Pledge Medical MSO, LLC

1101 Bayside Drive, Suite 100 Corona Del Mar, CA 92625
Telephone (833)753-3435 Fax (949) 478-8358

PATIENT NAME: _____ *TELEPHONE:* _____ *E-Mail:* _____

PATIENT ADDRESS: _____

Attorney Name: _____ *Date of Injury:* _____

Attorney Telephone: _____ Attorney FAX #: _____ E-mail: _____

Attorney Address: _____

I do hereby authorize and direct the **Provider**** to furnish my attorney with all reports, findings, interpretations, impression, diagnosis, etc. of any and all diagnostic studies that you may perform on me, including those studies performed in connection with any accident in which I was involved.

I hereby authorize and direct the my attorney, who is identified above, as well as any subsequent attorney I may obtain in addition to or replacement of my above identified attorney, to pay directly to **Pledge Medical MSO, LLC ("Pledge")** all amounts that may be due and owing for medical services rendered to me both in connection with the accident in which I was involved and amounts owed by me for services unrelated to the accident. I hereby authorize and direct my attorney (as well as any future attorneys) to withhold from any settlement, judgment, verdict, or other economic recovery I may receive such amounts as are necessary to adequately protect Pledge. I understand that, by this agreement, I am giving the above Provider a lien on any settlement, judgment, verdict, or other economic recovery I may obtain in my case, including any amounts held by my attorney that are payable to me. I further understand that Pledge has purchased this lien and has obtained all rights to collect thereon.

I fully understand that, notwithstanding this agreement, I am directly and fully responsible to the above Provider/Pledge (as assignee) for all medical bills associated with the services provided to me and this agreement is made solely for additional protection and in consideration of the Provider agreeing to awaiting payment. I understand that this agreement tolls any laws that limit the time for the Provider/Pledge to take action to collect amounts I may owe for the services provided and that my obligations to pay the same are not contingent on my receiving any recovery in my case. I further understand and agree this agreement is not a payment arrangement with respect to the satisfaction of my account whatsoever.

I do hereby authorize my attorney to communicate with the Pledge concerning the status of me and my case and direct my attorney to answer all questions that may be asked concerning me or my case. I agree to notify, and hereby direct my attorney to notify, Pledge if I change attorney representation. I agree to notify, and herby direct my attorney to notify, Pledge in writing within 2 weeks of the settlement of my case.

I had a chance to inquire into Provider's fees and I acknowledge that Provider's charges for its services are fair and reasonable and that the same appropriately reflect Provider's risk of waiting for its payment until my case is resolved. I further acknowledge that this agreement is an agreement that provides collateral for the amounts I owe with respect to the services rendered to me and does not constitute a payment arrangement or other agreement regarding the payment of any amounts I may owe with respect to services rendered to me. I hereby authorize Provider to assign my account receivable and its right, title and interest hereunder. The reasons may include but not limited to the following; collections for unpaid medical services.

I UNDERSTAND THAT NO WRITTEN NOTATION OR OTHER WRITTEN COMMUNICATION ON OR ACCOMPANYING ANY PAYMENT TO PLEDGE, WHETHER BY CHECK, DRAFT, OTHER NEGOTIABLE INSTRUMENT, OR OTHERWISE, STATING THE SAME IS GIVEN AS PAYMENT IN FULL SHALL BE EFFECTIVE AS AGAINST PLEDGE WHATSOEVER UNLESS I RECEIVE A WRITTEN CONFIRMATION FROM PLEDGE SPECIFICALLY ACCEPTING THE SAME AND ACKNOWLEDGING THE SAME CONSTITUTES PAYMENT IN FULL OF MY OBLIGATIONS TO PLEDGE.

_____ _____ _____

DATE PATIENT'S SIGNATURE PRINT NAME

The undersigned being the attorney of record for the above patient does hereby agree to honor the above lien, and agrees to withhold such sums for any settlement, judgment or verdict as may be necessary to adequately protect the above provider.

_____ _____ _____

DATE ATTORNEY SIGNATURE PRINT NAME

Attorney: Please date, sign and return one copy to the healthcare provider. Keep one copy for your own records.

