GENESIS
PAIN SPECIALISTS
PRECISION PAIN & INJURY RELIEF

601 Daily Drive, Suite 228 ▪ Camarillo, California 93010
O 805-914-0637 F 805-693-4327 Text 805-232-7909
info@genesispainspecialists.com
genesispainspecialists.com

Dear Valued Patient,

Thank you for choosing Genesis Pain Specialists. We believe that each patient's pain is unique and should be treated as such. Genesis Pain Specialists utilizes a variety of treatment modalities, such as: Physical Therapy, Injection Therapies, Spinal Stimulators, and Medications.

To best serve our patients, we require that all new patients complete the "New Patient Packet" (NPP). New patients will also be required to complete two functional questionnaires, which may be repeated multiple times throughout the course of treatment, as they allow Dr. Cabaret to monitor progress. Please fill out the NPP to the best of your ability. The NPP must be completed and returned to the office before we schedule your initial consultation. Once we have received your NPP, we will contact you to schedule a consult. Please return this NPP to our office:

By email: info@genesispainspecialists.com
By fax: (805) 693-4327
By mail or hand delivered: 601 E Daily Drive #228, Camarillo CA, 93010

WORKMAN'S COMP/PERSONAL INJURY CLAIMS (This is very important!):

Do you have an open Workman's Comp and/or Personal Injury Case?

☐ **Yes (please answer questions below)** ☐ **No**

Which type (Workman's comp or PI Lien):	**Date of Injury:**
Approved Body Part(s):	**Attorney Name:**
Attorney Phone Number:	**Fax Number:**

Patient name: _____ Date of Birth: _____

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Practice Policies

Late/Missed Appointment Policies
Patients are required to arrive on time for all appointments. Patients who arrive late for visits cannot expect or demand to be seen. Late patients may be placed on a waiting list to be seen if an appointment allocation becomes available. All patients who arrive on time will be seen prior to late patients. Patients who arrive 10 minutes or later will be considered a no show and rescheduled to the next available appointment time. Patients on medications should take extra care to arrive on time; no prescriptions will be written without a physician appointment. In addition, if you are on a controlled substance, missed/late appointments are considered as aberrant behaviors and your medications may be tapered.

Should you need to cancel or reschedule your appointment, we will require a minimum of 24 hours' notice. **No-show fees for appointments missed without notice will be charged as follows: $50 for the first no-show, $100 for the second no-show, and $150 for the third no-show.** No-show fees are due at the date of the next appointment and patients will not be able to see the physician without making payment**.** Appointments will not be rescheduled following the third no-show. Insurance companies do not cover fees for missed appointments.

Patient Information Updates
Patients are required to provide us with any updates or changes to patient information. These updates include, but are not limited to, insurance policy, address, phone number, and medication lists. We regularly contact patients and cannot provide adequate service (including appointment reminders) without up-to-date contact information.

Billing Information and Policies
Payments are dependent on services rendered and insurance coverage. Co-payments are dependent solely on insurance coverage ("Specialist" fee). New cash patients are required to pay a $1200 consultation fee. All follow up visits have a $300 fee. Urinalysis fees must be paid when prompted; urine screens are mandatory in some types of medication management. Please be prepared to pay the entire amount at each visit.

I hereby authorize Dr. Cabaret to release my medical information to necessary insurance companies for the sole purpose of obtaining payment for care. I hereby assume financial responsibility for all charges incurred for services rendered not covered by my insurance company. I understand that I will be required to pay co-payments, amounts applied to deductibles, and balances of bills not paid in accordance with benefits of my insurance. If I am unable to make payments in full within 30 days of treatment, I agree to call the billing company, Excel Medical Billing and Management at (541)488-7715 to make payment arrangements.

I certify that the information I have reported regarding my insurance coverage is correct and current. I authorize Dr. Cabaret to verify insurance coverage and benefits allowed in accordance with my insurance company.

I hereby authorize payment for all medical insurance benefits which are payable under the terms of my insurance policy to be paid directly to Dr. Joseph Cabaret, MD or designates for services rendered.

_____
Patient Initials & Date

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HIPAA Release Form

By signing this form, I am consenting to allow the physician to use and disclose my Patient Health Information (PHI) to carry out Treatment, Payment, Health Care Operations (TPO).

I may revoke my consent in writing except that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the physician may decline to provide treatment to me.

