or need for continued treatment. Your cooperation is appreciated.

_____ Initial **Phone calls** during normal business hours are screened to assess their nature and level of urgency. If you have an urgent medical problem, we will try our best to accommodate you the same day or within twenty-four hours. For all non-urgent calls, a message will be taken and forwarded to the appropriate staff member. Dr. Beatty's cell phone number is available to patients for medical questions. However, Dr. Beatty will not be able to treat patients over the phone, nor will he authorize the refill medications over the phone.

_____ Initial **After hours**: We are available to discuss and direct your medical needs twenty-four hours a day, 7 days a week. If you experience medical problems that you fear may be truly life threatening, notify 911 immediately: Do not wait to speak with your health care provider by phone. Non-urgent issues such as appointment scheduling should be addressed during normal business hours.

_____ Initial **Appointments**

- There will be a 15 minute allowable grace period for appointments. After 15 minutes, the Appointment will be subject to cancellation and rescheduling at a later time.
- Failure to cancel an existing appointment 24 hours in advance of the appointment will result in a $25.00 no-show fee. The no-show fee must be paid before or at your next visit.

_____ Initial **Walk-ins** will be treated only for the symptoms at hand. Any previous test results will not be discussed unless related to the patient symptoms. The number of walk-ins allotted each day will be determined by the amount of appointments previously scheduled.

_____ Initial If you are in need of an **Obstetrics and Gynecology** referral one will be issued to you during your initial visit Please note, Dr. Beatty will not prescribe birth control pills or devices or the morning-after pill, nor will he refer for abortions.

_____ Initial **Medications**, such as narcotics and pain relievers, will not be refilled over the phone. Patients seeking refills must schedule a follow-up appointment with the doctor.

_____ Initial **Fees**

- Copays, deductibles, and fees not covered by your insurance are due at the time of service.
- Administration fees are charged for forms requiring a health care provider's signature. This includes, but is not limited to, DMV and Doctor's Release to Participate in Physical Activities forms.

_____ Initial **Disability certification** must meet very specific requirements. If you are capable of walking unassisted into this office, chances are you are not permanently disabled. Disability for mental or emotional disorders must be established by a Board Certified Psychiatrist.

_____ **Jury Duty** excuses are provided only to those individuals who have a clearly defined medical or
Initial mental condition that prevents jury duty service. Common human encounters such as work related issues, depression, minor aches and pains, or controlled medical conditions do not apply.

_____ **Compliance** on the part of the patient is essential to quality health care. As a patient of
Initial this practice, you have the right to be informed about your treatment options. As your health care provider, we are working toward a common goal to improve or stabilize your medical condition. To accomplish this, it is crucial that a standard of compliance be maintained in order to minimize poor health outcomes.

_____ **Discharge from care** has unfortunately, on occasion, been necessary in order to ensure the
Initial integrity of this practice. Patients will be discharged from care for reasons including, but not limited to, inappropriate or abusive behavior, gross non-compliance on the part of the patient, or an obvious lack of doctor/patient rapport.

Patient understanding and adherence to these principles will allow us to provide efficient medical care.

I have read and understood the above Patient Care Policies.

_____ _____

Signature of Patient or Legal Guardian Date

HUGH BEATTY, M.D.

6001 Truxtun Avenue, Suite 240, Bakersfield, CA 93309 Phone: (661)395-0315 (661) 395-0277

Patient Care Policies for Pain Management Referrals

_____ Initial **Follow-up treatment**: Test results will not be discussed over the phone. Therefore, any patient requiring blood work or other diagnostic testing will be scheduled for a follow-up appointment. The exception to this policy will be those results that are critically abnormal, or results which indicate immediate changes in your present treatment. In the event of such exceptions, you will be contacted by phone and given further instructions. This policy is necessary in order to document your progress or need for continued treatment. Your cooperation is appreciated.

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_____ Initial **Fees**

- Copays, deductibles, and fees not covered by your insurance are due at the time of service.
- Administration fees are charged for forms requiring a health care provider's signature. This includes, but is not limited to, DMV and Doctor's Release to Participate in Physical Activities forms.

_____ Initial **Disability certification** must meet very specific requirements. If you are capable of walking unassisted into this office, chances are you are not permanently disabled. Disability for mental or emotional disorders must be established by a Board Certified Psychiatrist.

_____ Initial **Compliance** on the part of the patient is essential to quality health care. As a patient of Hugh Beatty, M.D., you have the right to be informed about your treatment options. As your health care Provider, we work with you toward a common goal: to improve or stabilize your medical condition. To accomplish this, it is crucial that a standard of patient compliance be maintained. Patient compliance will minimize poor health outcomes.

