

AUTHORIZATION AND MEDICAL LIEN
iSCORE (Interventional Spine Care and Orthopedic Regenerative Experts)
PO Box 8323, La Crescenta, CA 91214
Tel: 818-338-6860; 626-460-1096; Fax: 888-425-9079
Email: billing@iscorinc.com; Website: www.iscorinc.com

I, _____ desire to undergo an examination, consultation, and any potential treatment regarding any possible injuries I sustained because of an incident causing injury (hereinafter the "Claim") which occurred on or about _____. Having been counseled by the attorney of my choosing, I agree as follows:

1. PROVIDER'S LIEN. I hereby grant **iSCORE** (hereinafter, "Provider") a lien on my Claim against all proceeds of any settlement, judgment, verdict, or award in the amount of Provider's standard billing costs for services provided to me or a family member for whom I am responsible.

2. ATTORNEY AUTHORIZATIONS. I hereby authorize and direct my attorney, _____, **Esq.**, and any of my subsequent attorneys (hereinafter "Attorney"), to pay Provider all amounts owing under this lien from the proceeds of my Claim before any payments are made to me. I further authorize and direct said attorney to notify Provider of any subsequent change of representation regarding my Claim.

3. PROVIDER AUTHORIZATIONS. I hereby authorize Provider to furnish Attorney with all medical records pertaining to my treatment, including reports on examination, diagnosis, treatment, prognosis, and other medical bills on record.

4. RESPONSIBILITY FOR PAYMENT. I acknowledge that I am directly and fully responsible to Provider for all medical bills submitted for services rendered to me and that this agreement is made solely for Provider's additional protection and in consideration of Provider awaiting payment. I further understand that such payment is not contingent upon any settlement, judgment, or verdict I may eventually receive on the Claim.

5. INTEREST. Provider (or Assignee) shall be entitled to receive, and I shall be required to pay, interest at the rate of ten percent (10%) per annum on all amounts owed by me for services rendered by Provider. Interest shall begin to accrue forty-five (45) days after settlement/judgment funds are received and shall continue until full payment of this Lien.

6. MISSED APPOINTMENTS. I have been informed and agree that if I am more than 30 minutes late to an appointment or fail to cancel an appointment 48 hours in advance, I may be billed 50% of the scheduled appointment charge by Provider.

7. WAIVER OF HEALTH INSURANCE. I declare that I have thoroughly discussed with my attorney all possible sources of funding for the treatment of my injuries including, but not limited to, commercial health insurance, health management organizations, and government programs such as Workers' Compensation. I have decided that obtaining medical treatment on a lien is the best option. As such, bills for my treatment will not be submitted to any such health insurance program for payment.

8. INTEGRATED/ENTIRE AGREEMENT. This Agreement, and Provider's statement of fees and costs which will be generated after treatment, constitute the final, complete, and exclusive statement of the terms of the agreement between the parties and supersedes all prior and contemporaneous understandings or agreements of the parties. This agreement may only be modified by a written statement signed by Provider (or Assignee of Provider) and myself.

9. STATUTE OF LIMITATIONS. I hereby agree to waive the running of any Statute of Limitations for an additional period of four (4) years as provided in CCP 360.5.

10. ACKNOWLEDGMENT. I acknowledge that I have read this entire agreement and that all provisions, rights, and obligations have been explained to me by my attorney. We consent to the terms of this contract and agree to be bound by it.

11. COUNTERPARTS. This Agreement may be executed in counterparts, each of which may be comprised of original signatures, or copies or facsimiles thereof, but all of which shall be taken together to constitute the same Agreement. Facsimile or emailed signatures will have the same force and effect as original signatures.

12. ATTORNEYS FEES: In any action to enforce this lien or to collect on Provider's bills, the prevailing party will be entitled to reasonable attorney's fees and costs.

Date: _____
PATIENT/ GUARDIAN SIGNATURE

_____, **Esq.** agrees that the attorney's status as trustee of the client funds will change from trustee to debtor if attorney (1) pays any other party other than Provider for Provider's services, or (2) releases/forwards said settlement, judgment or award funds directly to client without paying Provider; requiring Provider to seek payment directly from the client rather than the attorney.

