Paul E. Kim M.D.
3549 Camino del Rio South Suite A, San Diego, CA 92108
240 W Mission Ave Suite C, Escondido, CA 92025

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your best possible health requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Scheduling Consultation and Treatment Appointments

Your initial visit will be a Consultation to discuss your medical history. Once a treatment plan is established you may be scheduled for any injection/procedure/ and/or follow-up appointment. A follow-up visit will be necessary two weeks after any injection/procedure to see the results of the injection/procedure.

Keep Follow-Up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide *Not* to Follow His Recommended Treatment Plan

I understand that after examining me, my doctor may make certain a recommendation based on what he feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his recommendations so that he may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your healthcare. We invite you, at any time, ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

_____	_____	_____
Patient Signature	Date	Physician Signature

_____
Print Patient Name

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION

I hereby authorize: _____
Physician/Healthcare Facility

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis, or prognosis, including X-rays, correspondence and/or medical records by means of mail, fax, or other electronic methods.

To: _____
Name

_____
Address

_____ _____ _____
City State Zip Code

The medical information/records will be used for the following purpose: _____
This authorization is:
[ ] Unlimited (all records, excluding substance abuse, mental health, HIV Diagnosis/Treatment)
[ ] Limited to the following information: _____

I also consent to the specific release of the following records:
Drug/Alcohol/Substance Abuse _____ (initial) Tests for Antibodies to HIV _____ (initial)
Psychiatric/Mental Health _____ (initial) HIV Diagnosis/Treatment _____ (initial)

DURATION This authorization shall be effective immediately and remain in effect until _____.
Date

RESTRICTIONS
Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.
A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.
I have been advised of my right to receive a copy of this authorization.

_____ _____
Signature of patient of legal/personal representative Relationship if other than patient

_____ _____
Patient's Name (Print) Date

_____ _____
Patient's Date of Birth Witness Signature

Paul E. Kim, M.D. Pain Management
Board Certified Pain Management Specialist
UCLA Pain Management Fellowship

Contract for Controlled Substance Prescriptions

Controlled Substance medications, such as narcotics, tranquilizers, and barbiturates are very useful, but have the potential for misuse.

Since Dr. Paul Kim is prescribing such medication for me to help manage my pain, I agree to the following conditions:

1. I am responsible for taking the medications only in the amount prescribed and will only take more with Dr. Kim's approval.
2. I will not request or accept controlled substance medications from any other physician, emergency room, or any outside source.
3. Prescriptions of controlled substance medication will be made only during regular office hours. Refills will not be made by phone or during holidays or weekends unless approved by Dr. Kim.
4. If the medication prescription is lost, misplaced, or stolen they will not be replaced and I will not receive a new prescription until the next renewal date. If lost or stolen, a police report must be presented.
5. I am willing to obtain psychiatric help if recommended by Dr. Paul Kim.
6. I agree to comply with random urine or serum sampling on each office visit to determine my compliance with taking these prescribed medications, if it is deemed necessary by my physician as well as urine sampling in initial visit.

I understand that if I violate any of the above conditions, my controlled substance prescriptions may be terminated at Dr. Kim's discretion.

_____	_____
Patient Name Printed	Patient Date of Birth
_____ __	_____
Patient Signature	Date
_____ __	_____
Witness	Date

Paul E. Kim, M.D. Pain Management
3549 Camino del Rio South, Ste A
San Diego, CA 92108

A Message to Our Patients about Arbitration

Our goal is to provide medical care to our patients in a way that will avoid disputes. We know that most problems occur as a result of miscommunication. So, if you have concerns about your medical care, please discuss them with us.

Please read the attached contract entitles Physician-Patient Arbitration Agreement. By signing the contract, we are agreeing that any dispute arising out of the medical services you receive will be resolved in binding arbitration before an arbitration panel instead of by a lawsuit in a court of law.

Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts.

We believe that the method of resolving disputes in arbitration spares the parties some of the rigors of the court trial and the publicity which may accompany judicial proceedings.

Thank you.

