The Spine Clinic of Los Angeles
1245 Wilshire Boulevard, Suite # 717
Los Angeles, California 90017

213.481.8500 (o) 213.481.8555 (f)
www.laspineclinic.com
patients@laspineclinic.com

The Spine Clinic of Los Angeles
CONSENT FORM

General Consent for Treatment:

I consent to care and treatment by Dr. Larry Khoo and associated physicians, health care providers and other staff members in accordance with their professional judgment. I understand that my treatment and care may include routine care, and a variety of other medical services depending on my condition, such as laboratory testing. I am aware that the practice of medicine, including surgery is not an exact science, and no one has made any guarantees about the results of my treatments, examinations, or procedures.

I, _____, consent to care and treatment by Dr.
(Print Name)
Larry Khoo and associated physicians, health care providers and other staff members in accordance with their professional judgment, as may, in their professional judgment, is necessary to provide for the medical, surgical or emergency care of my
_____ _____, a minor.
(Relationship) *(Print Name)*

General Consent for Use and Release of Information:

I give permission to Larry T Khoo MD including its treating and referring providers and other staff members to release information about me including my health, the health services provided to me, medications, or payment for my health services, that may be necessary: (1) for my treatment (to health care providers or facilities that need the information for my continued care); (2) for any purposes related to payment by me or a third party for services (to determine eligibility, to process an insurance claim, for utilization and quality review, or for billing or collection purposes, as necessary to obtain payment); or (3) for the health care operations.

Financial Responsibility:

I authorize payment of medical benefits to Larry T. Khoo MD Inc. for any services furnished. I understand that I am financially responsible for any amount not covered by insurance. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me for the purpose of evaluating and administering claims of benefits.

I understand that filing of insurance claims is a courtesy only and that if payment from your insurance company is not received within 30 days after a claim is filed, I will be notified of the balance due and payment will be expected in full or other arrangements made at that time. I understand that should my account become delinquent, I will be legally responsible for all cost involved with the collection of this account including all court costs, reasonable attorney fees and all other related cost as allowed under law.

Co-Pays and Deductibles:

You are responsible for your deductible and co-payment. If your deductible has been satisfied, we will bill your health plan. If your deductible has not been satisfied, payment is required at the time of service. Your co-payment is also dues at the time of services.

Medicare:

We accept Medicare assignment. You are responsible for you deductible and co-payment. If you have a secondary insurance carrier, a portion of your co-payment maybe covered.

Non-Covered Services:

If we provide services to you that are not covered by your health plan, you will be responsible for payment in full for those services. Your signature, below, constitutes agreement to pay for such series.

Methods of Payment Accepted:

Payment is expected at the time of service. We accept: Visa, MasterCard, Discover, cash, and checks.

_____ _____

Patient Signature **Date**

THE SPINE CLINIC OF LOS ANGELES
DEMOGRAPHIC SHEET

PATIENT INFORMATION			
Last Name	First	M.I	DOB
Legal name (if different)		S.S NO.	
Street Address		Apartment/Unit #	
City	State	ZIP	
Phone	Cell	E-Mail	
Occupation	Employer	Employer Phone	
Marital Status SINGLE ☐ MAR. ☐ DIV. ☐ SEP. ☐ WID. ☐		Sex Female ☐ Male ☐	
Race	Ethnicity	Language	

INSURANCE *(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)*			
Are you the primary Insured	YES ☐ NO ☐ *If NO Please fill out the Italic sections*		
Is this a patient? YES ☐ NO ☐	*Primary Insured Name:*	*DOB:*	*S.S. NO.*
Address (If different)	*Phone (if different)*		*Relationship*

NAME OF PRIMARY INSURANCE		
Type Medicare ☐ HMO ☐ PPO ☐ COMMERCIAL ☐ SELF PAY ☐ WCOMP ☐ OTHER ☐		
Subscribers name	DOB	S.S. NO.
Group No.	Policy No.	Co-Pay

NAME OF SECONDARY INSURANCE *(ONLY IF APPLICABLE)*		
Type Medicare ☐ HMO ☐ PPO ☐ COMMERCIAL ☐ SELF PAY ☐ WCOMP ☐ OTHER ☐		
Subscriber Name	DOB	S.S. NO.
Relationship		
Group No	Policy No.	Co-Pay

IN CASE OF EMERGENCY	
Name of Contact	Relationship
Phone Number	Cell Number

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize SCLA or insurance company to release any information required to process my claims.