Please complete the following information:

Phone: _____ Cell: _____ Email: _____

Please indicate any people that you give us permission to leave your health information with.

Name: _____ Relation: _____

Name: _____ Relation: _____

*Note: We cannot guarantee that cell phone calls are confidential due to the nature of this type of communication.

☐ I decline to share my PHI.

_____ _____

Patient or Legally Authorized Individual Signature **Date**

_____

Relationship to Patient if Signed by Anyone Other Than Patient

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Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **the physician** to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO) (The Notice of Privacy Practices provided by the physician describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. The physician reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the physician.

With this consent, the physician may **call my home or other alternative location and leave a message on voice mail or in person** in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory tests, results, among others.

With this consent, the physician may **text to my cellphone** any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request the physician restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

With this consent, the physician may **mail to my home or other alternative location** any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, the physician may **email to my home or other alternative email** any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request the physician restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I understand that Joseph A. Cabaret M.D., APC cannot guarantee the security and confidentiality of Voicemail, text, mail, or e-mail communication. Joseph A. Cabaret MD, APC will not be responsible for messages that are not received or delivered due to technical failure or for disclosure of confidential information unless caused by intentional misconduct.

I understand that appointments should be made to discuss any new or any sensitive medical information.

I understand that either I or Joseph A. Cabaret MD, APC may stop using voicemail, text, mail, or email as a means of communication upon my written request.

I have read and understand this form. I have had the opportunity to ask questions and my questions have been answered to my satisfaction. I understand and agree with the information contained in this form and give my consent for voicemail, text, mail, or email communications to and from Joseph A. Cabaret, MD APC.

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Random Urine Drug Screening (UDS)
New and existing patients who are being prescribed medications are required to submit to random urine screening as per the narcotics agreement when prompted by their physician. We may elect to not release prescriptions without obtaining a current urine sample. Patients with questions or concerns may address their physician during their scheduled appointment. All samples may be sent to a secondary lab for confirmation screening.

Medical Records
We require that patient records be obtained before the initial consultation. It is the responsibility of the patient to ensure that all pertinent medical records are obtained from existing/past physicians. Furthermore, it is the responsibility of the patient to verify that medical records pertinent to their treatment with Dr. Cabaret are sent in a timely manner to our office. This is required throughout the entire course of treatment.

To obtain copies of medical records from this office, there is a $15 clerical fee plus $0.25 per page. Patients may assess what they would like to have copied. Payment must be made upon record pick-up. Records processing my take up to 14 days; it is the patient's responsibility to request the records at the appropriate time.

Prior Authorization Requests/Disability Forms/Other Forms
All paperwork requests for prior authorizations, disability forms, etc., may be completed for a $50 fee. Paperwork or online processing will be completed within 7 days of receipt of said form. Fees must be paid prior to form being filled out, or online forms submitted.

Notice to Consumers Regulation
Medical doctors (M.D.) are licensed and regulated by the Medical Board of California: (800) 633-2322 or www.mbc.ca.gov. I understand that the physician is licensed and regulated by the board.

I, _____ agree to the above outlined policies and requirements of Dr. Joseph A. Cabaret, MD. I understand that my continued treatment is dependent on compliance with all office policies and physician orders.

_____ _____
Patient or Legally Authorized Individual Signature **Date**

_____
Relationship to Patient if Signed by Anyone Other Than Patient

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Dear Valued Patient:_____,

New Law Requires Notice to Patients About Open Payments Database Beginning January 1, 2023

"The open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov."

By signing below I acknowledge receipt of this form.

_____ _____
Patient or Legally Authorized Individual Signature Date

_____
Relationship to Patient if Signed by Anyone Other Than Patient

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Patient Rights, Responsibilities, and Advance Directives

It is the responsibility of the Office of Joseph Cabaret, M.D. to notify you of specific policies in advance of your procedure. The following are those policies:

