Kevin S. Smith, M.D. / Nicole Wright, PA-C / Steven Lebowitz, PA-C

Board Certified in Pain Management and Anesthesiology

Dear Sir/Madam:

Enclosed you will find several forms; which we ask that you complete and bring with you to our office prior to your consultation. Please arrive thirty (30) minutes prior to your appointment; this will help expedite the process of setting up your account. If your paperwork is not completed prior to your appointment time you will need to be rescheduled.

Our office will obtain records from your referring physician prior to scheduling your appointment. If you have any additional records or radiology studies you would like to have reviewed, bring them to your appointment, please arrive a few minutes early so that we can get them into your chart for the doctor's review.

Upon check-in with the receptionist, please provide your identification and insurance card(s) to copy for your chart and pay any co-pays that apply. **If your co-pay is not paid at the time of service there will be a twenty ($20) charge to bill for a co-payment.**

Our Practice focuses on one on one personalized service, quality care and attention to detail. To do so, we must ensure that we allow enough time for each patient's appointment. With this in mind, for all appointments longer than one hour, we require indication of commitment by payment at the time of scheduling.

In the event that you must cancel your appointment, the following is our cancellation policy.

Appointments – 48 hour notice or $45 charge

Procedures Scheduled 1 hour or less – 48 hour notice or $100 charge

Procedures Scheduled longer than 1 hour and less than 2 hours – 72 hour notice or $175 charge.

Procedures Scheduled 2 hours or more – 7 day notice or $500.00 charge

We look forward to meeting you at your consultation with Dr. Smith.

Sincerely,

Medical Office Staff
Integrated Pain Specialists

Integrated Pain Specialists
(619) 398-2988 – Phone
(619) 398-2987 – Fax
(858) 300-1156 – Alt Fax
(619) 270-4951 – Answering Service

Main Office
7910 Frost Street Suite 280
San Diego, CA 92123

East County Office
5525 Grossmont Center Drive Suite 609
La Mesa, CA 91942

Integrated Pain Specialists of Southern California

*Updated By:*_____ *Date:*_____

PATIENT REGISTRATION

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks below the line.

Patient Name	Today's Date	Date of Birth	Sex	Age
Social Security Number	Marital Status (circle): S M W D	Primary Language	Race	Ethnicity ☐ Refuse to report
Home Address	City	State	Zip	
Mailing Address if Different	City	State	Zip	
E-mail	☐ I would like to be web-enabled so I may update my information, view reports & appointment info, receive confirmation calls, send & receive e-messages through the Patient Portal.			
Home Telephone Number	Work Telephone Number	Cell Telephone Number		
Permission to leave telephone message(s) at:	Home: ☐ Yes ☐ No ☐ Primary Phone #	**Message:** ☐ Brief ☐ Detailed		
	Work:: ☐ Yes ☐ No ☐ Primary Phone #	**Message:** ☐ Brief ☐ Detailed		
	Cell: ☐ Yes ☐ No ☐ Primary Phone #	**Message:** ☐ Brief ☐ Detailed		
Occupation	Employer's Name			
Employer's Address	City	State	Zip	
Spouse Name	Employer			
Primary Physician's Name				
Whom May We Thank for Referring You to Our Practice?				

NOTIFY IN CASE OF EMERGENCY

Name	Relationship		
Address	City	State	Zip
Home Telephone Number	Work Telephone Number	Cell Telephone Number	
Nearest Relative (not living with you)	Relationship		
Home Telephone Number	Work Telephone Number	Cell Telephone Number	

FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES

Name	Telephone		
Address	City	State	Zip
Insurance Company	Claim Address		
Subscriber/Primary Insured's Name	Subscriber's Date of Birth	Subscriber's SSN#.	
Insurance ID No.:			
Secondary Insurance	Claim Address		
Subscriber/Primary Insured's Name	Subscriber's Date of Birth	Subscriber's SSN#.	
Were You Injured on the Job? YES NO	Have you Informed Your Employer? YES NO		
Original Date of Injury:	Name of Claims Adjuster:	Adjuster Phone:	Adjuster Fax:
Attorney Name:	Attorney Phone:	Attorney Fax:	

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Kevin S. Smith M.D. I understand that I am financially responsible for any balance. I authorize Integrated Pain Specialists or my insurance company to release any information required to process my claims.