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: it is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of occurrence giving raise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit or the small claims court against the physician, and the physician's partners, associates, association, corporation, or partnership, and the employees, agents and the estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: Procedures and Applicable Law: A demand or arbitration must be communicated through writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neural arbitrator) shall be selected by the arbitrators appointed by the parties within the thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. The immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. any party may bring before the arbitrators a motion for summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to the Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident , transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below: _____

Patient's or Patient's Representative's Initials

If any provision of this arbitration is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____ _____

Patient's or Patient Representative's Initials Date Print Patient's Name

_____

(If Representative, Print Name and Relationship)

By: _____ _____ Paul E. Kim, M.D.

Physicians or Authorized Representative's Signature Date Print Name of Physician

A signed copy of this document is to be given to the Patient. Original is to be filed in the Patient's medical records.

Paul E. Kim, M.D. Pain Management

3549 Camino del Rio South, Ste A
San Diego, CA 92108

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception are, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

Signed:_____ Date:_____

Print Name:_____ Telephone:_____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Name and Address of Patient: _____

_____

_____

Por lo presente reconzco que he recibido una copia del Aviso de esta practica medica de practicas de privacidad. Adenas reconozco que una copia del aviso actual sera fijada en la zona de recepcion, y que una copia de la Notificacion de Practicas de Privacidad modificado estara disponible en cada cita.

☐ Me gustaria recibir una copia del Aviso de Practicas de Privacidad por e-mail a:

Firmado: _____ _ Fecha:_____

Imprimir Nombre:_____ _ Telefono:_____

Si no esta firmado por el paciente por favor indique la relacion:

☐ El padre o tutor del paciente menor de edad

Tutor o curador de un paciente incompetente

Nombre y direccion del paciente:_____

_____

_____

Paul E. Kim, M.D. Pain Management
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San Diego, CA 92108

Financial Agreement for Services Provided

Government Payers, Commercial Payers

I understand that I am responsible for providing my correct and updated information along with current insurance information at each visit in order to help the process of reimbursement for services rendered.

I understand that I am responsible for the co-payment or deductible requirements of my insurance if applicable.

I understand that if this visit is related to any type of injury for personal injury or workman's compensation case I have notified my medical insurance carrier.

I understand that I will be financially responsible if a refund request is made by my medical insurance carrier due to any incorrect information that I have provided to the office.

_____ _____
Patient Name and Signature Date

****

Financial Agreement for Services Provided

Worker's Compensation, Self Pay, Personal Injury

I understand that I will provide the correct date of injury, adjuster, and or attorney's information to help the process of reimbursement.

I understand that if my case settles I will be responsible for any visit effective date of settlement.

I understand that I cannot seek medical attention for the same area under my healthcare coverage once my case has settled unless my healthcare coverage has been notified.

I understand that I will be financially responsible if a refund request is made by my insurance carrier due to any incorrect information that I have provided to the office

_____ _____
Patient Name and Signature Date

Paul E. Kim, M.D. Pain Management
3549 Camino del Rio South, Ste A
San Diego, CA 92108

Effective April 27, 2015

I acknowledge that I have been informed that Paul E. Kim, M.D. **is not contracted with Medi-Cal for Primary or Secondary Insurance Coverage.**

I have agreed to continue my care with Paul E. Kim, M.D. I am aware that I will be financially responsible for all the charges accrued that are not covered by Medi-Cal.

Patient Signature:_____ Date:_____

Print Patient Name:_____

Witness:_____ Date:_____

Paul E. Kim, M.D. Pain Management
3549 Camino del Rio South, Ste A
San Diego, CA 92108

Disclosure of Beneficial Interest

"California Business and Professions Code Section 654.2 requires your physician to notify you when your physician, or someone in her or his immediate family, has a "significant beneficial interest," as that term is defined under Section 654.2, in any organization to which your physician refers you for services." We are providing this notice to inform you that Dr. Paul E. Kim has a significant beneficial interest in Physicians Surgery Center. Please be advised that you may choose any organization for the purpose of obtaining the services ordered or requested by your physician, and a list of such organizations can be obtained by the San Diego County Medical Society.

Patient Name: _____ Date: _____

New Patient Medical History

For office use only:	WC	PI	PVT	MC

Interpreter: _____ Historian: _____

Notice to Patient: This is a history form concerning your injury. This form must be filled out completely and accurately prior to being seen by the doctor. We ask that you fill out this form with truthful answers regarding your past and present injury (ies) for which you are going to be seen. Any information that is omitted or incorrect may affect your case. Please notify us of any medical condition from which you suffer, even those which may seem insignificant.