Patient Rights

1. Considerate and respectful care and the right to exercise his or her rights without discrimination or reprisal and be free from all forms of abuse or harassment.
2. Knowledge of the name of the physician who has primary responsibility for coordinating his or her care and the names and professional relationships of other physicians who will see the patient.
3. Receives information from his or her physician about his or her illness, his or her course of treatment and his or her prospects for recovery in easily understood terminology.
4. Receives as much information about any proposed treatment or procedure as he or she may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedures or treatment, the medically significant risks involved and knowledge of the person who will carry out the procedure or treatment.
5. Participates actively in decisions regarding his or her medical care, to the extent permitted by law, including the right to refuse treatment.
6. Receives full consideration of privacy concerning his or her medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to know the reason for the presence of any individual.
7. Is given confidential treatment of all communications and records pertaining to his or her care and his or her stay in Joseph Cabaret, M.D.'s office. His or her written permission shall be obtained before his or her medical records can be made available to anyone not directly concerned with his or her care.
8. Receives reasonable responses to reasonable requests he or she may make for services.
9. He or she may leave Joseph Cabaret, M.D.'s office, even against the advice of his or her physicians.
10. Receives reasonable continuity of care and advance knowledge of the time and location of appointment, as well as knowledge of the physician providing the care.
11. If Joseph Cabaret, M.D.'s office proposes to engage in or perform human experimentation affecting his or her treatment, the patient has the right to refuse to participate in any research projects.
12. Will be informed by his or her physician, or delegate of his or her physician, of his or her continuing health care requirements following his or her discharge from Joseph Cabaret, M.D.'s office.
13. May choose a different physician than was assigned to that patient.
14. Is made aware that this facility does not honor Advance Directives.

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Patient Responsibilities

1. To work with your health care team and to follow all safety rules.
2. To show respect and consideration to our staff and to other patients and visitors.
3. To respect the privacy of other patients.
4. To give your health care team complete and correct information about your health including medications, including over the counter products and dietary supplements and any allergies or sensitivities.
5. To tell your doctor about any changes in your health after you leave our facility.
6. To keep, or cancel in a timely manner, your scheduled appointments for your health care.
7. To follow the directions given by your health care team after you have agreed to treatment in our facility.
8. To tell your health care team if you wish to change any of your decisions.
9. To ask for clarification if you do not understand any information or instructions given to you by your health care team.
10. Accept personal financial responsibility for any charges not covered by your insurance.

Advance Directives

1. Advance directives are legal documents that allow you to convey your decisions about end-of-life care ahead of time. They provide a way for you to communicate your wishes to family, friends, and health care professionals, and to avoid confusion later on.
2. A living will states how you feel about care intended to sustain life. You can accept or refuse medical care. There are many issues to address, including, but not limited to:
    a. The use of life sustaining machinery (ventilators, dialysis)
    b. Whether or not you want to be resuscitated if breathing or heartbeat stops
    c. Tube feeding and other life sustaining processes
    d. Organ or tissue donation
3. A durable power of attorney for health care is a document that names your health care proxy. Your proxy is someone you trust to make health decisions if you are unable to do so.
4. If you have an Advance Directive, please bring it with you and we will place a copy in your medical record for reference in the unlikely event you are transferred to the hospital. If you do not have an Advance Directive and would like more information, please access the following link to get more information concerning California State Law and the necessary forms to complete an Advance Directive. Or you may ask our receptionist for more information. https://oag.ca.gov/consumers/general/care

Disclosure of Physician Ownership: Joseph A. Cabaret, M.D. has a financial interest in Spanish Hills Surgery Center and A Health Place, The Estates.

Grievance Policy

For complaints or comments about your medical care, you may contact our administrator Medical Director at (805) 914-0637 or you may write to 601 E Daily Drive Ste 228, Camarillo, CA 93010. If you are not satisfied with how your complaint was handled, you may also contact DHS, Licensing and Certification, 1889 N Rice Ave, Oxnard, CA 93030 (805) 604-2926. Or you may contact the Office of the Medicare Beneficiary Ombudsman at https://www.cms.gov/Center/Special-Topic/Ombudsman/Medicare-Beneficiary-Ombudsman-Home.html
By signing you are acknowledging that you have received this information in advance of your procedure.