Patient/Guardian Signature: _____ Date: _____

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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 including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To: _____

Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____

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 medical information: _____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____(initial)

HIV Diagnosis/Treatment _____(initial)

Psychiatric/Mental Health _____(initial)

Genetic Information _____(initial)

Tests for Antibodies to HIV _____(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 *(or legal/personal representative)*

_____ Relationship *(if other than patient)*

_____ Patient's Name *(please print)*

_____ Today's Date

_____ Patient's Social Security Number

_____ Patient's Date of Birth

_____ Witness Name

_____ Witness Signature

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Notice of Privacy Practices

Consent to the Use and Disclosure of Health Information
for Treatment, Payment or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations and laboratory results, diagnoses, treatments, and any plans for future care or treatment. I understand that this information serves as:

- A basis of planning my care and treatment
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which third-party payers can verify that services billed were actually provided.
- A tool for routine healthcare operations, such as accessing quality and reviewing the competence of healthcare professionals.

I understand that I have the right to view and or request a Notice of Privacy Practices that provides a more complete description of information uses and disclosures prior to signing this consent. I understand that the organization reserves the right to change their notice and practices, and; prior to implementation will post and make available, the revised notice at physical practice site(s). I also understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my healthcare operations; and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing; except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information.

_____

_____

I request the following to be allowed to discuss my medical care with the Clinic.

_____

_____

I have read and understand the Notice of Privacy Practices.

_____ _____
Signature of Patient or Legal Representative Witness

_____ _____
Today's Date Notice of Effective Date

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Financial Agreement for Services Provided

I have chosen **Integrated Pain Specialists, Kevin S. Smith, M.D.** to provide medical services. **I agree to be financially responsible for all of the fees charged for medical services provided that are not covered by my health insurance.**

_____

I understand that I am responsible for the co-payment or deductible requirements of my insurance and for payment for any services that are not covered or are ineligible for payment by my insurance. If it is determined that I am not eligible for insurance coverage, I agree to pay the fee charged by IPS.

_____

I acknowledge that if I present for medical services without the proper authorization or referral which is required by my insurance company, I will be responsible for paying the fee charged by IPS. I also understand that if a service is provided that is not included as a benefit under my insurance coverage, that I will be responsible for paying the fee charged by IPS.

_____

I understand I may be personally responsible for payment of services that I am electing to proceed with. I agree to pay for all services at the time of service or within 30 days of receipt of a bill as well as pay for any outstanding fees owed to IPS. I also agree that if my account is transferred to any outside entity for collection, I will pay for the collection agency and any attorney's fee and costs in connection with obtaining payment.

_____

If my appointment has been scheduled at a facility, I understand that I will receive bills for services rendered by the facility separate and apart from the physicians' charges.

_____

I understand if I have an HMO with POS option and wish to use my PPO benefits without using HMO benefits, I cannot switch once treatment has been initiated.

_____

I have asked and had answered to my satisfaction, all questions I have regarding my responsibility for payment of services. I understand and agree to proceed with medical services.

_____

Signature of Patient/Responsible Party **Patient Name (Please Print)** **Date**

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No Show / Cancellation Policy

We strive to provide excellent medical care with. With this in mind, we require that you give us notice if you are unable to keep your scheduled appointment. This allows other patients to be scheduled into that appointment. A cancellation fee will be applied for missed appointments without any notice given as follows:

- **Office Appointments** – 48 hours business notice or $45 cancellation fee will be applied
- **Procedures Scheduled 1 hour or less** – Requires 48 business hours notice or $100 cancellation fee will be applied
- **Procedures Scheduled longer than 1 hour and less than 2 hours** – Requires 72 business hours notice or $175 cancellation fee will be applied
- **Procedures Scheduled 2 hours or more** – Require 7 business day notice or $500.00 cancellation fee will be applied.

We apologize for the need of this but when a patient No Shows or Cancels last minute it is too late to fill that appointment time with another patient who may have been in need of an urgent appointment.

Please be informed that multiple cancellations or "no-shows" may result in the termination of our physician/patient relationship and discharge from the practice.

I have read and understand the above policy.

Patient Signature	**Name** *(please print)*	**Date**

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Medi-Cal Acknowledgment

Effective: March 8, 2011

I acknowledge that I have been informed that Integrated Pain Specialists **is NOT contracted with Medi-Cal** as a Primary or Secondary insurance coverage. I have agreed to continue my care with Integrated Pain Specialists. I am aware that I will be financially responsible for all charges accrued that are not covered by my insurance.

