



680 Kinderkamack Road
Suite 207
Oradell, NJ 07649

Office: (201) 487-7246
Fax: (201) 225-0207
www.njpainmedicine.com

Date: _____

Name: _____
(Last) (First) (Middle)

Address: _____
(City) (State) (Zip)

Home: () Work: () Cell: ()

Age: _____ DOB: _____ SS#: _____ E-Mail _____

Height: _____ Weight: _____ M F Race _____ Ethnicity _____

Preferred Language _____ Occupation: _____

Referring MD: _____ Telephone: ()

Address: _____
(City) (State) (Zip)

Primary MD: _____ Telephone: ()

Address: _____
(City) (State) (Zip)

Emergency Contact: _____ Tel. # ()

Pharmacy Name: _____ Telephone: ()

Address: _____
(City) (State) (Zip)

Chief Complaint: _____

Medical History:

Are you currently under medical treatment? Yes No

Please list all issues _____



Surgical History: Yes No

List type of surgery _____

Allergies:

Do you have any allergies to medication, foods, dye (iodine)? Yes No

If yes please list: _____

Any **Latex allergies?** Yes No

Reaction: _____

Medications:

Please list all your current **pain** medications-prescriptions and non-prescriptions: *(please include your dosage and how many per day)*

Please list all your current **non-pain** medications: *(please give doses and how often you take your medication)*
(Ex: high blood pressure, cholesterol, blood thinner, **non-prescription** and **herbal**)

List any doctors, chiropractors, physical therapy, treatment plans or other health care professionals who have treated your pain and treatment done:

Family History of Medical Problems: _____

Social History:

Do you smoke? Yes No How many packs per day: _____ For how many years: _____

Do you drink alcohol? Yes No What do you drink: _____ How frequent: _____

Have you ever used any illegal/illicit drugs? Yes No (i.e.: marijuana, heroin, cocaine, etc.)

Please explain and list: _____



Domestic Situation:

Marital status: Single Married Divorced Widowed Other: _____

With whom do you live? _____ No. of children: _____

Are there any substance abuse issues in the household? Yes No

If yes, please explain: _____

Are you able to take care of yourself? Yes No

If no please enter name of care giver: _____

Work History Job Yrs Worked Reason for leaving

_____	_____	_____	_____
_____	_____	_____	_____

Legal Matters

Are you presently involved in a lawsuit? Yes No

If yes please explain: _____

Are you filing for disability? Yes No

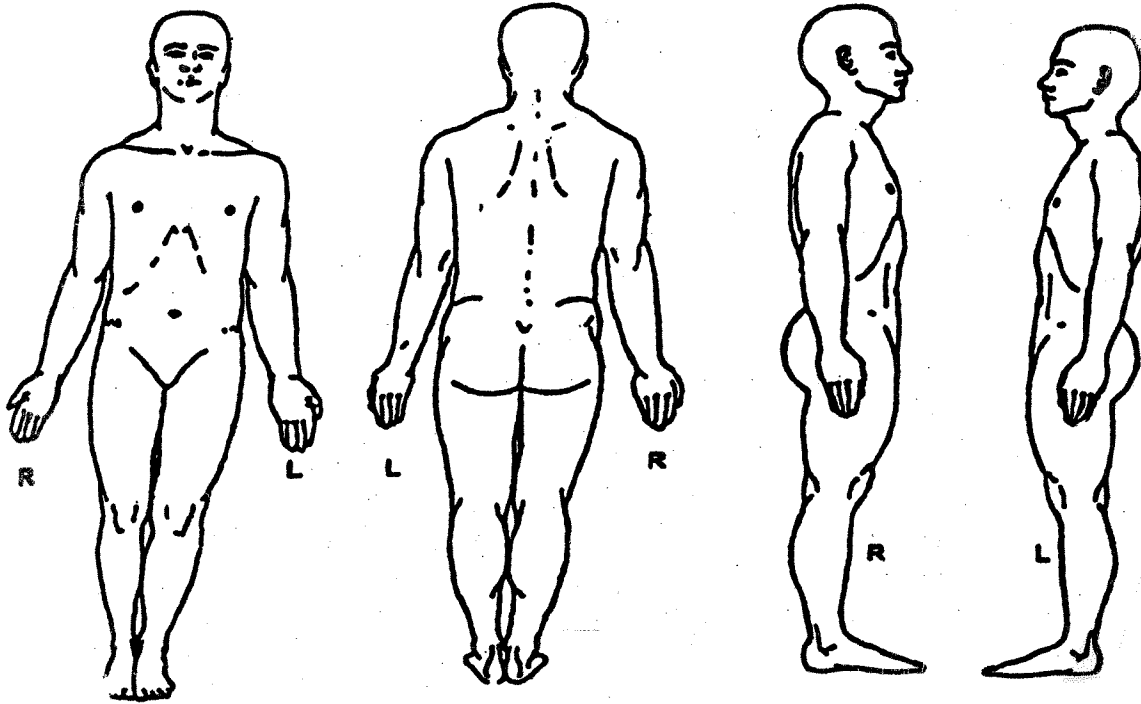
If yes please explain: _____

Review of System:

Have you ever had any of the following? (Please check either Yes or No)

	Yes	No		Yes	No		Yes	No
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>
						Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
			Hepatitis: type: _____			Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Back Problem	<input type="checkbox"/>	<input type="checkbox"/>				Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding tendency	<input type="checkbox"/>	<input type="checkbox"/>		when: _____		Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Tonsilitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Other conditions: _____		
Chronic fatigue syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>			
Circulatory problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>			
Cough (persistent or bloody)	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>			
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>			

Physical Exam & Pain Focus



1. Please indicate on the diagram above the location of your pain. Use an asterisk (*) to show where the pain starts and is most severe. Use an arrow to show the direction or how the pain travels. You may use more than one asterisk and arrow. By each asterisk please rate the level of pain using 0-10.

2. Pain site in order of severity: 1 _____ 2 _____ 3 _____

3. Please check the words that best describe your pain:

- Dull Stabbing Tender Shock like Numb Throbbing Gnawing
 Burning Penetrating Unbearable Shooting Sharp Tiring Nagging

4. What time of day is your pain the worst? (Please check one) Morning Afternoon Evening Night Time

Please rate your pain on the numerical scale below. "0" indicates no pain. "5" indicates mild to discomforting pain. "10" indicates severe, excruciating and debilitating pain.

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild		Discomforting		Distressing		Horrible		Excruciating

5. What time of day is your pain the least? (Please check one) Morning Afternoon Evening Night Time

Please rate your pain on the numerical scale below. "0" indicates no pain. "5" indicates mild to discomforting pain. "10" indicates severe, excruciating and debilitating pain.

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild		Discomforting		Distressing		Horrible		Excruciating

6. Duration of pain _____

INTERVENTIONAL PAIN MEDICINE
PO BOX 9500-4430
PHILADELPHIA PA 19195-4430

ASSIGNMENT OF BENEFITS & LTD. POWER OF ATTORNEY

I irrevocably assign to you, my medical provider, all of my rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize you to act on my behalf. I consent to your acting on my behalf in this regard and in regard to my general health insurance coverage pursuant to the "benefit denial appeals process" set forth in the NJ Administrative Code.

As medical provider I agree to comply with the PIP carrier's decision point review/pre-certification plan and to hold the patient harmless if I fail to comply with same, in consideration for the carrier's consent to this assignment.

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is challenged or deemed invalid, I execute this **limited/special power of attorney** and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case in my name including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me.

I authorize you and or your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to you about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my physical condition.

Dated:

Patient's signature: _____
Print name: _____



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of New Jersey

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***** AN IMPORTANT MESSAGE TO OUR PATIENTS
ABOUT YOUR INSURANCE BENEFITS *****

PROTECT YOUR INSURANCE BENEFITS

In this age of managed care, with so many different insurance programs available, it is impossible for any doctor's office to keep up to date with each program's provisions.

- ❖ Some programs require pre-authorization, while others do not
- ❖ Some programs require use of a specific laboratory
- ❖ Some programs require that the patient notify them when they are admitted to the hospital.
- ❖ Some programs require a second opinion prior to surgery.

It must be YOUR responsibility to know and to advise us of your program's requirements in advance, each and every time we provide a service. We will do our best to comply with any reasonable requirements that your program may have.