Signature patient/guardian	Date

THE SPINE CLINIC OF LOS ANGELES

Referring and Other Physicians involved in Medical Care

MUST BE COMPLETED

PRIMARY CARE
Physicians Name:
Specialty:
Address:
Phone Number:
Fax Number:

REFERRING
Physicians Name:
Specialty:
Address:
Phone Number:
Fax Number:

PAIN MANAGEMENT
Name:
Address:
Phone Number
Fax Number:

PHARMACY
Name:
Address:
Phone Number
Fax Number:

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The Spine Clinic of Los Angeles
PAIN MEDICATION POLICY

Dear Patient:

Due to strict guidelines imposed by the Drug Enforcement Agency (DEA) we have a new pain medication refill policy that will become effective immediately. *As of October 21, 2014*, our policy is as follows:

For *surgical patients*, all pain medications will be filled up to one year post operatively with the exception of fusion surgical patients. These patients may have their medications filled for up to 2 years. After this time, you will then need to choose a pain management doctor for all subsequent pain medication prescriptions. We can recommend a pain medication doctor near you to help with this transition.

For patients who have had surgery more than 2 years ago and are currently receiving prescriptions from our office, we will fill one more prescription at your next visit in order to allow time for you to find a pain management doctor. No further pain medication prescriptions will be filled after that time.

For *non-surgical patients*, if Dr. Khoo prescribes pain medication at your initial consultation but you do not proceed with surgery, we will prescribe one refill after which time you will need to choose a pain management doctor or contact your primary care physician for all subsequent requests. If you currently under the care of a Pain Management Doctor, we will be unable to

prescribe any narcotic pain medications. Please understand that this is for your safety.

Please allow 24-48 hours for your prescription to be refilled. Also remember that we do not accept pain medication refill requests on weekends. Thank you for your understanding.

Dr. Larry Khoo and Staff
The Spine Clinic of Los Angeles

Print Patient Name

Patient Signature/date

THE SPINE CLINIC OF LOS ANGELES
Medical Intake Questionnaire

"Please take some time to carefully fill out these sheets so that we can provide you with the very best care."

Tell us a little about yourself.

Name:
Last First Middle

Birthdate (mo/day/year) Age Sex M / F Weight Height Right or Left Handed

Your occupation(s):

Are you presently (working / disabled /retired)? _____

Are you: [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed

Do you have children (yes/no and how many):

In your words, please describe your problem and reason for visiting us today.

Symptoms	**Duration**

Please tell us what treatments you have had up to now for the problems you described above:

Treatment	**When / How Long**	**Did it help?**

Please tell us about surgical procedures you have had in the past:

Previous operations	Dates	Any Problems (y/n?)

Please tell us about any medical conditions you have (ex: hypertension, diabetes, stroke, cancer, etc.):

Medical Conditions	How Long	Any Treatment?	When?

Do you smoke? Y / N **How many packs per day? _____** **For how many years? _____**
Do you drink? Y / N **What do you drink? _____** **How often? _____**

[Y/N] Osteoporosis	**[Y/N] Rheumatoid Arthritis**	**[Y/N] Cancer**
[Y/N] Recent Infections	**[Y/N] HIV/AIDS**	**[Y/N] Hepatitis**
[Y/N] Heart Attacks	**[Y/N] Chest Pain**	**[Y/N] Lung Problems**

Family History: Parents, Grandparents, and Siblings (alive or deceased; list age of death and cause):

Please list ALL medications you are currently or have recently taken (pain pills, aspirin, supplements, etc.):

Medication	Strength/Amount	How many pills and times per day?

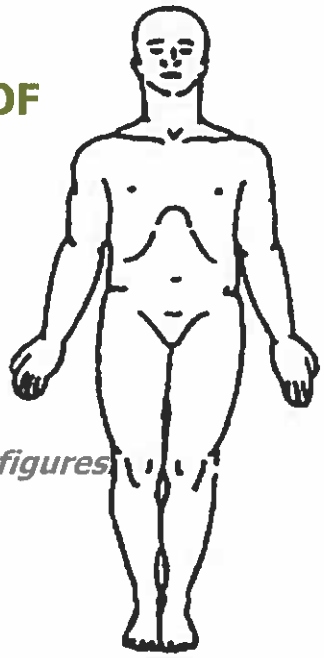
Allergies to medications	other allergies