Provider is included in Pledge Medical MSO, LLC's *Network of Qualified Providers*, specifically identified at http://www.pledgemedical.com/networkofpreferredproviders/

PLEDGE MEDICAL

Office 833-PLEDGE 5
Fax 949-478-8358
casemanager@pledgemedical.com

Patient Name:_____ **DOB:**_____ **DOI:**_____

CAR ACCIDENT

Were you the driver, or passenger (front or back)? _____

Model/make of your car? _____ Model/make of the second car? _____

Did you go to an emergency or urgent care after the accident? Yes No

If so, when? _____ What did they do? _____

Did you lose consciousness? Yes No Did the airbags deploy? Yes No

Was a police report filed? Yes No Setbelt? Yes No

Briefly explain how the accident occurred:

_____

_____

_____

SLIP AND FALL

_____

Where did the accident occur: _____

Was a police report filed? Yes No

Did you go to an emergency or urgent care after the accident? Yes No

If so when? _____ What did they do?_____

Did you lose consciousness? Yes No

Briefly explain how the accident occurred:

_____

_____

_____

OTHER type of accident

_____

_____

_____

_____

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PATIENT HISTORY

Today's Date: _____ Date of Birth:_____ Age:_____
Height_____ Weight_____ **Dominant hand** ☐ Right ☐ Left
What body parts are injured? _____

HISTORY OF INJURY

Please rate your pain on a scale of 1 to 10 (10 being the worst pain):
At rest: 0 1 2 3 4 5 6 7 8 9 10 At worst: 0 1 2 3 4 5 6 7 8 9 10

Is the pain:

Worsening	Occasional	Stabbing
Stable	Sharp	Throbbing
Improving	Dull	
Constant	Aching	

What symptoms are you experiencing?

Locking	Grinding	Other (describe)
Catching	Bruising	_____
Giving away	Numbness	
Popping	Tingling	

What, if anything, makes your symptoms <u>better</u>?

Rest Cold Therapy Medication Activity Heat Therapy Other

What, if anything, makes your symptoms <u>worse</u>?

Inactivity
Exercise
Other: _____

Have you seen another physician for this injury? Yes No If yes, who? _____

What treatments have you tried?

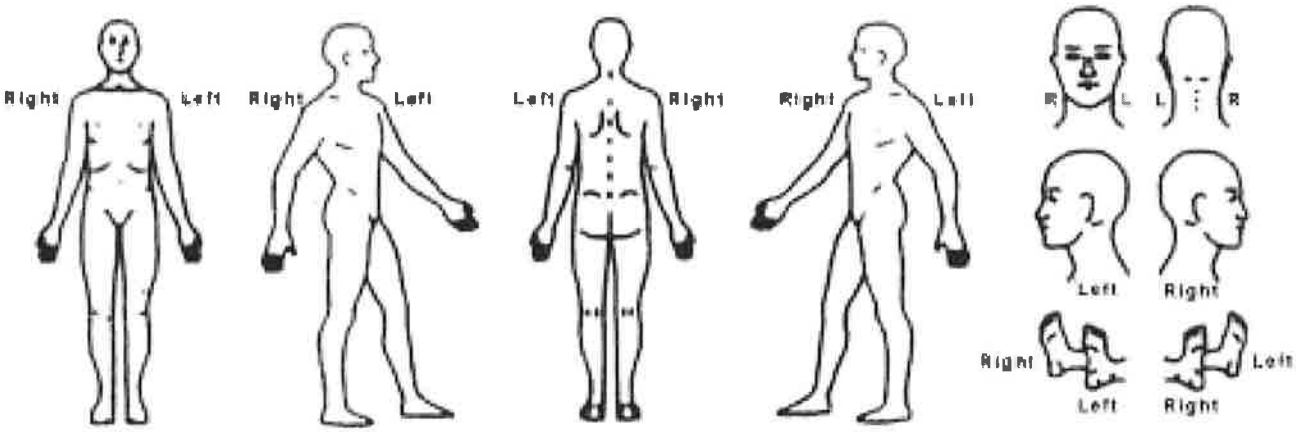
Nothing	Decreased activity	Chiropractic
Physical therapy	Injections	Ice
Exercise	Bracing	Other
Acupuncture	Medications	

Have you had any of the following tests/studies?