General Information

Patient Name: _____ Date of Birth: _____

Age: _____ Gender: Male Female

Date of Injury or Illness: _____ Occupation: _____

Injured body part(s): _____

Case accepted by Insurance: Accepted Denied Pending

Referring Doctor: _____

Attorney Name: _____

Address: _____

Phone Number: _____

Job Description (for Work Injury Only)

Employer at the time of Injury: _____

Occupation or job title at the time of Injury: _____

Employed since: _____ To: _____ (put present if still working)

Hours per day: _____ Days per week: _____ Overtime per week: _____

Date last worked: _____ (put present if still working)

List any dates you missed due to Injury: _____

_____

Describe in your own words what your job duties are: _____

_____

_____

Physical Requirements

Please put the corresponding letter next to the activity in order to describe the amount of time you spend doing this during an average work day.

C=Constant F=Frequent O=Occasional N=Not at all

___ Stand ___ Kneel ___ Twist ___ Detailed hand work
___ Squat ___ Stoop ___ Drive ___ Walk
___ Reach ___ Sit ___ Climb ___ Bend
___ Working looking up ___ Working looking down ___ Overhead work
___ Lifting ___ Lbs _____ Types of objects
___ Push ___ Lbs _____ Types of objects
___ Pull ___ Lbs _____ Types of objects

Prior Occupational History (types of jobs, length of employment, duties): _____

_____

_____

_____

_____

Present Employment Status

Temporarily disabled since: _____

Working Full Duty: Yes No

Working light duty (please describe your work) :

_____

_____

_____

HISTORY OF INJURY

Please describe how the injury happened. If the injury is of continuous trauma in nature, please describe which activities cause the pain, include how many times a day you performed this duty. Please give details on how the injury occurred, whether you reported the injury to your supervisor, treatments you have received, what treatments have helped your symptoms and how your work activities affect your pain.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Past Medical History

Important: You must inform us of all injuries you have sustained in the past or subsequent to your work injury. Please list the date of injury, body parts injured, diagnosis, treatment received and the length of treatment. Include whether you were left with residual pain or if you have recovered. If you did not recover, please indicate physical limitations as a result of this injury.

Prior Work Related Injuries: _____

_____

_____

Automobile, Motorcycle, or Personal Injuries: _____

_____

_____

Other Injuries Not Related (Sports, home, etc.): _____

_____

_____

Allergies to food or medication: _____

Surgery: _____

_____

List any Medical Problems: _____

_____

_____

Current Medications: _____

_____

_____

Past Pain medications you have tried: _____

_____

_____

Family History

Father's Age: ___ If deceased, cause _____

Mother's Age: ___ If deceased, cause _____

Siblings: Brothers _____ Sisters _____

Family Diseases:	Heart problems	Y	N
	Cancer	Y	N
	Diabetes	Y	N
	Hypertension	Y	N
	Sickle Cell	Y	N
	Thyroid	Y	N

Social History

Alcohol: Yes No Occasional

Smoking: Yes No Number of pack a day: _____

Marital Status: Married Single Divorced Separated Widowed

Number of Children: _____ Ages: _____

Education (years, degrees): _____

Occupation: _____

Review of System

1. Has there been any change in your general health in the last year?	Y	N
2. Have you gained or lost much weight recently?	Y	N
3. Are you on a special diet?	Y	N
4. Have you had any loss of energy or a reduction in exercise tolerance?	Y	N
5. Have you had any change in appetite?	Y	N
6. Do you bleed or bruise easily?	Y	N
7. Do you get out of breath easily?	Y	N
8. Do you have spells of dizziness?	Y	N
9. Do you ever black out?	Y	N
10. Do your ankles ever become badly swollen?	Y	N
11. Do you have high blood pressure or a heart murmur?	Y	N
12. Do you have abnormal tolerance to heat and cold?	Y	N

13. Do you have frequent colds or sore throat? Y N
14. Do you have stomach trouble, frequent, diarrhea or constipation? Y N
15. Do you have problems urinating? Y N
16. Do you have arthritis or joint trouble? Y N
17. Do you have skin ulcers or rashes? Y N
18. Have you had a general or local anesthetic? Y N
19. Do you have trouble falling asleep? Y N
20. Do you wake up frequently during the night? Y N
21. Do you consider yourself a nervous person? Y N
22. Do you often feel unhappy or depressed? Y N
23. Are you easily upset? Y N
24. Do you have any other complaints or unusual symptoms? Y N

a) _____

b) _____

c) _____

Pain Experience

Each of the following questions is about your experience of pain. Usually the question can be answered by circling a word or words, by making a mark along a line, or by a brief description.