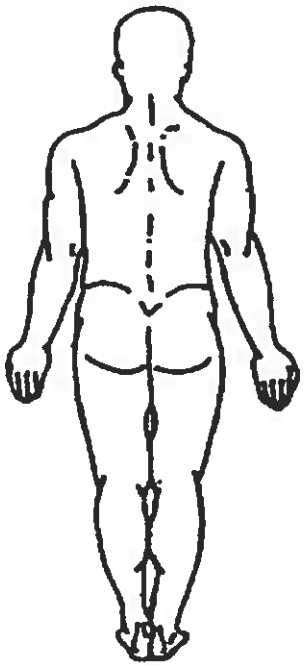
Please list all recent X-RAYs, CTs, MRIs (or other studies related to your condition) dates/where:

Are you claustrophobic to scans? Y/N Have you required sedation in the past? Y/N

Implants (ex: stimulators, medication pumps, metal (titanium/steel, etc.) please include location of implant:

THE SPINE CLINIC OF LOS ANGELES





Please help us better understand the Pain that you are experiencing.

Indicate the locations of your pain by shading in the painful areas on these figures.

1. Please indicate the **current** intensity of your pain by making an X anywhere on the line below:

NO PAIN — THE MOST INTENSE PAIN IMAGINABLE

2. Please indicate the **worst** intensity of your pain over **the past month** by making an X anywhere on the line below:

NO PAIN — THE MOST INTENSE PAIN IMAGINABLE

3. Please indicate your **mood** over **the past month** by making an X anywhere on the line below:

EXTREMELY GOOD MOOD — EXTREMELY BAD MOOD

4. Please rate how **often** your pain problem **stopped you** from doing what you wanted to do over **the past month:**

DID NOT STOP ME — COMPLETELY STOPPED ME

5. Please indicate how many **days per week** you have had **adequate** relief of your pain over **the past month** (*by circling a number*):

0 1 2 3 4 5 6 7

6. If your are taking pain medications, please indicate the **amount of relief** you receive after taking your medication by making an X anywhere on the line below:

NO RELIEF — COMPLETE RELIEF

7. Overall, how satisfied are you with the results of your pain treatment? *(circle your response)*

1	**2**	**3**	**4**	**5**	**6**	**7**
extremely satisfied	very satisfied	somewhat satisfied	mixed	somewhat dissatisfied	very dissatisfied	extremely dissatisfied

8. Circle all the words that describe your pain this month:

Aching	Throbbing	Shooting	Stabbing	Gnawing	Fearful	Sharp	Tender
Heavy	Burning	Exhausting	Splitting	Punishing	Sickening	Cramping	

THE SPINE CLINIC OF LOS ANGELES
Review of Systems

Please tell us if you are experiencing any of the following:

Allergies
[ ] Asthma
[ ] Hay Fever
[ ] Skin eruptions

Cardiovascular
[ ] Chest Pain
[ ] Irregular heart beat
[ ] High/low blood pressure
[ ] Poor circulation
[ ] Rapid heart beat
[ ] Swelling of ankles
[ ] Varicose veins

Constitutional
[ ] Chills/sweats/fever
[ ] Fainting
[ ] Forgetfulness
[ ] Headache
[ ] Loss of sleep
[ ] Nervousness
[ ] Weight loss

Ears, Nose, Mouth, Throat
[ ] Bleeding gums
[ ] Difficulty swallowing
[ ] Earache
[ ] Ear discharge
[ ] Hearing loss
[ ] Hoarseness
[ ] Nosebleeds
[ ] Persistent cough
[ ] Ringing in ears
[ ] Sinus problems

Endocrine
[ ] Spontaneous nipple discharge
[ ] Intolerance to warm room
[ ] Multiple broken bone
[ ] Cessation of menstrual period
[ ] Excessive hunger/thirst
[ ] Loss of libido

Eyes
[ ] Blurred vision
[ ] Crossed eyes
[ ] Double vision
[ ] Vision flashes or halos

Genitourinary
[ ] Blood in urine
[ ] Lack of bladder control
[ ] Painful urination

Gastrointestinal
[ ] Bloating
[ ] Bowel changes
[ ] Constipation
[ ] Diarrhea
[ ] Gas
[ ] Hemorrhoids
[ ] Indigestion
[ ] Nausea
[ ] Poor appetite
[ ] Rectal bleeding
[ ] Stomach pain

Hematologic/Lympathic
[ ] Swollen lymph nodes
[ ] Easy skin bruising
[ ] Prolonged bleeding

Integumentary
[ ] Skin rashes or eruptions
[ ] Chronic skin itching

Musculoskeletal
[ ] Pain, weakness numbness, swelling in Hands, wrists, hips, knees, or joints