Date: _____
ATTORNEY SIGNATURE



NEW PATIENTS' INFORMATION SHEET

www.iscoreinc.com

Please print clearly. Please complete all information so that your claim can be processed quickly and efficiently. Thank you!

PATIENT INFORMATION

Name _____

Date of Birth: _____ Sex: _____ Marital Status: _____

(Street)

(City)

(State)

(ZIP)

Address: _____

Phone #: _____ Social Security #: _____

Employer: _____ Work #: _____

Employer's Address: _____

If Student, School Name: _____ Full / Part Time _____

Primary Emergency Contact

Name: _____ Number: _____

Relationship: _____

Email: _____

WORKER'S COMP/ACCIDENT INFORMATION

Insurance Name: _____

Address: _____ Phone #: () -

Adjuster Name: _____ Adjuster Phone #: () -

Date of Injury or Accident: _____ Claim #: _____

Type of Injury: Back Leg Hip Neck Shoulder Arm Head Other: _____

Place of work during time of accident: _____ Phone #: () -

In Litigation: Yes NO Amount of Medical Benefits: _____ Notice of Compensation Payable: Yes NO

Attorney Information

Law Office Name: _____

Law Office Address: _____

Law Office Telephone: _____

Law Office E-Mail: _____

Attorney Name: _____

City: _____ State: _____

Law Office Fax: _____

Law Office Contact Name: _____

Maxim Moradian, M.D., DABPMR, CAQSM, DABPM, DABRM, Q.M.E.

Revik Vartanian, D.O.

James J. Lieu, D.O.

Specializing in Physical Medicine and Rehabilitation, Pain Management, Sports Medicine, Regenerative Medicine, and Electrodiagnostic Medicine

Patient Name: _____

DOB: _____

DOS: _____

PAIN SCORES (Scale 0 - 10)

0 = No Pain → 10 = The most pain you have ever felt in your life

CURRENT pain level (today / now): _____

HIGHEST pain level over the last week: _____

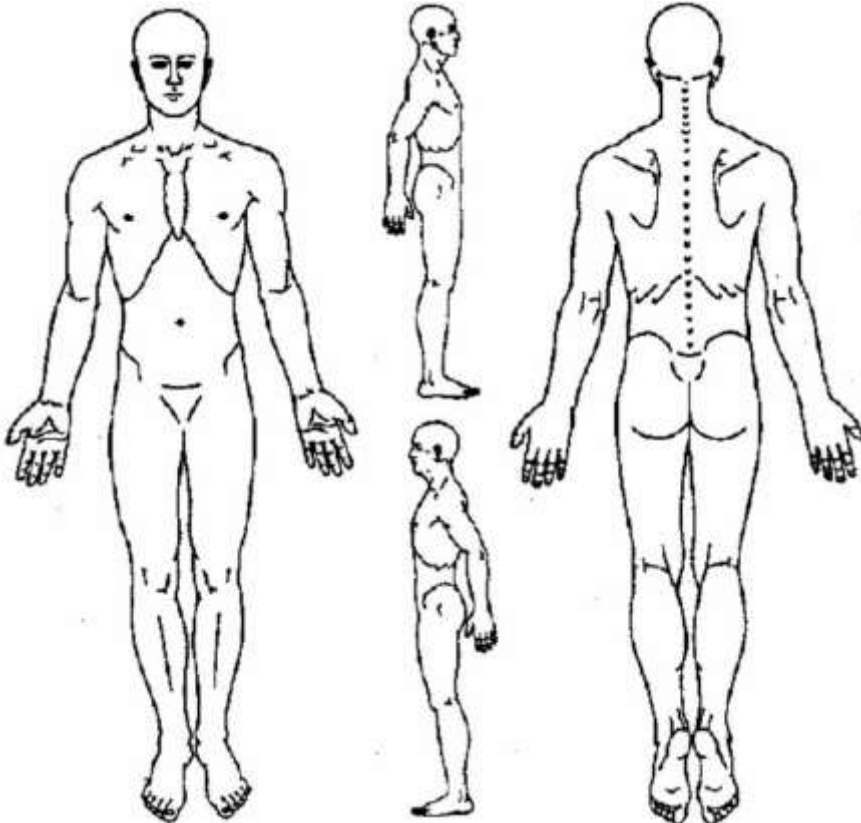
LOWEST pain level over the last week: _____

PAIN DIAGRAM

FRONT

RIGHT

BACK



LEFT

Please mark the figure with the location of your symptoms. Do not use circles.