1. List all the area of your pain.

_____

_____

2. Current pain complaint #1: (Circle the ones that best describe your pain)

_____

Constant Intermittent Sharp Stabbing Dull Aching Burning
Sore Shooting Numbness Weakness Pulling Sensitive to the touch
Stinging Throbbing

3. Current pain complaint #2: (Circle the ones that best describe your pain)

_____

Constant Intermittent Sharp Stabbing Dull Aching Burning
Sore Shooting Numbness Weakness Pulling Sensitive to the touch
Stinging Throbbing

4. Date of injury or onset of pain: _____

   Did your pain start after an injury or trauma? Yes ___ No ___

   If yes, what? _____

5. Rate how often your pain occurs:

Frequency	Duration
___ Several times a day	___ Momentary
___ Once a day	___ Minutes
___ Several times a week	___ Hours
___ Several times a month	___ Day long
___ Less frequent than once a month	___ Several days
___ Too variable to specify	___ Weeks
___ Continuous	___ Continuous
___ Never	

6. What makes your pain worse?

   a) _____

   b) _____

   c) _____

   d) _____

7. How can you lessen your pain?

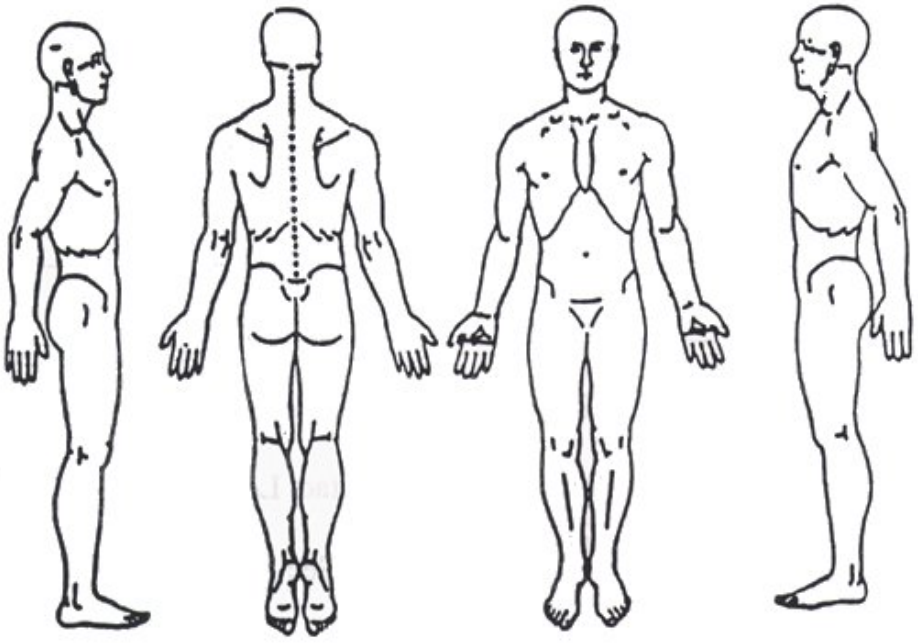
   a) _____

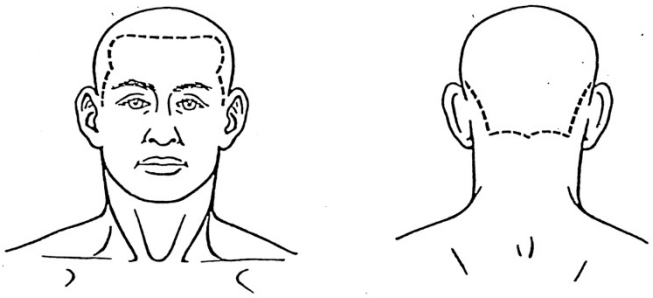
   b) _____

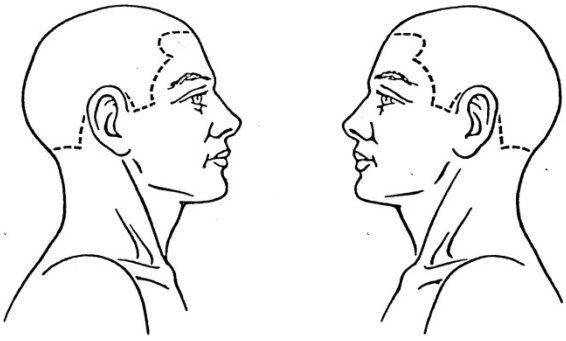
   c) _____

   d) _____

8. Use the figures below and draw where your pain is located. If the pain spreads as the intensity increases, or if the pain moves from one point to another, please indicate with arrows.







Pain Intensity

1. Place a slash (/) somewhere along the scale below to indicate the intensity of your pain at its highest intensity (1), usual intensity (2), and lowest intensity (3) over the last month.

Current Pain

No pain — The most intense pain imaginable

Average over the last month

No pain — The most intense pain imaginable

2. Place a slash (/) somewhere along this scale to indicate the pain intensity of you chief complaint right **now.**

No pain — The most intense pain imaginable

3. Rate the usual intensity of your pain with a slash (/) along the scale below at the following periods throughout the day.

Time	No Pain	The most intense pain imaginable
Morning	_____	
Noon	_____	
Afternoon	_____	
Evening	_____	
Sleep	_____	

9. What kinds of feelings accompany your pain? Check the boxes that apply directly to your chronic experience of pain.

	NONE	MILD	MODERATE	SEVERE
Depression	___	___	___	___