Neurological
[ ] Fainting
[ ] Headache
[ ] Numbness of arms or legs
[ ] Seizures
[ ] Tingling of hands, feet arms or legs

Psychiatric
[ ] Anxiety
[ ] Restlessness
[ ] Depression
[ ] Panic attacks

Respiratory
[ ] Blood
[ ] Cough
[ ] Dizziness
[ ] Shortness of breath

Men
[ ] Breast lump
[ ] Lump in testicle
[ ] Penis discharge
[ ] Sore on penis

Women
[ ] Abnormal Pap Smear
[ ] Bleeding between periods
[ ] Breast Lump
[ ] Extreme mensutral pain
[ ] Hot Flashes
[ ] Nipple Discharge
[ ] Painful Intercourse
Last Period: _____
Last Pap Smear: _____
Last Mammogram: _____
Are you pregnant: _____
# of Children: _____

THE SPINE CLINIC OF LOS ANGELES
NDI/ODI SURVEY

Please help us understand the activity of your life right now: We realize you may consider that two of the statements in any one section relate to you, but please mark only the box that most closely describes your problem. Do not skip any sections.

How long have you had **BACK** *pain?* _____ years/months
How long have you had **LEG** *pain?* _____ years/months

On a scale from **"0" to "100"** *how bad is your* ***BACK*** *pain?* _____
On a scale from **"0" to "100"** *how bad is your* ***LEG*** *pain?* _____

How long have you had **NECK** pain? _____ years/months
How long have you had **ARM** pain? _____ years/months

On a scale from **"0" to "100"** *how bad is your* ***NECK*** *pain?* _____
On a scale from **"0" to "100"** *how bad is your* ***ARM*** *pain?* _____

Section 1: Pain intensity

- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

Section 2: Personal care (washing, dressing, etc.)

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it is very painful
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but manage most of my personal care
- ☐ I need help every day in most aspects of care
- ☐ I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, *e.g.* on a table
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift only very light weights
- ☐ I cannot lift or carry anything at all

Section 4: Walking

- ☐ Pain does not prevent me from walking any distance
- ☐ Pain prevents me from walking more than one mile
- ☐ Pain prevents me from walking more than a quarter of a mile
- ☐ Pain prevents me from walking more than 100 yards
- ☐ I can only walk using a cane or crutches
- ☐ I am in bed most of the time and have to crawl to the toilet

Section 5: Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting for more than 1 hour
- ☐ Pain prevents me from sitting for more than half an hour
- ☐ Pain prevents me from sitting for more than 10 minutes
- ☐ Pain prevents me from sitting at all

Section 6: Standing

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than 1 hour
- ☐ Pain prevents me from standing for more than half an hour
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

Section 7: Sleeping

- ☐ My sleep is never disturbed by pain
- ☐ My sleep is occasionally disturbed by pain
- ☐ Because of pain I have less than 6 hours sleep
- ☐ Because of pain I have less than 4 hours sleep
- ☐ Because of pain I have less than 2 hours sleep
- ☐ Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)

- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life is normal but causes some extra pain
- ☐ My sex life is nearly normal but is very painful
- ☐ My sex life is severely restricted by pain
- ☐ My sex life is nearly absent because of pain
- ☐ Pain prevents any sex life at all

Section 9: Social Life

- ☐ My social life is normal and causes me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g. sports, etc.)
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

Section 10: Traveling

- ☐ I can travel anywhere without pain
- ☐ I can travel anywhere but it causes extra pain
- ☐ Pain is bad but I manage journeys over 2 hours
- ☐ Pain restricts me to journeys of less than 1 hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from travelling except to receive treatment

THE SPINE CLINIC OF LOS ANGELES

SF-36 (tm) Health Survey

Instructions for completing the questionnaire: Please answer every question. Some Questions may look like others, but each one is different. Please take the time to read and answer each question carefully by filling in the bubble that best represents your questions.