Pain = × × × ×

Numbness/Tingling = # # # #

Characteristic(s) of pain
(Check all that apply)

- DULL
- ACHING
- BURNING
- SHARP
- SHOOTING
- THROBBING
- SPASMS
- OTHER: _____



INTERVENTIONAL SPINE CARE & ORTHOPEDIC REGENERATIVE EXPERTS

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NEW PMR & INTERVENTIONAL PAIN MANAGEMENT INTAKE QUESTIONNAIRE

Name: _____ Age: _____ Weight: _____ Height: _____

What is your reason for visit?: _____

How did it begin (suddenly, gradual, accident)? _____

How long has this been going on? _____

Is it constant or occasional? _____

Is it getting worse, same, or better? _____

Does the pain/discomfort go into the arms or legs? Which one? _____

If pain/discomfort goes into arms or legs, is there numbness, tingling, or weakness? _____

What makes it worse (examples - lifting, bending, sitting, walking)? _____

What makes it better (examples - resting, sitting, standing, nothing)? _____

Have you: (please circle)

Lost control of bowel or bladder because of this? YES NO. Explain: _____

Had prior x-rays, CT, MRI, bone scans for this? YES NO. Explain: _____

Had previous spine surgery for this problem (what type)? YES NO. Explain: _____

Had any spinal injections for this? YES NO. Explain: _____

When? _____ Did they help? _____

What other conservative treatments have you tried?

- Physical Therapy/Exercise TENS/E-Stim Opioid Medications Cast/Boot/Walker/Cane
- Massage/Ultrasound Traction Anti-Inflammatories Orthotics
- Chiropractic Acupuncture Muscle Relaxants Other _____

What other medical problems do you have? (eg Asthma, Diabetes, High Blood Pressure, etc)

Allergies to any medications? Check box if No Known Drug Allergies →

Medication:	Reaction:	Medication:	Reaction:

Family medical problems? (eg Asthma, Heart disease, Diabetes, Cancer, etc)

Father: _____

Mother: _____

Sibling: _____

Do you **smoke**? current everyday smoker current some days smoker former smoker never smoked

Use **drugs**? never in the past currently type of drug: _____

Drink **alcohol**? never rarely socially frequently (more than twice per week) alcoholic

What medications are you currently taking? (You may attach a list)

What surgeries have you had in the past?

Approximate date of surgery:

Patient Name _____

Patient DOB _____

Patient DOS _____

Please check off any of the following symptoms you have been recently experiencing:

- | | | | | |
|--------------------------|---|--|---|---|
| General: | <input type="checkbox"/> Chills | <input type="checkbox"/> Fever | <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Weight Loss |
| Skin: | <input type="checkbox"/> New Lesions | <input type="checkbox"/> Rash | <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Itching |
| HEENT: | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Discharge |
| Respiratory: | <input type="checkbox"/> Cough | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Sputum |
| Cardiovascular: | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Abnormal Blood Press. | <input type="checkbox"/> Palpatations | <input type="checkbox"/> Arrhythmia |
| Gastrointestinal: | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting |
| Muskuloskeletal: | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Dec. Range of Motion | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Muscle Pain |
| | <input type="checkbox"/> Mid-Back Pain | <input type="checkbox"/> Swelling of Extremities | <input type="checkbox"/> Joint Stiffness | <input type="checkbox"/> Muscle Spasms |
| | <input type="checkbox"/> Low-Back Pain | <input type="checkbox"/> Deformities | <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Fatigue |
| Neurological: | <input type="checkbox"/> Headaches | <input type="checkbox"/> Fainting | <input type="checkbox"/> Unsteadiness | <input type="checkbox"/> Numb/Tingling |
| | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Poor Coordination | <input type="checkbox"/> Stroke | <input type="checkbox"/> Weakness |
| | | <input type="checkbox"/> Trouble Walking | | <input type="checkbox"/> Incontinence |
| Psychiatric: | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Flashbacks | <input type="checkbox"/> PTSD |
| Endocrine: | <input type="checkbox"/> Cold Intolerance | <input type="checkbox"/> Heat Intolerance | <input type="checkbox"/> Excessive Sweating | <input type="checkbox"/> Diabetes |
| Hematology: | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Blood Thinners |
| Genito-Urinary: | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Discharge | <input type="checkbox"/> Urinary Incontinence | <input type="checkbox"/> UTI |

