*PRESIDIO PAIN RELIEF*
*ROBERT SAVALA, MD*
*Board Certified Anesthesiologist,*
*Fellowship Trained Pain Specialist*
*Specializing in Diagnosing and Treating Pain Disorders*

*2000 Van Ness Ave, Suite 208*
*San Francisco, CA 94109*
*San Francisco 415.827.3832*
*F: 415.881.6198*

Name: _____ Date of Birth: _____

Address: _____

_____

Phone: _____

Email: _____

Emergency Contact: _____ Phone: _____

_____

Primary Insurance Carrier: _____

Member ID: _____ Group Number: _____

Rx BIN: _____ RX PCN _____ RX Group: _____

Secondary Insurance: _____

Member ID: _____ Group Number: _____

Rx BIN: _____ RX PCN _____ RX Group: _____

_____

Pharmacy: _____

Phone: _____ Fax: _____

Address: _____

_____

We will only send prescriptions to one pharmacy, except for an emergency situation.

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## Private Contract

This agreement is between Dr. Robert Savala ("Physician"), whose principal place of business is 2000 Van Ness Ave, suite 208, San Francisco, CA 94109 and the Patient, _____, ("Patient"), Date of Birth: _____.

The Physician has informed the Patient that the Physician has opted out of all commercial insurance plans and The Medicare Program effective March 1, 2024.

Physician agrees to provide medical services to patient (the "Services") as described in the form of:

Outpatient Pain Management Consultations and Procedures

In exchange for the Services, Patient agrees to make payments to Physician pursuant to his Fee Schedule. Physician agrees to provide Patient with all related fees prior to Services. Physician also agrees to provide Patient with a super bill to submit to insurance for possible reimbursement upon request. Patient agrees, understands, and expressly acknowledges the following:

- Patient acknowledges that neither commercial insurance fee limitations nor any other reimbursement regulations apply to charges for Services.
- Patient acknowledges that he or she has a right to obtain covered Services from physicians and practitioners who have not opted out of their commercial insurance plan.
- Patient agrees that he or she was fully notified by our office prior to scheduling that we are not contracted with any insurance carriers.
- The patient agrees to be responsible, and to make payment in full for Services, and acknowledges that the Physician will not submit a claim for Services on their behalf.
- Physician does not guarantee insurance reimbursement for Services from insurance carrier.
- We require 24 hours' notice to cancel an appointment. There will be a $100 late cancellation/no show fee for failure to not provide notice.
- There will be a rescheduling fee of $150 for failure to stop any blood thinners, or any other pre-procedural instructions causing a last minute to reschedule within 24 hours of your scheduled procedure.
- Patient acknowledges that they have reviewed and understand this contract.

_____ _____

Patient, Parent or Guardian Signature Date

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# CREDIT CARD PAYMENT AUTHORIZATION FORM

Date:

I hereby authorize Dr. Robert Savala, MD to charge my credit card for the services provided and any other fees related to my care

Credit Card Number:

Exp: CVV: Billing Zip Code:

Patient Signature:

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## PATIENT QUESTIONAIRE

Date: _____

Name: _____ Date of Birth: _____

Who referred you? _____

Who is your primary care doctor? _____

What is the reason for your visit today? _____

What is the cause of your pain? _____

Do you have any allergies? _____

Height: _____ Weight: _____

Have you done any physical therapy for this issue? __ YES __NO

If so, did it help? __ YES __NO

Are you doing any regular home exercises or stretching for this problem? __ YES __NO

In the past few months has your pain: __ Gotten worse __ Improved __ Remained the same

Is your pain worse: __ In the morning __Afternoon __ Evening __ No change throyght the day

Is you pain: __Constant __Occasional

Does your pain interfere with sleep __ YES __NO

What makes you pain worse? _____

What makes your pain better? _____

Please select any of the following that describes your pain:

__ Aching
__ Stabbing
__ Burning
__ Throbbing
__ Cramping
__ Burning
__ Weakness
__ Numbness/tingling
__ Pins and needles

