MICHAEL L. TRAN, M. D.

ANESTHESIOLOGIST & PAIN MANAGEMENT
4704 Hoen Avenue
Santa Rosa, CA 95405
PHONE (707) 546-7979
FAX (707) 546-7667

PATIENT:

Welcome to Dr. Tran's Medical Clinic.
At the request of Doctor ___________________ we have scheduled you for the following appointment:

Monday, Tuesday, Wednesday, Thursday, Friday

CONSULT APPT: _______________________________________

Monday, Tuesday, Wednesday, Thursday, Friday

PROCEDURE APPT: ____

(See enclosed)

Please **complete** the enclosed forms and bring with you at the time of your appointment, along with any **Spine MRI's, CAT scans, etc.**

Sincerely,

Michael L. Tran, M. D.

Associates:
Dr. Charles Evans, M.D.
Dr. Tobey Leung, M.D.
Rachel Chavez, PA-C
Teresa Martin, PA-C

<u>DIRECTIONS ON REVERSE SIDE</u>

MICHAEL L. TRAN, M.D.

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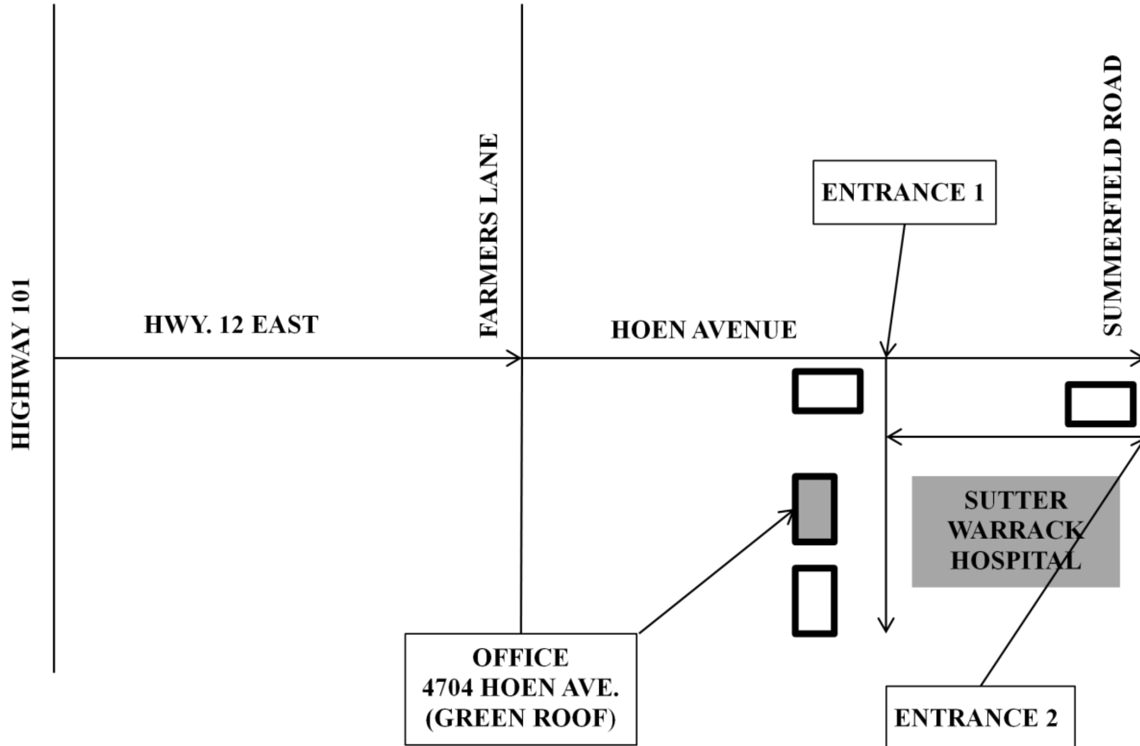
Santa Rosa, CA 95405
Tel: 707-546-7979 Fax: 707-546-7667

OFFICE LOCATION



IF YOU LIVE NORTH OF HWY. 12:

1. Take HWY 101, drive South to Exit HWY 12 EAST, Exit Sonoma
2. HWY. 12 EAST becomes HOEN AVENUE at FARMERS LANE
3. Go straight on HOEN AVENUE, take a right into the Hospital entrance
4. OFFICE is adjacent to Hospital, NOT IN HOSPITAL
5. IF you miss Entrance 1, you will intersect SUMMERFIELD RD.
6. Take RIGHT on SUMMERFIELD RD.
7. Take Second RIGHT to Hospital Entrance, circle around Hospital to OFFICE

IF YOU LIVE SOUTH OF HWY. 12:

1. Take HWY. 101, drive North to Exit HWY. 12 EAST, Exit Sonoma
2. HWY. 12 EAST becomes HOEN AVENUE at FARMERS LANE
3. Go straight on HOEN AVENUE, take a right into the Hospital entrance
4. OFFICE is adjacent to Hospital, NOT IN HOSPITAL
5. IF you miss Entrance 1, you will intersect SUMMERFIELD RD.
6. Take RIGHT on SUMMERFIELD RD.
7. Take Second RIGHT to Hospital Entrance, circle around Hospital to OFFICE

Michael L. Tran M.D.