None of The Above Apply

Your primary medical (family) doctor? Name: _____ Tel # _____

Address: _____

City: _____ State: _____ Zip: _____

Did a doctor refer you here, and if so who? Name: _____ Tel # _____

Address: _____

City: _____ State: _____ Zip: _____

OFFICE USE ONLY BELOW THIS LINE:

Vital Signs:

Physical Exam: (pertinent positives)



Auto versus Auto Accident Questionnaire

1. Were you struck from: Behind Front Driver's Side Passenger Side
2. Were you the: Driver Front Passenger Rear Passenger
3. Was your car pushed forward upon impact? Y N
4. Did your car hit anything after it was hit? _____
5. Did you lose consciousness (blackout) upon impact? Y N. If so, how long? _____

Pedestrian versus Auto Accident Questionnaire (If applicable)

1. What part of your body was contacted by the vehicle? _____
2. Were you thrown into the air: Yes No
3. Did you lose consciousness (blackout) ? Y N
4. If so, estimate how long? _____

Fall (ex: Trip/Slip and Fall) Injury Questionnaire (If applicable)

1. Where did the incident occur? _____
2. How did the incident occur? _____
3. What part(s) of your body hit the ground? _____
4. Did you lose consciousness (blackout) upon injury? Y N, If so, how long? _____

Current Injury

1. Have you seen any other doctor/ medical facility prior to visiting this office for injuries sustained as a result of the incident? Y N
2. If yes, what is the name of the doctor/ facility you visited? _____

3. If yes, what studies were performed? (X-ray, MRI, CT scan, etc.) _____
4. Did paramedics / fire dept. arrive at the scene? Y N
5. If yes, were you taken to the hospital by ambulance? Y N

Pre-Existing Condition(s)

1. Prior to this incident, did you have any symptoms in the area(s) reported above? Y N
2. If YES, what body part(s)? _____
3. If YES, have your symptoms worsened? Y N
4. If YES, describe how it's worsened? _____

5. If YES, were you under the care of any musculoskeletal providers for the same areas immediately prior to this incident? Y N



Consent for Treatment with Controlled Substances

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

The long-term use of opioid pain medication, benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of the risk of developing an addiction disorder and uncertainty regarding the extent to which they provide long-term benefit.

These drugs are monitored by the State of California and the Drug Enforcement Agency because these drugs have potential for abuse or diversion. Therefore strict accountability is required. For this reason the following policies are agreed to by you, the patient, as a condition for the initial and/or continued prescription of controlled substances to treat your chronic pain.

1. Controlled substances must come from the physician who signs below or, during his or her absence, by the covering physician. Exceptions apply only when a controlled substance is being prescribed in a routine manner by another provider who is aware of all medications.
2. All controlled substances must be obtained at the same pharmacy, notwithstanding pharmacy-related issues made known by you to the practice.
3. You will inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take, or if you change pharmacies.
4. The prescribing physician has permission to discuss treatment details with dispensing pharmacists, or other professionals who provide you health care, to maintain accountability.
5. Unannounced urine, serum, or saliva toxicology screens may be requested and your cooperation is required.
6. You may not use any illicit substances while taking controlled substances including, but not limited to cocaine, heroin, methamphetamine, ecstasy, etc.
7. You may not share, sell, or otherwise permit others to have access to these medications.
8. You will take these medicines as prescribed or you will otherwise notify the physician.
9. **Original containers of medication will be brought to each visit for which a medication refill is being requested with the remaining corresponding medication inside.**
10. **You will maintain a journal of your medication use and bring it to each visit for which a medication refill is being requested.** An example will be provided to you. Maintain a blank original and make copies for use.
11. If your medication has been damaged, misplaced, or stolen you must complete a police report regarding the theft and provide a copy to this office.
12. Renewals are contingent on keeping scheduled appointments no less than 3 days in advance of the end of your current medication cycle. Urgent appointment requests for this purpose will not be honored and it is your responsibility to plan accordingly. Phone calls for prescriptions after hours or on weekends are not compliant with this requirement.
13. Early refills will generally not be given. You may not run out of your medications before an appointment for medication refill.
14. It is understood that any medical treatment is initially a trial and that continued prescription is contingent on evidence of benefit and safety.
15. The risks and potential benefits of these therapies are explained elsewhere (and you acknowledge that you have received such explanation). You agree to not operate heavy machinery while under the influence of these medications.
16. If the legal authorities have questions concerning your treatment all confidentially is waived and these authorities may be given full access to our records of controlled substance administration.
17. You understand that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment
18. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