Patient Signature: _____ Date: _____

Print Patient Name: _____

Witness: _____ Date: _____

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Please have this form completed prior to your visit and bring along with you to your appointment. Thank you.

Patient's Name: _____ Date of Appt: _____

Patient's Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female

Referring Physician: _____ Primary Care Physician: _____

Reason for Referral: _____

Diagnosis: _____

When did your pain start/Date of injury? _____

If you were injured, please describe the injury: _____

Name of Employer (if work related): _____

Are you involved in litigation: ☐ Yes ☐ No

Attorney's Name and Address: _____

If your pain is due to an accident at work:

a. Are you still working: ☐ Yes ☐ No
b. If you are still working, are your activities or hours restricted because of pain? ☐ Yes ☐ No
c. Are you receiving disability benefits? ☐ Yes ☐ No

Have you ever had nerve blocks or injections to relieve the pain? ☐ Yes ☐ No
If yes, did they relieve the pain? ☐ Yes ☐ No

If yes, how long did the pain relief last? _____

What type of injection did you have? _____

Have you used any of the following to relieve the pain?

☐ Acupuncture
☐ TENS Unit
☐ IDET, other disc procedures
☐ Chiropractor
☐ Biofeedback/Relaxation Training
☐ Massage
☐ Bed Rest
☐ Psychotherapy
☐ Trigger Point Injections
☐ Steroid Injections
☐ Physical Therapy
☐ Others: (Describe) _____

Studies:

Please circle all diagnostic tests for your pain.

Tests	Of what body part	Results(+/-)	Date	Location	Requesting Physician
MRI Scan					
CT Scan					
X-ray					
Bone Scan					
Thermography					
EMG/NCS					

For office use only:

B/P _____ **P** _____ **T** _____ **O_2** _____ **Rm #** _____ **MA:** _____

NP Packet Entered By: _____ *Date:* _____

Patient Name: _____

Please check ☑ the box next to any of the medications that you have used in the past for relief of your pain.

Non-Steroidal Anti-inflammatories:
- ☐ Aspirin
- ☐ Motrin (Ibuprofen)
- ☐ Vioxx
- ☐ Orudis
- ☐ Naprosyn
- ☐ Relafen
- ☐ Lodine
- ☐ Feldene
- ☐ Toradol
- ☐ Bextra
- ☐ Celebrex
- ☐ Indocin

Anti-migraine
- ☐ Inderal
- ☐ Fiorinal
- ☐ Cafergot/Ergotamines
- ☐ Imitrex

Opioids:
- ☐ Morphine
- ☐ MS Contin
- ☐ Roxanol
- ☐ Duragesic (Fentanyl)
- ☐ Actiq
- ☐ Levo-Dromoran
- ☐ Methadone
- ☐ Percodan
- ☐ Percocet
- ☐ Codeine
- ☐ Vicodin-Hydrocodone
- ☐ Norco
- ☐ Dilaudid
- ☐ Oxycodone (OxyFast)
- ☐ Demerol
- ☐ Darvocet/Darvicet-N
- ☐ Darvon
- ☐ Lortab

Muscle Relaxants:
- ☐ Flexeril
- ☐ Robaxin
- ☐ Valium
- ☐ Soma
- ☐ Baclofen

Stimulant
- ☐ Dexedrine
- ☐ Ritalin
- ☐ Provigil

Anti-anxiety:
- ☐ Ativan (Lorazepam)
- ☐ Xanax

Anti-hypertensive:
- ☐ Clonidine (Catapres)

Anti-epileptics:
- ☐ Depakote
- ☐ Neurontin
- ☐ Topamax
- ☐ Tegretol
- ☐ Dilantin
- ☐ Lyrica

Anti-depressants:
- ☐ Nortriptyline
- ☐ Elavil (Amitriptyline)
- ☐ Zoloft
- ☐ Paxil
- ☐ Trazadone
- ☐ Cymbalta
- ☐ Effexor
- ☐ Remeron

Non-opioids:
- ☐ Tylenol

List all PAIN MEDICATIONS you are currently taking:

Medicine	Dose (amount)	Times each day

Are you taking medications to prevent your blood from clotting? ☐ No ☐ Yes

- ☐ Warfarin (COUMADIN)
- ☐ Clopidogrel (PLAVIX)
- ☐ Enoxaparin (LOVENOX)
- ☐ Ticlopidine (TICLID)
- ☐ Dalteparin (FRAGMIN)
- ☐ Fondaparinux (ARIXTRA)
- ☐ Heparin
- ☐ Cilostazol (PLETAL)
- ☐ Other: _____

Have you ever stopped these medications for medical procedures? ☐ No ☐ Yes

List all OTHER MEDICATIONS you are currently taking:

Medicine	Dose (amount)	Times each day

List all MEDICATION ALLERGIES:

_____

_____

_____

Patient Name: _____

Describe the pain:

Is there a ***constant*** (continuous, non-stop, all of the time) component to your pain? If yes, circle any words that best describe your pain.

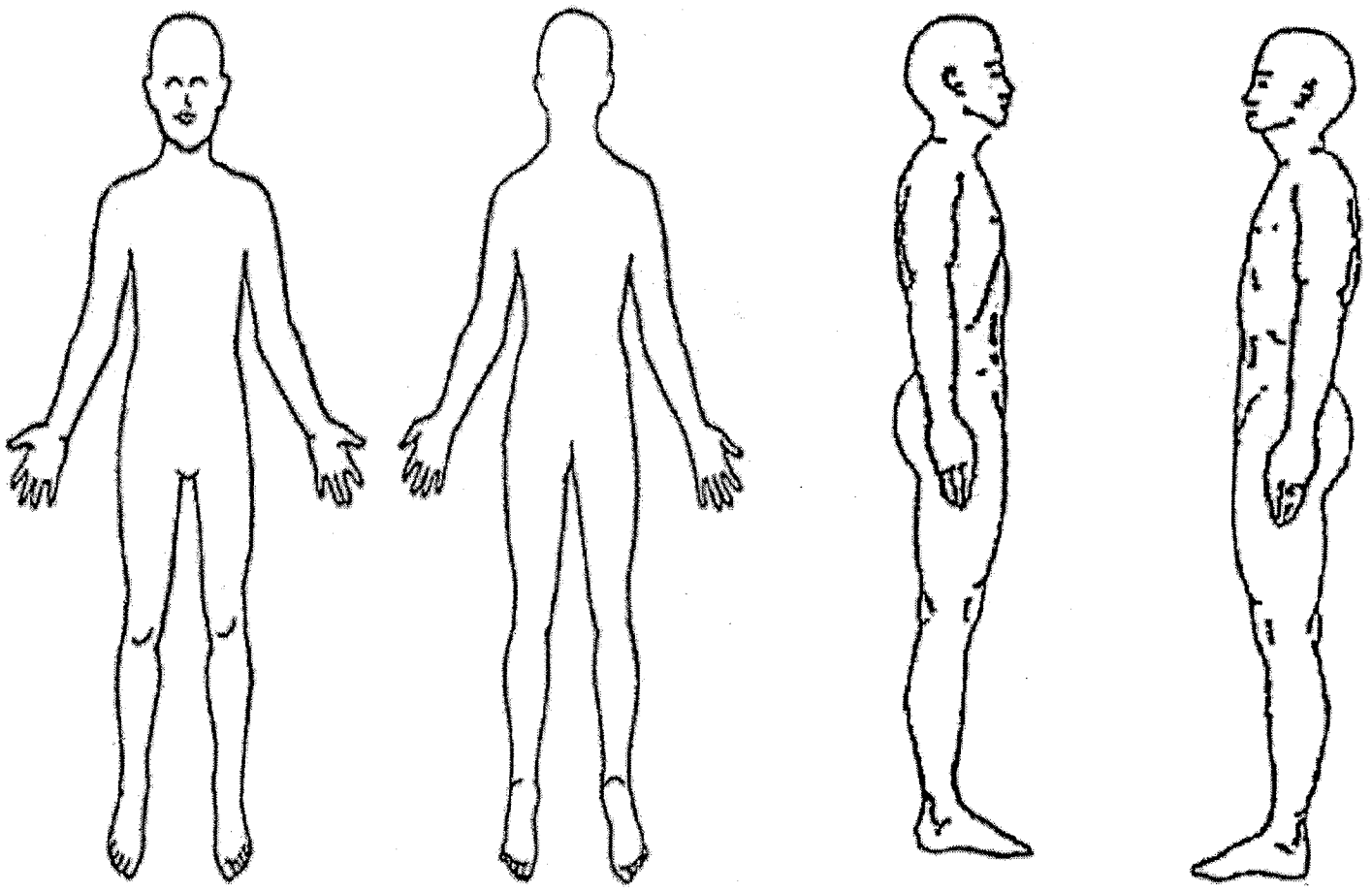
Pulsing, throbbing, pounding, dull, sore, aching, radiating, penetrating, shooting, tender, taut, tight, numb, squeezing, tearing, pricking, stabbing, tiring, cold, sharp, pinching, gnawing, cramping, pulling, hot, burning, scalding, tingling, itchy, stinging, intense, unbearable, or _____