Patient/Parent/Guardian Signature **Date**

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Authorization of Release of Information

I, _____ , hereby give authorization for Joseph A. Cabaret, MD to:

RELEASE MY RECORDS TO: _____

OBTAIN MY RECORDS FROM: _____

Street Address: _____ City, State, Zip Code: _____

Telephone: _____ Fax: _____

Patient Name: _____ Date of Birth: _____

Patient's Signature: _____

Parent/Guardian/Authorized Representative: _____

Witness Signature: _____

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Patient Information

Patient Name: _____ **Date of Birth:** _____

Gender: ☐ **Male** ☐ **Female** **SSN:** _____

Contact Information:

Cell Phone:	Home Phone:	Email:	
Address:	City:	State:	Zip Code:
Pharmacy:	Pharmacy Phone:		

Demographics:

Preferred Language:		
Race/Ethnicity:	☐ American Indian or Alaska Native ☐ White ☐ Asian ☐ Hispanic/Latino	☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ Non-Hispanic/Latino ☐ Decline to Specify

Care Team:

Referring Physician:	Primary Physician:
Phone Number:	Fax Number:

Next of Kin:

Emergency Contact Name:	Relationship:	Phone:

Insurance Information:

Primary Insurance:			
Insurance ID:		Group #:	
Insurance Co. Address:		City, State, & Zip:	
Name of Subscriber:	Relationship:	SSN:	DOB:

Do you have additional insurance? If yes, please complete the following section:

Secondary Insurance:			
Insurance ID:		Group #:	
Insurance Co. Address:		City, State, & Zip:	
Name of Subscriber:	Relationship:	SSN:	DOB:

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PAST MEDICAL HISTORY. Do you have any of the following medical conditions? (Please check **ALL** that apply):

☐ Seizures	☐ Stroke	☐ TIA	☐ Head Injury	☐ Migraine
☐ TMJ	☐ Glaucoma	☐ TBI (Brain Injury)	☐ Headache	☐ Coronary Disease
☐ Heart Attack	☐ Stents	☐ Heart Failure	☐ Palpitations	☐ Arrhythmias
☐ Atrial Fibrillation	☐ Pacemaker	☐ AICD Implant	☐ Hypertension	☐ DVT
☐ Asthma	☐ Bronchitis	☐ Emphysema	☐ Sleep Apnea	☐ CPAP
☐ Tuberculosis	☐ Pneumonia	☐ Pulmonary Embolism	☐ Gastritis	☐ Ulcers
☐ Irritable Bowel	☐ IBD (UC/Crohn)	☐ Gastric Bypass	☐ Hepatitis	☐ Cirrhosis
☐ Pancreatitis	☐ Kidney Stones	☐ Bladder Infections	☐ Renal Failure	☐ Hemodialysis
☐ Fibromyalgia	☐ Arthritis	☐ Bursitis	☐ Chronic Fatigue	☐ Restless Legs
☐ Periph Neuropathy	☐ Eczema	☐ Shingles	☐ Herpetic Pain	☐ Lyme Disease
☐ Multiple Sclerosis	☐ Parkinson's	☐ Dementia	☐ Depression	☐ Suicidal Ideation
☐ PTSD	☐ ADHD	☐ Anxiety	☐ Thyroid Disease	☐ Diabetes
☐ Anemia	☐ Aneurysm	☐ Cancer	☐ Chemotherapy	☐ Lupus
☐ HIV/AIDS	☐ Transplants	☐ Immunosuppression	☐ Immunodeficiency	☐ Infection

☐ I do NOT have any of the above conditions

Are you taking any blood thinners? (Please check appropriate box):

☐ Coumadin ☐ Plavix ☐ Eliquis ☐ Xarelto ☐ Pradaxa ☐ Other: _____

PAST SURGICAL HISTORY. Please list all previous surgeries/procedures with approximate dates:

MEDICATION ALLERGIES: ☐ No medication allergies (check box if applicable).

ALL CURRENT MEDICATIONS. Please list **ALL current** medications (or attach a separate medication list):

Medication Name	Dosage (e.g. mg/mcg)	Instructions (e.g. Frequency/Day)
1.		
2.		
3.		
4.		
5.		

☐ I am providing a separate medication list attached to this packet.

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Pain Disability Questionnaire

These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question by checking **ONE** box that corresponds with the number on **EACH** scale that best describes how you feel.

1. Does your pain interfere with your normal work inside and outside the home?
   Work Normally — Unable to work at all
   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?
   Take care of myself completely — Need help with all my personal care
   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

3. Does your pain interfere with your traveling?
   Travel anywhere I like — Only travel to see doctors
   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

4. Does your pain affect your ability to sit or stand?
   No Problems — Cannot sit/stand at all
   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?
   No Problems — Cannot do at all
   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop or squat?
   No Problems — Cannot do at all
   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

7. Does your pain affect your ability to walk or run?
   No Problems — Cannot walk/run at all
   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

8. Has your income declined since your pain began?
   No decline — Lost all income
   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

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9. Do you have to take pain medication every day to control your pain?