Patient Name: _____

SSN#_____ Date:_____

Person hailing to complete this form: _____

1. In general, would you say your health is:
   a) Excellent
   b) Very good
   c) Good
   d) Fair
   e) Poor
2. Compared to one year ago, how would you rate your health in general now?
   a) Much better now than a year ago
   b) Somewhat better now than a year ago
   c) About the same as one year ago
   d) Somewhat worse now than one year ago
   e) Much worse now than one year ago.
3. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If So, how much?
   a. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports.
      - ☐ Yes, limited a lot
      - ☐ Yes, limited a little
      - ☐ No, not limited at all
   b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?
      - ☐ Yes, limited a lot.
      - ☐ Yes, limited a little
      - ☐ No, not limited at all
   c. Lifting or carrying groceries.
      - ☐ Yes, limited a lot
      - ☐ Yes, limited a little
      - ☐ No, not limited at all
   d. Climbing several flights of stairs.
      - ☐ Yes, limited a lot
      - ☐ Yes, limited a little
      - ☐ No, not limited at all
   e. Climbing one flight of stairs.
      - ☐ Yes, limited a lot
      - ☐ Yes, limited a little
      - ☐ No, not limited at all
   f. Bending, kneeling or stooping.
      - ☐ Yes, limited a lot
      - ☐ Yes, limited a little
      - ☐ No, not limited at all

g. Walking more than one mile
   - ☐ Yes, limited a lot
   - ☐ Yes, limited a little
   - ☐ No, not limited at all

h. Walking several blocks.
   - ☐ Yes, limited a lot
   - ☐ Yes, limited a little
   - ☐ No , not limited at all

i. Walking one block.
   - ☐ Yes, limited a lot
   - ☐ Yes, limited a little
   - ☐ No, not limited at all

j. Bathing or dressing yourself.
   - ☐ Yes, limited a lot
   - ☐ Yes, limited a little
   - ☐ No, not limited at all.

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?
   a. Cut down the amount of time you spent on work or other activities?
      ☐ Yes ☐ No
   b. Accomplished less than you would like?
      ☐ Yes ☐ No
   c. Were limited in the kind of work or other activities.
      ☐ Yes ☐ No
   d. Had difficulty performing the work or other activities (for example, it took extra time)
      ☐ Yes ☐ No
5. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)
   a. Cut down the amount of time you spend on work or other activities?
      ☐ Yes ☐ No
   b. Accomplished less than you would like
      ☐ Yes ☐ No
   c. Did not work or other activities as carefully as usual
      ☐ Yes ☐ No
6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?
   a) Not at all
   b) Slightly
   c) Moderately
   d) Quite a bit
   e) Extremely
7. How much bodily pain have you had during the past 4 weeks?
   a) Not at all
   b) Slightly
   c) Moderately
   d) Quite a bit
   e) Extremely
8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework?)
   a) Not at all
   b) Slightly
   c) Moderately
   d) Quite a bit
   e) Extremely

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks.
    a. Did you feel full of pep?
        - ☐ All of the time
        - ☐ Most of the time
        - ☐ A good bit of the time
        - ☐ Some of the time
        - ☐ A little of the time
        - ☐ None of the time
    b. Have you been a very nervous person?
        - ☐ All of the time
        - ☐ Most of the time
        - ☐ A good bit of the time
        - ☐ Some of the time
        - ☐ A little of the time
        - ☐ None of the time
    c. Have you felt so down in the dumps nothing could cheer you up?
        - ☐ All of the time
        - ☐ Most of the time
        - ☐ A good bit of the time
        - ☐ Some of the time
        - ☐ A little of the time
        - ☐ None of the time
    d. Have you felt calm and peaceful?
        - ☐ All of the time
        - ☐ Most of the time
        - ☐ A good bit of the time
        - ☐ Some of the time
        - ☐ A little of the time
        - ☐ None of the time
    e. Did you have a lot of energy?
        - ☐ All of the time
        - ☐ Most of the time
        - ☐ A good bit of the time
        - ☐ Some of the time
        - ☐ A little of the time
        - ☐ None of the time
    f. Have you felt downhearted and blue?
        - ☐ All of the time
        - ☐ Most of the time
        - ☐ A good bit of the time
        - ☐ Some of the time
        - ☐ A little of the time
        - ☐ None of the time
    g. Did you feel worn out?
        - ☐ All of the time
        - ☐ Most of the time
        - ☐ A good bit of the time
        - ☐ Some of the time
        - ☐ A little of the time
        - ☐ None of the time

h. Have you been a happy person?
   - ☐ All of the time
   - ☐ Most of the time
   - ☐ A good bit of the time
   - ☐ Some of the time
   - ☐ A little of the time
   - ☐ None of the time

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities? (like; visiting friends, relatives, etc.)?
   - ☐ All of the time
   - ☐ Most of the time
   - ☐ Some of the time
   - ☐ A little of the time
   - ☐ None of the time