X-rays Where? _____ When? _____
MRI scan Where? _____ When? _____
CT scan Where? _____ When? _____
EMG/NCV Where? _____ When? _____

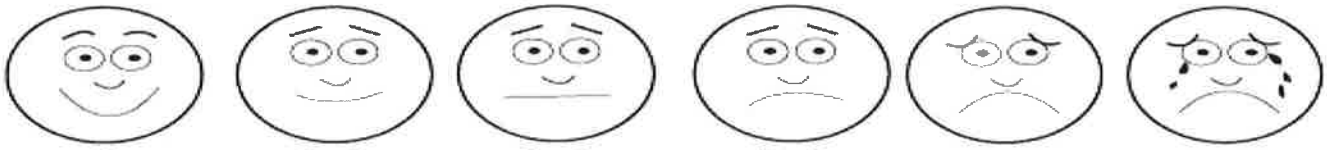
PLEDGE MEDICAL
Comprehensive Injury Program
Office 833-PLEDGE 5
Fax 949-478-8358
info@pledgemedical.com

On the following diagram, Please Indicate the area where you currently feel pain
En el siguiente diagrama, indique el área donde actualmente siente dolor



Choose the face that best describes how you feel

Are you in pain? (¿Tiene Dolor?)



0	1 - 2	3 - 4	5 - 6	7 - 8	9 - 10
very happy, no pain (Muy feliz Sin dolor)	hurts just a little bit (Duele un poquito)	hurts a little more (Duele un poco más)	hurts even more (Duele aún más)	hurts a whole lot (Duele mucho)	hurts as much as possible (Duele tanto como pueda imaginar)

Firma del Paciente:_____ Fecha:_____

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PAST MEDICAL HISTORY

Check if you currently suffer or have previously suffered from:

High blood pressure _____
Deep vein thrombosis _____
Liver disease _____
Heart disease or attack _____
Stroke _____
Cancer (where) _____
Elevated cholesterol _____
Ulcer disease _____
Gastritis _____
Reflux disease _____
Asthma _____
Osteoporosis _____

Kidney disease/ problem _____
Seizures _____
Arthritis _____
Thyroid (hyper or hypo) _____
Tuberculosis _____
Pulmonary embolism _____
Polio _____
Rheumatic fever _____
Gout _____
Depression _____
Diabetes _____
Other, please list: _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, when? _____

PAST SURGICAL HISTORY

Please list all surgeries you have had in the past:

Type of surgery	Date	Surgeon

Have you had any problems with anesthesia? Yes No If yes, explain: _____

ALLERGIES

Are you allergic to any medication? ☐ Yes ☐ No known drug allergies
If yes, please list all medications that you are allergic to (i.e. penicillin (hives) etc):

_____

Are you allergic to: Sulfa? ☐ Yes ☐ No Latex? ☐ Yes ☐ No Steroids? ☐ Yes ☐ No

Please list all food allergens (i.e. eggs, shellfish): _____

MEDICATIONS

Please list all medications you are currently taking. Include antibiotics, blood thinner, insulin, heart medications, aspirin, and any over the counter medications.

Medications	Dosage	Frequency

SOCIAL HISTORY

Occupation:_____

Tobacco Use: ☐ Everyday ☐ Some days ☐ Former smoker ☐ Never smoke ☐ Unsure how often

Alcohol Use (drinks per day): ☐ 6 or more ☐ 4-5 ☐ 2-3 ☐ Less than 1 Occasionally Don't drink

Recreational Drug Use: No Yes Frequency:_____

FAMILY HISTORY

Please check family history conditions:

Blood Clots Diabetes Hypertension Rheumatoid Arthritis Anesthetic problems

☐ Cancer ☐ Heart Disease ☐ Osteoporosis ☐ Stroke ☐ Seizures

Please describe any immediate family history medical problems: _____

REVIEW OF SYSTEMS

1. **CONSTITUTIONAL GENERAL** None Weight gain/loss Chills Fever Weakness/Fatigue Other: _____