No medication needed — On pain medication throughout the day

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10

10. Does your pain force you to see doctors much more often than before your pain began?

Never see doctors — See doctors weekly

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10

11. Does your pain interfere with your ability to see the people who are important to you as much as you would like?

No Problem — Never see them

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10

12. Does your pain interfere with recreational activities and hobbies that are important to you?

No interference — Total interference

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10

13. Do you need the help of your family and friends to complete everyday tasks (including both work outside the home and housework) because of your pain?

Never need help — Need help all the time

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10

14. Do you now feel depressed, tense, or anxious than before your pain began?

No depression/tension — Severe depression/tension

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10

15. Are there emotional problems caused by your pain that interfere with your family, social and/or work activities?

No Problems — Severe Problems

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10

OFFICE USE ONLY:

Functional: 1___ + 2___ + 3___ + 4___ + 5 ___ + 6 ___ + 7 ___ + 12 ___ + 13 ___ = _____

Psychosocial: 8 ___ + 9 ___ + 10 ___ + 11 ___ + 14 ___ + 15 ___ = _____

Total = _____/150

Anagnostis C, Gatchel RJ, Mayer TG. The Pain Disability Questionnaire: A New Psychometrically Sound Measure for Chronic Musculoskeletal Disorders. *Spine* 2004; 29 (20): 2290-2302

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Directions

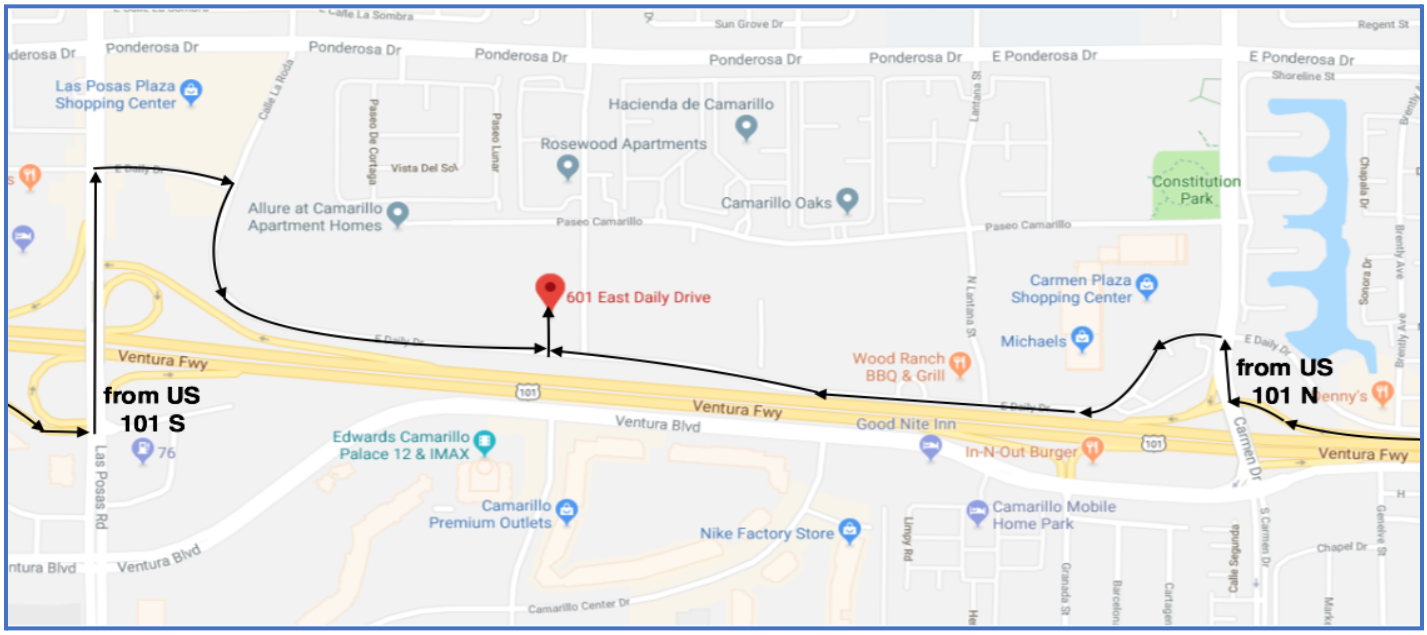
ADDRESS: 601 E Daily Drive, Suite 228
Camarillo, CA 93010