11. How **TRUE** or **FALSE** is each of the following statements of you?
   a. I seem to get sick a little easier than other people
      - ☐ Definitely true
      - ☐ Mostly true
      - ☐ Don't know
      - ☐ Definitely false
   b. I am as health as anybody I know
      - ☐ Definitely true
      - ☐ Mostly true
      - ☐ Don't know
      - ☐ Definitely false
   c. I expect my health to get worse
      - ☐ Definitely true
      - ☐ Mostly true
      - ☐ Don't know
      - ☐ Definitely false
   d. My health is excellent
      - ☐ Definitely true
      - ☐ Mostly true
      - ☐ Don't know
      - ☐ Definitely false

PATIENT SIGNATURE: _____ **DATE:** _____

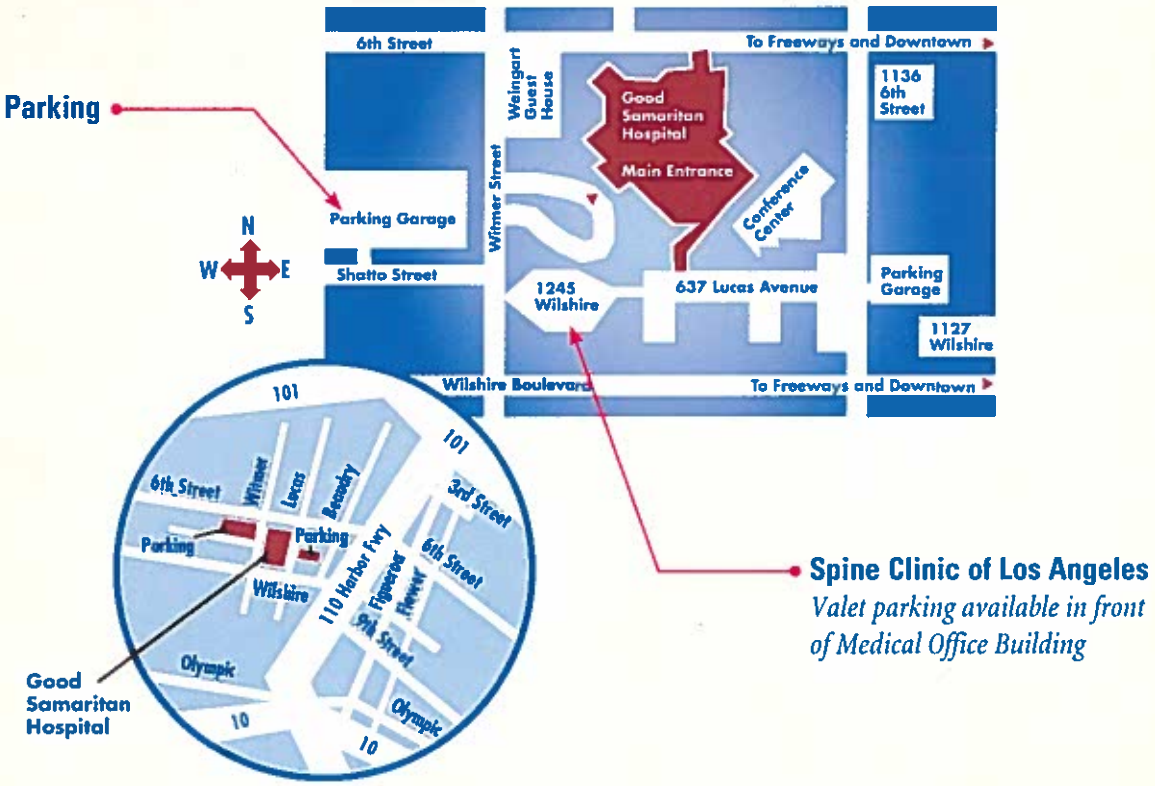
Directions:

The Spine Clinic of Los Angeles

(Larry T. Khoo, M.D.)

1245 Wilshire Blvd., Suite 717 • Los Angeles, CA 90017

(213) 481-8500 (O) • (213) 481-8555 (F)



From the Harbor Freeway (110):
Going South:

- Watch signs for "Downtown Exits" and "Wilshire Blvd."
- Take the Wilshire Blvd. offramp.
- Turn right onto Wilshire.
- Proceed west 5 blocks to Witmer Avenue and turn right
- Medical Office Building on right side

From the Harbor Freeway (110)
Going North:

- Take the 3rd Street exit.
- Turn left at Beaudry.
- Turn right at 6th Street.
- Turn left at Witmer
- Medical Office Building is on left side before Wilshire.

Good Samaritan Hospital
A Tradition of Caring