Office use only: Initl Consult Auth Reqstd Date _________
Auth Rcd. _________

Welcome to our office. We are committed to the best, most comprehensive care possible. We encourage you to ask questions. Let us know your concerns and communicate openly with us. Please assist us by providing the following information. All information is confidential and is released only *with your consent.*

NEW PATIENT INFORMATION ***Please fill in information blanks BELOW the lines***

First Name Last Name	Date of Birth	Today's Date	Sex: M F	Age	
Parent If Patient Is A Minor	Patient's Social Security Number	Legal Guardian Name			
Primary Physician's Name	City	Phone #			
Referring Physician Name	City	Phone #			
Mailing Address # And Street Name	Apt.#	City	State	Zip	
Home Address (If Different Than Above)	Apt.#	City	State	Zip	
Home Phone # (including area code)	Work Phone #	Cell or Message Phone #			
Employer	Occupation				
Employer' s Address	City	State	Zip		
Spouse Name	Employer	Work Phone #			
Marital Status (Please Circle) Single Married Divorced Widowed					

WHOM TO NOTIFY IN CASE OF EMERGENCY

Name	Relationship		
Address	City	State	Zip
Home Phone # (Including area code)	Work Phone #	Cell Phone #	
Nearest Relative (Not Living With You)	City	State	
Home Phone #	Work Phone #	Cell Phone #	

FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES AND/OR INSURANCE INFORMATION

Primary Insurance	Claim Address	Phone #	
Subscriber's Name	Subscriber's Date of Birth	Subscriber's Social Security #	
Insurance ID #	Group #		
Secondary Name	Claim Address	Phone #	
Subscriber's Name	Subscriber's Date of Birth	Subscriber's Social Security #	
Insurance ID #	Group #		
Were You Injured On The Job? Yes No Have You Informed Your Employer? Yes No	Date of Original Injury	**Claim Number**	
Worker's Compensation Carrier Name	Address	Phone #	
Claims Adjuster Name	Phone #	Fax#	
Pharmacy You Use	City	Phone #	Fax#

Please Read And Sign Our Office Financial Policy And Agreement On Reverse Side

TURN SHEET OVER

OFFICE FINANCIAL POLICY (back of new pt form)

Patient Name: ___________ _______________________ **Date of Birth:**____________ __ **Today's Date:** _____________________

BASIC POLICY: Payment for all professional service/care, including co-payments and deductibles are due and payable in full at the time of your office visit. We accept checks, money orders and cash and will eventually be accepting credit cards for full payment.

FOR PATIENTS WITH INSURANCE: As a courtesy, we bill your primary insurance for you and need all necessary information to do so. We bill secondary insurance carriers for our patients. All patients having any insurance other than Medicare or Workers Compensation will be responsible for the full balance of their account after their primary and/or secondary insurance has paid. All co-payments and deductibles are due and payable at the time of your office visit. Your insurance carrier may require that you obtain prior authorization to be seen by our office in order to cover your care. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. You are ultimately responsible for all amounts billed.

INJURED WORKERS/WORKERS COMPENSATION PATIENTS: We are glad to provide services for injured workers provided we are given all information necessary to receive reimbursement from your carrier. We will need your case number, claims coordinator name and carrier name and phone number prior to your visit/s in order to bill the worker's compensation insurance company. Your office visit for evaluation or care may require that you obtain prior authorization from your employer and/or the Work Comp carrier before the doctor sees you.

PERSONAL INJURY CASES: We do not accept liens however are glad to see patients upon referral from a personal injury attorney. Care or evaluation will require prior authorization and confirmation of prompt payment from your legal counsel. Our office will bill your attorney and payment will be due and payable in full from your referring attorney within 15 days of billing.

MEDICARE PATIENTS: We are a participating provider for Medicare and will bill Medicare for you. We also bill Medicare supplemental insurances. Your approved portion of payment for your bill will be due and payable in full after Medicare and your secondary carriers have paid.