Violation of any component of this contract may be met with one warning and repeat review of this agreement. No further warnings will be given. Final violation of this agreement indicates that safe outpatient management using these medications has not been demonstrated and therefore results in immediate termination of controlled substance prescribing. A referral to a detoxification program will be provided at that time.

Patient Name: _____

Patient DOB: _____

Patient Signature: _____

Physician Signature: _____

Date: _____



PATIENT INFORMATION

Patient Name: _____

Patient DOB: _____

Patient Telephone: _____

Patient E-Mail: _____

PHARMACY INFORMATION

Name of Pharmacy: _____

Address of Pharmacy: _____

* If Address unknown, please mention cross streets

Telephone of Pharmacy: _____

Fax Number of Pharmacy: _____

ADDITIONAL PHARMACY INFORMATION (If Applicable)

Name of Pharmacy: _____

Address of Pharmacy: _____

* If Address unknown, please mention cross streets

Telephone of Pharmacy: _____

Fax Number of Pharmacy: _____



Consent to Receive Text Message Appointment Reminders

By signing below, I authorize iSCORE to contact me by automated SMS text message for appointment reminders. I understand that message/data rates may apply to messages sent by iSCORE under my cell phone plan. My text/mobile phone number is: _____

Initials _____

I know that I am under no obligation to authorize iSCORE to send me text messages. I may opt-out of receiving these communications at any time by calling the office at 626-460-1096 or 818-338-6860. Please allow 2-3 business days for processing. I understand that text messaging is not a secure format of communication. There is some risk that individually identifiable health information or other sensitive or confidential information contained in such text may be misdirected, disclosed to or intercepted by unauthorized third parties. Information included in text messages may include your first name, date/time of appointments, name of physician, and physician phone number, or other pertinent information. By signing below, I indicate I am the primary user for the mobile phone number listed above, I accept the risk explained above and consent to receive text messages via automated technology from iSCORE.

Patient Name: _____

Signature: _____

Date: _____ Date of Birth: _____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership and the employees, agents and estates of any of them, must be arbitrated, including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provision of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitration shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If the patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:


Effective as of the date of first medical services

Patient's or Patient's Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By:  _____
Physician's or Authorized Representative's Signature Date
MAXIM MORADIAN, MD
Print or Stamp Name of Physician or Authorized Agent of Medical Group

By: _____ _____
Patient's or Patient Representative's Signature Date
By: _____
Print Patient's Name

(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.



Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient name: _____ Date of Birth: _____

Facility Name: _____ Fax No.: _____

Facility Address: _____ Tel No: _____

The information you may release subject to this signed release form is as follows:

- | | | |
|--|---|---|
| <input type="checkbox"/> Complete Records | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Care Plan | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Treatment Record | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Hospital Reports | <input type="checkbox"/> Medication Record | <input type="checkbox"/> Other (please specify) |

Release my protected health information to the following entity:

iSCORE (Interventional Spine Care and Orthopedic Regenerative Experts)

Providers: **Maxim Moradian, MD** **Revik Vartanian, DO** **James J. Lieu, DO**

Address: 317 S. Brand Blvd., Suite 103, Glendale, CA 91204

51 N. 5th Ave, Suite 301, Arcadia, CA 91006

Tel: (818) 338-6860 & (626) 460-1096; Fax: (888) 425-9079

Email: medicalrecords@iscoreinc.com

Patient Name

Signature of Patient or Personal representative

Patient Date of Birth

Printed Name of patient or Personal representative

Date

Description of Personal Representative's Authority