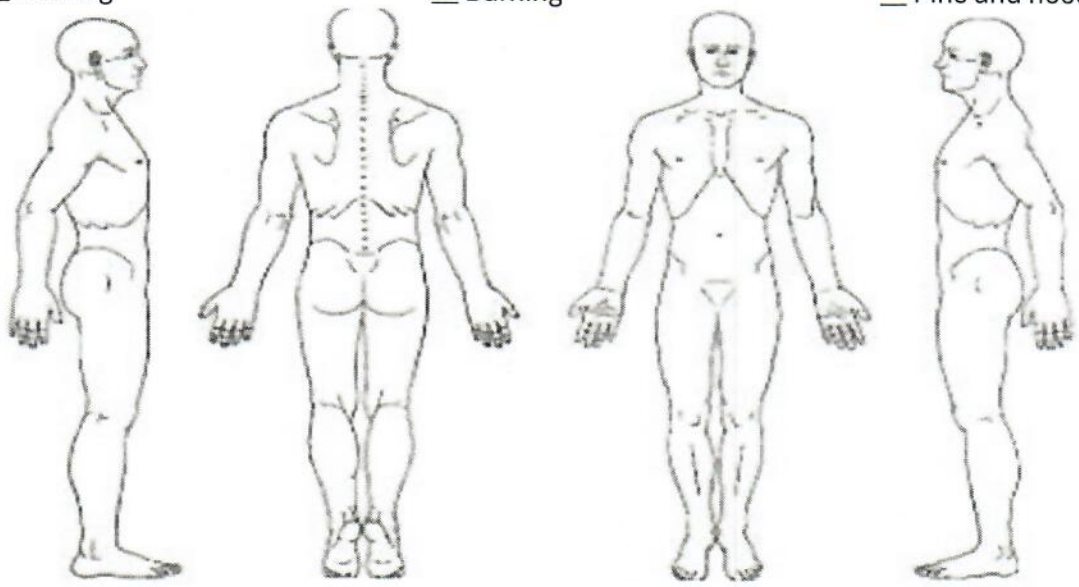
Please rate your pain on the scale below


Please select any of the following that describes your pain:

__ Aching
__ Stabbing
__ Burning

__ Throbbing
__ Cramping
__ Burning

__ Weakness
__ Numbness/tingling
__ Pins and needles



Please indicate any areas of discomfort

Hve you ever been experienced with any of the following:

__ Sedation or drowsiness
__ Insomnia
__ Sucidal thoughts
__ Memory impairment
__ Dizziness
__ Blurred vision
__ Loss of Balance
__ Fainting
__ Hallucinations

__ Stomach pain
__ Constipation
__ Nausea/vomiting
__ Blood in stool
__ Weight loss
__ Headaches
__Black tarry stools
__ Diarrhea
__ Loss of appetite

__ Trouble urinating
__ Severe chest pain
__ Chills/ninght sweats
__ Dramatic increase in pain
__Trouble breathing,
__Fevers
__ Serious rash

Were you ever diagnosed with depression? __ YES __NO

If so, is your pain the source of your depression? __ YES __NO

Do you smoke? __ YES __NO

Have you ever been treated for drug or alcohol addiction? __ YES __NO

Do you belong to any Na/ AA programs? __ YES __NO

| Current Medical History: | Yes | No |
|---|---|---|
| Diabetes | | |
| Heart Disease | | |
| High Blood Pressure | | |
| Respiratory Disease | | |
| Stomach/GI Problems | | |
| Liver Problems | | |
| Kidney Problems | | |
| Gynecological/Prostate Problems | | |

| Family Medical History: | Yes | No |
|---|---|---|
| Diabetes | | |
| Heart Disease | | |
| Cancer | | |
| Bleeding Disorder | | |
| Depression | | |
| Substance/Alcohol abuse | | |
| Auto-immune disorders | | |
| Serious reaction to anesthesia | | |

Please list any previous surgeries and the approximate date:

| Procedure | Date of Procedure |
|---|---|
| | |
| | |
| | |
| | |
| | |

What medications are you currently taking for your pain?

| | | |
|---|---|---|
| | | |
| | | |
| | | |

Are you taking any blood thinners? __ YES __NO

Are you __Married __Single __Divorced __Widowed

Is this a Workers Compensation injury: __ YES __NO

Do you have any litigation pending because of this problem? __ YES __NO

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# MEDICAL RECORDS REQUEST

Date: _____

To: _____

Fax: _____ Phone: _____

Re: _____ DOB: _____

I hereby authorize _____

To release the following medical records to Dr. Robert Savala, M.D.

_____

_____

_____

_____

Date range: _____

Patient signature: _____