PROFESSIONAL FEES for SPECIAL PROCEDURES, INJECTIONS, TREATMENT, PERIODIC EXAMS or OTHER NON-COVERED SERVICES: Some care recommended may not be covered by your health insurance, Medicare or by your Work Comp carrier. Fees for these non-covered or denied services are due and payable in full at the time of your office visit or upon denial of your claim from your carrier. Please check with your carrier *prior to* your appointment date.

DISCLOSURE OF FINANCIAL INTEREST: Your procedure may be performed at a hospital or outpatient surgery center. If your procedure is scheduled at North Coast Medical Center, you have a right to know that Dr. Michael L. Tran has financial interest at NCMC. At your request, alternatives will be freely discussed and/or you are free to choose any facility that Dr. Tran is currently a staff physician. Potential sources of information concerning alternatives can either by obtained in the Yellow Pages or the county medical association.

MISSED APPOINTMENTS: In fairness to other patients and the doctor, we require at least 24 hours notice to cancel appointments. You may be charged for missed appointments or dismissed from the practice after repeated missed appointments.

I hereby duly authorize Michael L, Tran M.D. and Staff to furnish my insurance company with all information that said company may request or require on my behalf concerning my illness or injury.

ASSIGNMENT OF WORKERS COMPENSATION INSURANCE BENEFITS AND MEDICARE BENEFITS:
Patients with Workers Compensation claims OR Medicare coverage, please read and sign below. I hereby assign all medical and/or other Workers Compensation or Medicare Medical benefit payments to which I am entitled, to Michael L. Tran M.D. and Staff. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Signature: ____________________________________ **Date:** ___________________________________

I have read, understand, and agree to the above financial policy for payment of all professional medical fees. The patient is ultimately responsible for all professional fees,

Signature: ____________________________________ **Date:** ___________________________________

Thank you for selecting us. We appreciate the privilege of assisting you with your pain management needs.

MICHAEL L. TRAN, M.D.
PAIN MANAGEMENT
INITIAL PAIN ASSESSMENT
Page 1

PATIENT: ________________________________

DATE: ________________________________

Height: ___________ **Weight:** ___________

CHIEF COMPLAINT: ____

Pain Score /10

PERTINENT MEDICAL HISTORY (CIRCLE):

Diabetes Glucophage Allergy to Contrast Agents

Coumadin Possible Pregnancy History of Fainting

DRUG ALLERGIES ______________________

____

____

(CIRCLE ALL CONDITIONS THAT APPLY)

HEAD, EARS, EYES, NOSE & THROAT

Hearing Loss Sinus Problems Glaucoma/Cataracts

Glasses Dentures

ENDOCRINE

Diabetes Insulin Dependent Glucophage

Excessive Thirst Excessive Urination Awake to Urinate

Hypothyroidism Addison's Disease

RESPIRATORY

Chronic Respiratory Problems Shortness of Breath Emphysema

History of TB Home Oxygen Home Breathing Treatment

Asthma Cough

CARDIOVASCULAR

Hypertension Angina MI (heart attack) Heart Murmur

Congestive Heart Failure Palpitations History of Rheumatic Fever

Shunt Pacemaker Artificial Valve

Bleeding Disorder Coumadin Therapy Coronary/ Artery Disease

GASTROINTESTINAL

Change in Appetite Weight Loss/Gain ________(Ibs) Heartburn

History of Hepatitis Liver Disease Ulcer Diarrhea

Gallbladder Disease Signs of Gl Bleeding Constipation

GYNECOLOGICAL

Last Monthly Period______________ Menopause Hysterectomy

GENITOURINARY

Kidney Pain Burning on Urination

Blood in Urine Frequent Urination

Urinary Infections Ostomy

Dialysis Catheter

MUSCULOSKELETAL

Back Pain Arthritis Osteoporosis

Amputation Artificial Limb

Joint Replacement

PSYCHOSOCIAL

Smoker, packs/day ________ # of years ________

Drink Alcohol Occasional Drinks per week ______

Depression Mood Disorder

History of Substance Abuse

Seeing Psychologist/Psychiatrist ________________

NEUROLOGICAL

Dizziness __________ Headaches____________

Stroke ________ When ____________ (Right/Left)

Residuals ______________________

Fainting_____ Numbness______ Paralysis_________

Multiple Sclerosis _________ Paraplegia _________

Quadriplegia ____________ Other _____________

CURRENT MEDICATIONS:

NAME OF MEDICATION	DOSE	FREQUENCY

SURGERY, NERVE BLOCKS OR INJECTIONS YOU HAVE HAD FOR *YOUR PAIN* AND WHEN?