From US 101 Southbound:

1. Exit on Las Posas Road
2. Turn **left** onto Las Posas Road
3. Turn **right** onto Daily Drive
4. Turn **right** at first stop sign
5. Go 0.4 mi and turn **left** onto Rosewood Avenue
6. Turn **left** into the first parking lot
7. Arrived: Smoke Tree Plaza

From US 101 Northbound:

1. Exit on Carmen Drive
2. Turn **right** onto Carmen Drive
3. Turn **left** onto Daily Drive
4. Go 0.9 mi and turn **right** onto Rosewood Avenue
5. Turn **left** into the first parking lot
6. Arrived: Smoke Tree Plaza



Location of our Suite #228 | Elevator located at center of plaza

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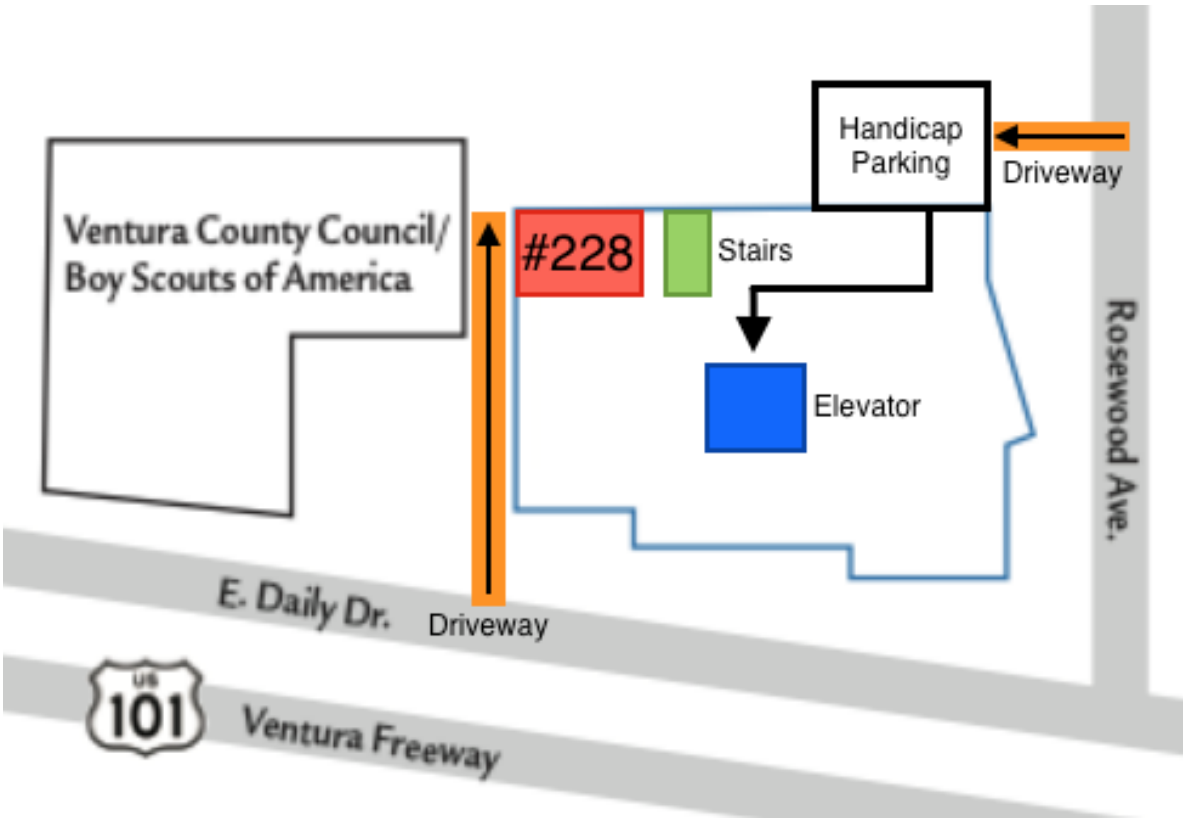

Front of Smoke Tree Plaza as viewed from Daily Drive