2. EYES ☐ None ☐ Blurred vision ☐ Glasses ☐ Contacts ☐ Eye pain ☐ Redness
Other: _____

3. EARS, NOSE, THROAT ☐ None ☐ Nose bleeds ☐ Ear ache or infection ☐ Ringing in ear ☐ Hoarseness
Other: _____

4. CARDIOVASCULAR ☐ None ☐ Chest Pain ☐ Swelling in legs ☐ Shortness in breath ☐ Palpitations
Other: _____

5. RESPIRATORY ☐ None ☐ Shortness of breath ☐ Wheezing/Asthma ☐ Frequent Cough
Other: _____

6. GASTROINTESTINAL ☐ None ☐ Heartburn ☐ Vomiting ☐ Nausea ☐ Abdominal Pain Other: _____

7. MUSCULOSKELETAL ☐ None ☐ Stiffness Muscle aches ☐ Swelling of joints ☐ Instability Other: ____

8. SKIN ☐ None ☐ Rash Itching ☐ Redness ☐ Keloid scars ☐ Psoriasis Other: _____

9. NEUROLOGICAL ☐ None ☐ Headaches ☐ Numbness, tingling, loss of sensation in any part of body
☐ Dizziness ☐ Poor balance ☐ Fainting spells ☐ Seizures Other: _____

10. PSYCHIATRIC ☐ None ☐ Depression ☐ Nervousness ☐ Anxiety Other: _____

11. ENDOCRINE ☐ None ☐ Excessive thirst or hunger ☐ Hot/cold intolerance ☐ Hot Flashes

12. HEMATOLOGICAL ☐ None ☐ Easy Bruising ☐ Easy Bleeding ☐ Varicose veins ☐ Blood clots

Signature:_____ Date: _____

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PATIENT INFORMATION (Informacion Del Paciente)			
Patients Last Name (Apellido):	First (Nombre):	Middle (Segundo Nombre):	Mr. Miss Mrs. Ms.
Birth Date (Fecha de Nacimeinto):	Age (Edad):	Patients Email:	
Marital Status (Circle One): Single Married Divorced Separated Widow (Soltero/a) (Casado/a) (Divorciado/a) (Separado/a) (Viudo/a)		Sex: Male/Female	Home Phone: (Telefono):
Street Address (Direccion):			Cell Phone (Cellular)
P.O. Box:	City (Ciudad):	State (Estado):	Zip Code (Codigo Postal):
Occupation (Occupacion):	Employer (Estado):	Employer phone number (Telefono del empleo):	
Referred to clinic by (Referido por):			

In Case of Emergency (En caso de una emergencia)		
Name (nombre):	Relationship to patient (Relacion al paciente):	Telephone (Numero De Telefono):

Attorney Information (Informacion del abogado)	
Attorney's Name / Firm's Name (nombre de abogado):	
Phone Number (Numero de telefono):	Date of accident (Fecha del accidente):

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MEDICATION POLICY

If you are prescribed medication during your treatment, there are several guidelines you MUST follow:

1. The medications given to you should be taken as prescribed by your doctor. The medications may not be used for any other purpose that which they were given to you. These medications may not be given or sold to any other individual. Patients may be asked to perform a urine/serum drug test at any time.
2. You will be given a specific amount of medication to last a specific length of time. You must keep track of your medications to make sure you do not run out before the specific time. It is your responsibility to have follow-up appointment scheduled far enough in advance so that you do not run out of your medication.
3. Request for medication refill will only be considered during regular office hours; Monday-Thursday 9:00a.m. to 5:00p.m. No refills will be given after hours, weekends, or holidays. All refill requests must be received by Thursday to be refilled for the weekend.
4. Request for medication refills should be called to your pharmacy who will, in turn, call our office. Please allow 48 hours for this procedure. No refills of medications will be given if you have not been seen for 3 months. Your refill will need to be reviewed by your physician and may not be refilled until you have been seen again. It is your responsibility to make a follow-up appointment with your doctor. This will be strictly enforced.
5. If you call for medication or refills outside regular office hours, you will be instructed to go to the emergency room. There, you will be evaluated by an emergency room physician who will decide whether to refill your medication. Emergency Department Policy regarding medication refills is typically very strict and there is no guarantee that you will get your refill. If the Emergency Department is busy, you may be required to wait a long period of time to be seen.
6. While in the care of IPSI, all pain medication will be given at our doctor's discretion. Do not seek pain medication from any other physicians. Breaking these rules will be grounds for termination of your treatment.
7. Telephone request for prescription renewals are accepted only during regular business hours. In some instance there is a 48 to 72 hour waiting period before prescriptions will be refilled, so call your refills accordingly. We are very cautious about refilling your medications too early, so follow your instructions carefully.