SURGERY/PROCEDURE	YEAR

OTHER MAJOR SURGERY

SURGERY	YEAR

DIAGNOSTIC STUDIES DONE (Circle and Indicate Where and When)

MRI **CT SCAN** **EMG** **MYELOGRAM**

BONE SCAN **X-RAYS** **DISCOGRAM**

ALL TREATMENT YOU HAVE HAD AND WHEN

Physical Therapy **Biofeedback** **TENS** **Home Exercises** **Relaxation Training**

Aqua therapy **Acupuncture** **Occupational Therapy** **Massage Therapy**

Chiropractic **Hypnosis**

PATIENT:________________________________

DATE:__________________________________

1) Briefly describe your current pain complaints:

____

____

2) Does this pain radiate (shoot) anywhere? ___________ Where? ______________________________

3) When did your pain start? Month & Year _________________

How did the pain start? (circle one) Auto Accident Work Related Following Surgery Fall Just Started Other

4) Are you worrying now? _____ Retired ________ Workman's Comp ________ Disabled ______________

5) What type of work do you do now? ____

6) What type of work did you do before the pain? ______________________________________

7) Have you seen a vocational counselor? ____

8) When does your pain occur? (Circle all that apply)

Intermittent (off and on) Constant (24 hrs a day) Less than 8 hours a day 8 - 16 hours a day

While resting While walking While sitting While lifting While bending

While standing When coughing When sneezing When urinating Having a bowel movement

9) What relieves your pain? (Circle all that apply)

Lying down Pain medicine Sex Drugs Alcohol Injections Nerve Blocks

Massage Standing Sitting Heat Cold TENS Pulling Knees to Chest

10) What makes your pain worse? (Circle all that apply)

Lying down Bending Cold Standing Stress Heat Sitting

Walking Massage Sex

11) Describe your pain (Circle all that apply)

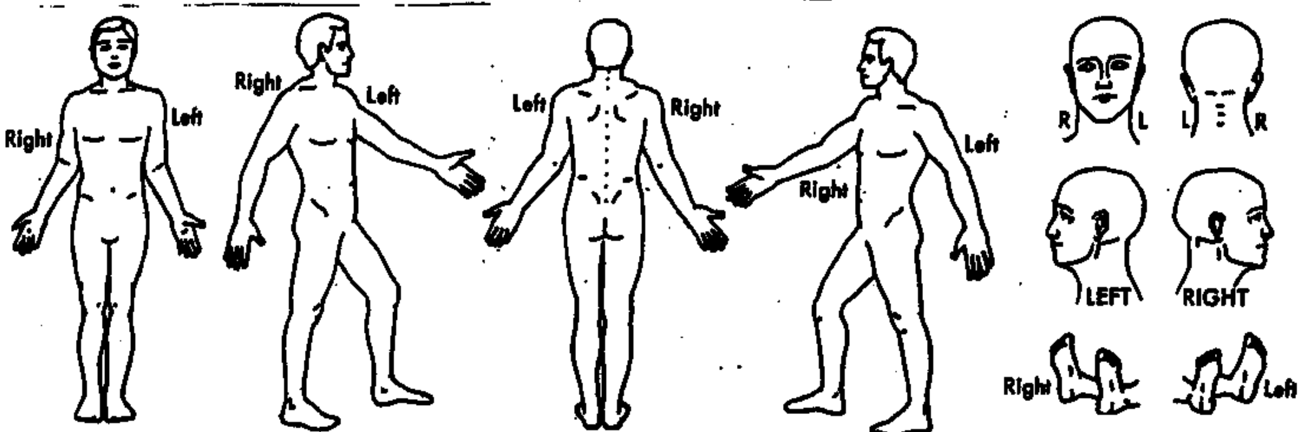
Aching Excruciating Intolerable Squeezing Strong Pulsating Piercing Just tolerable

Cramping Itching Weak Stabbing None Numbing Intense Cutting

Tingling Shooting Grinding Sharp Burning Stinging Severe Uncomfortable

Moderate Throbbing Increasing Staying the Same Electric-like Shock

12) Shade or draw in where your pain is located on the figures below



MICHAEL L. TRAN, M. D.
Anesthesiologist & Pain Management

Notice of Privacy Practices

All information that is obtained from you by this office is protected and kept confidential. Every reasonable measure to .prevent unauthorized disclosure of your protected health information is practiced.

Uses and Disclosures

- Your protected health information is accessed and used for healthcare related purposes only.
- Your protected health information is never sold, rented, transferred, exchanged, and/or used for non-healthcare related purposes including marketing activities without your written authorization.
- Your protected health information is disclosed to third-party entities without your written authorization for the purpose of treatment, to obtain payment for treatment, and for healthcare operations.