_____ **Jury Duty** excuses are provided only to those individuals who have a clearly defined medical or
Initial mental condition that prevents jury duty service. Common human encounters such as work related issues, depression, minor aches and pains, or controlled medical conditions do not apply.

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Patient understanding and adherence to these principles will allow us to provide efficient medical care.

I have read and understood the above Patient Care Policies.

_____ _____

Signature of Patient or Legal Guardian Date

HUGH BEATTY, M.D., INC.

6001 TRUXTUN AVENUE, SUITE 240, BAKERSFIELD, CA 93309 **Phone: (661)395-0315 FAX: (661)395-0277**

July 2, 2012

RE: Insurance Policy and Federal and State Regulations

Dear Patient:

Due to policy provisions in your contract with your insurance carrier, we are obligated to collect all patient responsibility balances.

If your insurance policy has provisions such as deductibles, co-insurances, or co-payments, these are provisions that have been agreed to between you and your insurance carrier. You are legally obligated to honor the contract provisions; we cannot dishonor, or in any way interfere with, the agreement between you and the carrier. In addition to a legal obligation to collect all deductibles, co-insurances, and co-payments, we cannot legally discount fees after their submission on your behalf to your carrier.

If we are part of your carrier's network, we have a further contractual obligation to collect balances as outlined by your carrier. Writing off patient responsibility balances could jeopardize our contract with your carrier.

If a portion of your fees is applied to an annual out-of-pocket maximum, and we do not collect that fee, your out-of-pocket maximum has not been correctly calculated.

Additionally, for Medicare patients that may have any medical services that are eligible under Medicare, we are legally obligated to collect the patient responsibility co-insurance, co-payment, or deductible under the terms of the anti-kickback laws.

We sincerely regret if any of these regulatory provisions cause you any inconvenience, but we are bound by federal and state law. Please feel free to contact us with any questions you may have concerning compliance with these provisions.

Sincerely,

Hugh Beatty, M.D.

I _____acknowledge that I have received a copy of this letter.

Signature:_____ Date:_____

Hugh Beatty, M.D.

6001 Truxtun Avenue, Suite 240, Bakersfield, CA 93309 Phone: (661) 395-0315 Fax: (661) 395-0277

Blood/Urine Test/Medication Use Agreement

I, _____, agree that I will submit to a blood and/or urine test if requested by my doctor to determine my compliance with my program of pain control medicines.

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

I will bring all unused pain medicines to every office visit.

I agree to follow these guidelines. The guidelines have been fully explained to me. All of my questions and concerns regarding treatment have been answered adequately. A copy of this Blood/Urine Test/Medication Use Agreement has been given to me.

This Agreement is entered into on _____
(Date)

Patient Signature _____

Physician Signature_____

Witnessed by _____

HUGH BEATTY, M.D. PATIENT REGISTRATION FORM

PATIENT REGISTRATION

Patient Name_____

DOB_____ AGE_____ Sex: M F

Social Security No._____
Marital Status: Single Married Divorced Widowed
(Circle One)
Name of Spouse or Parent_____
Home Phone(____)_____

Home Address: _____
City, State, Zip _____
Driver's License No:_____ State_____
Occupation_____
Employer _____
Work Phone (____)_____
Work Address _____

If patient is a minor, please provide the following information about the responsible party:

Full Name of Responsible Party
_____

Relationship to Patient_____

Primary Insurance:_____
Subscriber Name:_____
ID#_____Group No:_____
Address _____
Phone Number (____)_____

Secondary Insurance:_____
Subscriber Name: _____
ID#_____Group No:_____
Address _____
Phone Number(____)_____

Reason for visit today_____
_____
_____

HEALTH HISTORY: (Please check any condition you have now or have had in the past and give a brief description.)

____ Lung problems_____
____ Cancer_____
____ Diabetes_____
____ Frequent Infections_____
____ Heart problems _____
____ High Blood Pressure_____
____ Stroke _____
____ Kidney problems_____
____ Memory Loss_____
____ Confusion _____
____ Suicidal thoughts_____
____ Other _____

Past Surgeries:_____
_____

Have you ever had a blood transfusion? Yes No
(Circle One)

FAMILY HISTORY
(Please circle and state who in your family has had any of the following.)

Stroke_____ Diabetes_____
Heart
disease_____
Breast
cancer_____
Prostate Cancer
_____
Other
cancers_____

MEDICATIONS AND DOSAGES

_____
_____

WOMEN'S HEALTH
When was your last pap smear?_____
When was your last mammogram?_____