Is there an ***intermittent*** (occasional, periodic, at intervals) component to your pain? If yes, circle any words that best describe your pain.

Pulsing, throbbing, pounding, dull, sore, aching, radiating, penetrating, shooting, tender, taut, tight, numb, squeezing, tearing, pricking, stabbing, tiring, cold, sharp, pinching, gnawing, cramping, pulling, hot, burning, scalding, tingling, itchy, stinging, intense, unbearable, or _____

Location:

Please mark on the drawings below with a **"C"** the areas where you feel constant pain and with a **"T"** the areas you feel intermittent pain.



Patient Name: _____

Balance/Fall Assessment Self-Test

(PLEASE CIRCLE ALL THAT APPLY)

1. Have you fallen in the past year?	YES	NO
2. How many times	_____	
3. Were you injured with this fall?	YES	NO
4. Do you have balance problems when you are walking?	YES	NO
5. Do you have any migraines, hearing loss, or ringing in your ears?	YES	NO

Medicare and other Insurance companies ask us to help identify patients that may be at risk for falls

For Office Use Only:

☐ Documented in Report

Entered in by: _____
Initials

Patient Name:_____

This section has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the one box that applies to you. We realize you may consider that two of the statements in anyone section relate to you, but please **mark the box which closely describes your problem.**

I Pain Intensity
- ☐ I can tolerate the pain I have without having to use pain killers.
- ☐ The pain is bad but I manage without having to take pain killers.
- ☐ Pain killers give complete relief from pain.
- ☐ Pain killers give moderate relief from pain.
- ☐ Pain killers give very little relief from pain.
- ☐ Pain killers have no effect on the pain and I do not use them.

II. Personal Care (Washing, Dressing, etc.)
- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ 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 self care.
- ☐ I do not get dressed, wash with difficulty and stay in bed.

III. 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 of the floor, but I can manage if they are conveniently positioned, eg 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.

IV. Walking
- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than I mile
- ☐ Pain prevents me from walking more than a 1/2 mile.
- ☐ Pain prevents me from walking more than 1/4 mile.
- ☐ I can only walk using a cane or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

V. Sitting
- ☐ I can sit in any chair as long as I like.
- ☐ I can only 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 ½ hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.

VI. 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 30 min.
- ☐ Pain prevents me from standing for more than 10 min.
- ☐ Pain prevents me from standing at all.

VII. Sleeping
- ☐ Pain does not prevent me from sleeping well
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hrs sleep
- ☐ Even when I take tablets I have less than 4 hrs sleep.
- ☐ Even when I take tablets I have less than 2 hrs sleep.
- ☐ Pain prevents me from sleeping at all.

VIII. Sex Life
- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal but it 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.

IX. Social Life
- ☐ My social life is normal and gives 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, eg dancing, etc.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ I have no social life because of pain.

X. Traveling
- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over two hours.
- ☐ Pain restricts me to journeys less than thirty minutes.
- ☐ Pain prevents me from traveling except to the doctor or hosp.

What makes the pain better? _____

What makes the pain worse? _____

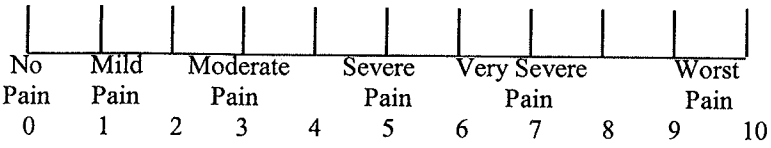
Numbness or tingling? ☐ Yes ☐ No If yes, describe: _____

Weakness? ☐ Yes ☐ No If yes, describe: _____

Bowel or bladder problem? ☐ Yes ☐ No If yes, describe: _____

Patient Name: _____

How severe is your pain?