Please understand that if we have not been advised in advance of your program's requirements and we provide service or use a laboratory that is outside of your program, you will be responsible for the appropriate fees.

These are not our regulations; they are your insurance company's regulations. Unless you follow them carefully, the insurance company may decline all or part of your claim. Your insurance carrier should have provided you with a phone number for you to use to obtain information about your coverage.

I have read the above statement regarding my responsibilities toward my insurance carrier, and agree that I am ultimately responsible for any fees which my carrier will not pay due to my failure to comply with their regulations.

Signature

Print Name

Date



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PAIN MEDICINE AGREEMENT/CONSENT FOR TREATMENT

I, (the "Patient") or I, (the Patient's authorized representative) _____ understand that in order to receive care for the management of pain, I must comply with the rules, regulations and policies that have been established by Interventional Pain Medicine of New Jersey.

I understand that Interventional Pain Medicine of New Jersey is a **consulting practice**. My primary or referring physician will continue to care for my medical needs and history. Once stabilized on a medical regimen, I will be sent back to my primary physician for continued prescriptions and follow up care. Interventional Pain Medicine of New Jersey will generally provide a treatment plan and set up goals which may or may not include a multidisciplinary approach using medications, physical therapy, psychotherapy, behavioral medicine, and stress management team for a period of not more than six months, at which time an assessment will be made to determine my need for future care.

I understand pain represents a complex problem and in some cases only limited progress can be achieved. I agree to assume full responsibility and actively participate in all aspects of the Pain Medicine Program, which includes medications, physical therapy, psychotherapy, behavioral medicine, and sessions with the stress management team.

GUIDELINES AND POLICIES

The physician has the right to exercise his/her judgment in determining any violations, which may include, but are not limited to: **compromised physician-patient relationships, violation of privacy by discussion of medications and/or treatment of other patients, displays of inappropriate behavior while in the office and hospital, infringements, infractions or inappropriate use of any medications including all pain medications prescribed at the Pain Management Office or obtained from another source which is in direct violation of our medication agreement or deemed illicit by law. The patient will be subject to immediate dismissal from our Pain Management Office.**

1. I agree to obtain my pain medications and adjuvant therapy **only** from Interventional Pain Medicine of New Jersey unless otherwise indicated by pain management physicians.
2. I agree to accept generic brand medications.
3. I am aware as a patient at Interventional Pain Medicine of New Jersey; I may be required to undergo a psychological and psychiatric evaluation periodically for stress evaluation, learning of coping skills, maintenance of opioid medication and adjuvant therapy, and setting goals.
4. I will take the medications at the doses and frequency prescribed by the physician or his designee. I will discuss any changes in scheduled dosing with the physician or his designee and may be during an office visit.
5. **I am aware that I am responsible for the allotted one month supply: if I use up the supply, additional medications may not be renewed.**
6. **I will give a minimum of 5 days notice for any refill.**
7. I am aware that **medication renewal is my responsibility**. I will make arrangements with my pharmacy for appropriate delivery. I am fully aware that any lost, stolen or damaged pain medications, including opioids, may not be replaced. **Stolen opioid medications must be reported to the police** and a police report should be obtained for your file in our office. In addition, medications lost, stolen or damaged during vacations, extended visits or holidays may not be renewed.
8. I understand that my prescribed medications can be dangerous to other people. I will protect my prescribed medications at all times. I will keep them away from children and safeguard those around me. I will not open the medications over a sink or bathroom. I will not share my prescribed medications with anyone else.
9. Interventional Pain Medicine of New Jersey from time to time requires patients to take a random urine or blood test for screen. **I understand that if I refuse to take such a test or if illegal or unprescribed medication is detected, this will result in my immediate dismissal our office.** I will not hold any members of the Pain Management Office including the physicians accountable or liable for the discontinuation of my care.