Certain Circumstances
Your protected health information can be disclosed without your written authorization in certain limited circumstances:

- Medical emergencies
- In situations required by law
- Individuals involved in your care
- When requested by public health agency
- When requested by a law enforcement agency

For any purpose other than treatment, obtaining payment, healthcare operations, or certain circumstances, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose protected health information, you can revoke that authorization in writing at any time.

Patient Rights

- You have the right to request in writing to inspect and/or receive a copy of your health information.*
- You have the right to request an alternate means or location to receive communications regarding your health information.*
- You have the right to request in writing to amend, correct, or delete any recorded health information within our possession.*
- You have the right to request in writing to restrict some of the uses and disclosures of your health information*
- You have the right to request in writing an accounting of certain disclosures of your health information that were made by this office.*

**conditions and limitations may apply; obtain additional information from front desk*

Changes To This Notice: We reserve the right to change privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an update notice will be posted and a copy will be sent to you.

MICHAEL L. TRAN, M. D.
Anesthesiologist & Pain Management

Acknowledgment of Receipt of Privacy Practices Notice

This document acknowledges that you have been informed regarding the Notice of Privacy Practices. This document is not a contract, authorization, release, or consent form. This document will remain in your records.

I, ____
Patient (Print Name)

____
Patient's Signature Date

If the patient is a minor or under care of legal guardian**,** legal guardian must sign,

____
Legal Guardian Signature Date

____
Relationship to Patient

MICHAEL L. TRAN, M.D.
Pain Center Patient Prescription Agreement

I, ____ understand that in order to receive any prescription medications for the treatment of pain from the pain center physicians, I must comply with the following rules and expectations of the pain center:

1. All medications prescribed by a physician at the pain center will be used only as ordered and for the reason ordered. Stopping a medication suddenly, using a medication for a reason other than that for which it was prescribed, or increasing a medication without medical advice is not acceptable behavior and can also be dangerous. **Any prescription changes must be addressed at the time of your appointment.** Early refills will generally not be given.
2. Triplicate medications will be refilled ONLY at the scheduled pain center appointments. I am expected to make and keep all the appointments. Prescriptions will NOT be mailed or called to the pharmacy.
3. I will not request or receive pain medications or controlled substances from any physician who is not from the pain center (or their designee).
4. I will not use illegal drugs or medications - if I am on medical marijuana I must provide a copy for my chart, with the understanding that no opiods will be prescribed from the pain center.
5. I will comply with a random blood or urine test when requested.
6. Out of town refills will not be processed, if leaving town for emergencies, please make arrangements before leaving, and itineraries may be requested.
7. It is my responsibility to protect my prescriptions from loss, selling, theft, or damage. A police report will be required if medications are stolen. Any stolen or lost medications will not be replaced. If a second loss, theft, or damage of medications should occur, you will be dismissed from the practice.
8. Please fill all prescriptions under one pharmacy.
9. I understand that I am not to drive while under the influence of medications (i.e. narcotics/opiates), nor should I operate heavy machinery or serve in any capacity related to public safety.
10. I am aware that the risks of opiates/benzodiazepines/muscle relaxants may include: addiction, sedation, physical dependence, nausea/vomiting, drowsiness, slowed reflexes and response time, and constipation.
11. Violation of any points in this agreement may result in dismissal from the practice at the discretion of the physician.

____

Patient Signature Date

____

Medical Provider Date

ADVANCE DIRECTIVE

Advance directive is a written document, which communicates your health care wishes clearly. There are two types of advance directive documents:

A Durable Power of Attorney for Health Care: Allows you to designate another person (known as a proxy agent) who is at least 18 years of age to make medical decisions for you in the event you are unable to do so. These decisions may include, but are not limited to, the withholding or withdraw of life prolonging procedures.

A Living Will or Health Care Directive: Allows you to state in advance your wishes regarding the use of certain medical procedures and treatments and becomes effective when you are unable to make your own decisions and can no longer communicate such decisions. It serves as a guide to your family or the person you name as your agent.

I have been explained the centers' policy on Advance Directives

I DO **have** an Advance Directive Please Initial ____________

I do NOT have an Advance Directive

Consent to Resuscitation

This signed document implies consent for resuscitation and transfer to a higher level of care should the patient suffer a cardiac or respiratory arrest or other life-threatening situation. Each patient has a right to self-determination, which encompasses the right to make choices regarding life-sustaining treatment (including resuscitative services). The right of self-determination may be effectuated by an advance directive.

Please Initial _______________

Date ______________________