Anxiety	___	___	___	___
Frustration	___	___	___	___
Anger	___	___	___	___
Fear	___	___	___	___

10. Place a slash (/) somewhere along the line indicating how much your pain stops you from doing what you want to do.

Doesn't stop me at all — Completely stops me

---

11. Rate how much your pain interferes with your daily activities.

Work	Family chores	Play	
___	___	___	Continuously
___	___	___	Several times a day
___	___	___	Once a day
___	___	___	Several times a week
___	___	___	Once a month
___	___	___	Less frequently than once a month
___	___	___	Never

12. Place a slash (/) somewhere along the scale below to indicate how much you want to rid yourself of pain.

No desire — The most imaginable desire

Sleep Disorder Questionnaire

Patient Name: _____ Height: _____
Email: _____ Weight: _____
Gender: M F DOB: _____

♦ OVER 18 MILLION AMERICANS SUFFER FROM SLEEP APNEA
♦90% OF SLEEP APNEA PATIENTS HAVE NOT BEEN DIAGNOSED

Do you snore?	Yes	No
Do you have high blood pressure?	Yes	No
Have you gained weight and find it difficult to lose?	Yes	No
Do you have unexplained awakenings from sleep?	Yes	No
Do you awaken from sleep gasping for air or choking?	Yes	No
Do you notice frequent twitching or jerking or legs while asleep?	Yes	No
Do you lack energy upon waking in the morning?	Yes	No
Do you have a headache upon waking up in the morning?	Yes	No
Do you often lay in bed unable to fall asleep?	Yes	No
Do you find it difficult to stay awake during the day?	Yes	No

*****If you have answered YES to any one of the above questions please consult your doctor*****

Do you use a CPAP machine when sleeping?	Yes	No
Are you currently using any medications to help you sleep?	Yes	No

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

Please answer with a 0 to 3

0=Would never doze **1=Slight chance of dozing**
2=Moderate chance of dozing **3=High chance of dozing**

Sitting and reading	____
Watching T.V.	____
Sitting inactive in a public place	____
As a passenger in a car for an hour without a break	____
Lying down to rest in the afternoon	____
Sitting and talking to someone	____
Sitting quietly after lunch without alcohol	____
In a car, while stopped for a few minutes in traffic	____
Total Score	**____**

*****If your Epworth score is 10 or greater please consult with your doctor*****

Physician Name: _____
Phone:_____ Fax:_____