Has the Pain affected your:			**If YES please describe:**
:	Mood	☐ Yes ☐ No	_____
	Sleep	☐ Yes ☐ No	_____
	Appetite	☐ Yes ☐ No	_____
	Social Life	☐ Yes ☐ No	_____
	Work	☐ Yes ☐ No	_____

Habits (circle all that apply)	***Currently Use***	***Previously Used***	***How much? How long? When Stopped?***
Tobacco	☐ Yes ☐ No	☐ Yes ☐ No	_____
Caffeine	☐ Yes ☐ No	☐ Yes ☐ No	_____
Alcohol	☐ Yes ☐ No	☐ Yes ☐ No	_____
Recreation/Street Drugs	☐ Yes ☐ No	☐ Yes ☐ No	_____

Have you been in a chemical dependency program? ☐ Yes ☐ No
Have you ever been to a pain doctor or pain clinic? ☐ Yes ☐ No
If YES, please list: _____
Location: City _____ Sate: _____

Have you ever been dismissed from a physician's office due to a disagreement over medications? ☐ Yes ☐ No

Enter Medical condition and ages for all family members:

Relative	***Current Age***	***(or age at death)***	***Current Medical Condition***	***(or cause of death)***
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brother	_____	_____	_____	_____
	_____	_____	_____	_____
Sister	_____	_____	_____	_____
	_____	_____	_____	_____
Children	_____	_____	_____	_____
	_____	_____	_____	_____
Spouse/Partner	_____	_____	_____	_____

Please list your exercise program by activity and frequency (example – run 20 minutes, 4 times a week)

_____

_____

_____

Please list any hobbies. (Example – sewing, painting, gardening, carpentry, auto repair)

_____

_____

Current Physical Activity Level: ☐ Little ☐ Moderate ☐ Very Active

Height: _____ ***Weight:*** _____

Patient Name: _____

Past Medical History:

Have you ever had . . . . .

Yes	*No*	*Condition*	*When*	*If YES, please explain*
☐	☐	Heart Disease		
☐	☐	Heart Murmur		
☐	☐	Heart Attack		
☐	☐	High Blood Pressure		
☐	☐	Stroke		
☐	☐	Palpitations		
☐	☐	Chest Pain		
☐	☐	Shortness of Breath		
☐	☐	Asthma or Wheezing		
☐	☐	Emphysema		
☐	☐	Bronchitis		
☐	☐	Tuberculosis		
☐	☐	Hepatitis (Jaundice)		
☐	☐	Kidney Disease		
☐	☐	Sickle Cell Disease		
☐	☐	Thyroid Disease		
☐	☐	Diabetes Mellitus		
☐	☐	Easy bruising/bleeding		
☐	☐	Blood disorder		
☐	☐	Glaucoma		
☐	☐	Frequent headaches		
☐	☐	Nerve Paralysis		
☐	☐	Fainting Spells		
☐	☐	Epilepsy (seizures)		
☐	☐	Back Problems		
☐	☐	Other Nervous System issues		
☐	☐	Phlebitis		
☐	☐	Drug Addiction		
☐	☐	Complicated pregnancy		
☐	☐	Smoking History		
☐	☐	Gastro intestinal		
☐	☐	Genitourinary		
☐	☐	MRSA/VRE		
☐	☐	Other		

Please list all surgeries and dates:

_____

_____

_____

Have you had surgery specifically for your present pain? ☐ Yes ☐ No

If yes, please list:

Operation	**Hospital**	**Date**	**Surgeon**	**Results**

Patient Name: _____

Have you had any unusual reactions to anesthesia? If so, please describe:

_____

_____

_____

Please list all hospitalizations and dates:

_____

_____

_____

For your convenience, the area below can be used by you to write down any questions you might have for your doctor.

_____

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Disclaimer

Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. Dr. Smith will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.

Integrated Pain Specialists of Southern California, Inc.
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Disclosure of Beneficial Interest

"California Business and Professions Code Section 654.2 requires your physician to notify you when your physician, or someone in his or her 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. Kevin Smith has a significant beneficial interest in Mission Valley Heights 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.