_____ _____

Print Patient Name Date of Birth

_____ _____

Patient Signature **(Parent or Guardian if patient is a minor)** Date

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AUTHORIZATIONS | ASSIGNMENTS | CONSENTS

PLEASE READ THE FOLLOWING CAREFULLY. IF YOU HAVE ANY QUESTIONS, PLEASE DO NOT HESITATE TO ASK FOR AN EXPLANATION FROM OUR OFFICE MANAGEMENT

- Normal office hours are from 8:30 am to 5:00 pm, Monday through Friday. All routine telephone calls to the office should be made during these hours.

Patient Initial: _____

- I hereby authorize and request Pledge Medical to release my complete medical records (including X-Rays) when referring to other facilities concerning my medical treatment.

Patient Initial: _____

- I hereby assign to Pledge Medical all benefits for surgical and medical care payable under medical insurance policy and/or policies. I also authorize release of information from Pledge Medical to my insurance carrier for service billed.

Patient Initial: _____

- I understand that if my care is on a lien, it is my responsibility to promptly notify Pledge Medical if there are any changes in my legal representation. I understand that I am financially responsible for all services rendered whether or not paid by insurance. Payment is expected pending outcome of case. There will be a charge of $25 for all returned checks.

Patients Initial: _____

Orthopedic and Spinal emergencies usually require hospital admissions. If you should find yourself in that emergency, please go to the nearest hospital emergency room. The emergency room staff will then contact your Physician. Please keep in mind that on the weekend there may be other doctors covering your doctor's practice and therefore, you may be seen by someone other than your doctor.

PATIENT ACKNOWLEDGEMENT OF DISCLOSURE INFORMATION

My signature below acknowledges the following:

- I have received a copy and am aware of the Patient Bill of Rights as required by law and have had an opportunity to receive assistance in understanding and exercising these rights.
- I have received a copy and am aware of this office's Notice of Privacy Practice, including the Private Health Information (PHI) designated at the time of visit.

I have read and fully understand the information that has been provided.

Signature of Patient/Representative: _____ DOB: _____ Date: _____

Office 833-PLEDGE 5
Fax 949-478-8358
casemanager@pledgemedical.com

PLEDGE MEDICAL

AUTHORIZATION TO REQUEST MEDICAL RECORDS

* The top portion MUST be completed whether or not medical records are requested *

Patient Name:	Date of Birth:	Date:
Address:		City:
State:	Zip Code:	Phone Number:

This is to authorize:

1101 Bayside Drive Suite 100, Corona Del Mar, CA 92625
2664 Atlantic Avenue, Long Beach, CA 90806
9730 Brimhall Road #3, Bakersfield, CA 93312
Ph: (833)753-3435 Fax: (949) 478-8358

TO REQUEST INFORMATION FROM:

Name of Doctor, Insurance Co., or Included:		
Address:	City:	State:
Zip Code:	Phone Number:	Fax Number:

(MARK ALL RECORDS TO BE REQUESTED)

All Medical Records	Operative Reports	NCV/EMG Reports	XRAY/MRI Reports
Lab Work	Office Notes	OTHER	

I realize that I am entitled to a copy of this authorization.

_____ _____
Signature of patient or responsible party Date

Office personal requesting: _____

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Office 833-PLEDGE 5
Fax 949-478-8358
casemanager@pledgemedical.com

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

I, _____, have been provided the opportunity to review this office's Notice of Privacy Practices. I understand that a copy will be proved upon request.

_____
Please Print Name

_____
Signature

_____
Date

****FOR OFFICE USE ONLY****

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, however acknowledgment could not be obtained because:

_____Individual refused to sign.

_____Communication barriers prohibited obtaining the acknowledgment.

_____An emergency situation prevented us from obtaining acknowledgment

_____Other: _____