10. Prescriptions will only be renewed during regular scheduled office visits.
11. Prescriptions will be renewed no sooner than five days before the last scheduled monthly dose. I will contact Interventional Pain Medicine of New Jersey between the hours of 9 AM to 5 PM Monday through Friday. I am also aware that the office is closed during the weekends and no renewals will be available. I am also aware that if I leave a message after 5 PM my message will not be picked up until the next business day.
12. During off hours, if my pain becomes severe, or I am experiencing side effects to my medication, I will go to the nearest Emergency Room and accept evaluation of the Emergency Department staff.
13. I will call to pick up medication prescriptions during regular office hours.
14. Opioids prescriptions will only be provided by certified mail to the designated pharmacy at the discretion of our office. No faxes, UPS, Fed-Ex, or scanning of any opioid prescription will be allowed. I understand that I will be responsible for all certified mail charges.
15. I give permission to Interventional Pain Medicine of New Jersey to download my medication history.
16. I understand that I must use the same pharmacy for all my prescriptions. The pharmacy I will use is: Pharmacy Name _____ Phone number _____

I will continue to strive for trust and confidence during my care. I will conduct myself, in a manner which is deemed appropriate, and safeguard and the privacy of other patients' diseases, ailments and/or treatment plans. I will be courteous to the staff and other patients while in our office. I will respect the office staff, their designee and their decision should a physician not be immediately available. This will continue to insure a healthy patient-physician relationship.

I have been made aware of the guidelines and policies of the physicians. I have read each of the above and fully understand. I have had the opportunity to ask questions which have been answered to my satisfaction. I am signing this agreement, which will be placed in my file. I will fully comply with the above which has been set forth. I am aware that with any violations, I will be subject to termination of my care at Interventional Pain Medicine of New Jersey .

I will maintain my scheduled office appointments and **will give a 24-hour notice if not able to attend**. Those who fail to comply may jeopardize future appointments and be subject to dismissal or a charged fee.

I give my consent to follow up on phone calls and consent to leave messages: Yes No

Notice of Privacy Practice for Physician Practices given

_____ Date

_____ **Patient's Signature**

_____ Witness (that signature is genuine)

_____ Signature of other responsible person

_____ Relationship to Patient

If the signature of other responsible person, reason patient did not sign _____

Copy Given to Patient Date: _____

Physician Certification

I hereby certify that I have discussed the procedures described in the Consent Form with my patient, and in my opinion, he/she fully understands what I told him/her and the matters set forth in the Consent Form

_____ Physician's Signature

_____ Date

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize you to furnish to: Physician Insurance Co. Legal Hospital Other
Name: _____

Address: _____ Phone #: _____
_____ Fax #: _____

Information, access to, or photocopies of the medical records of:
Patient's Name: _____ MR #: _____
Address: _____ Birth Date: _____
_____ Phone #: _____

The forgoing is subject to the limitations as listed below:

1. Nature of information to be released:
- | | | |
|--|--|---|
| <input type="checkbox"/> History/physical exam | <input type="checkbox"/> Discharge summary | <input type="checkbox"/> Consultative reports |
| <input type="checkbox"/> Operative reports | <input type="checkbox"/> Pathology reports | <input type="checkbox"/> X-ray reports |
| <input type="checkbox"/> Laboratory reports | <input type="checkbox"/> Physical therapy notes | <input type="checkbox"/> Progress notes |
| <input type="checkbox"/> Nurse's notes | <input type="checkbox"/> Emergency dept. records | other: _____ |

2. This authorization is confined to the following dates of treatment: from _____ to _____
(Month /date/ year) (Month /date/ year)

3. Purpose of release: _____

I understand that a statement that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the rule.

I further direct that only information prior to the date of my signature below be honored, and that a photocopy of this authorization be granted the same authority as the original.

I further hereby release The Pain Management Office and you personally from all legal responsibility and/or liability that may arise from the release of such records as specified above, and I hereby waive all rights I have to preserve their confidentiality.

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one year's time. If I fail to specify an expiration date, event or condition, this authorization will expire in one year.

Signature: _____ Date: _____ ** Valid for 1 year

SPECIAL AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

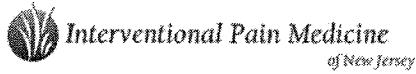
I understand that the specific type of information to be disclosed includes HIV, drugs, alcohol, or psychiatric symptoms or ailments, or any other infectious disease information and the purpose of need for this disclosure

I also understand that this consent is revocable except to the extent that action has been taken in reliance thereon, and that this consent will remain in force for a responsible time in order to effectuate the purpose for which it is given.

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal Regulation (42 CFR-Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A General Authorization for the release of medical or other information is NOT sufficient for this purpose.

Signature of patient or person authorized by law to give consent _____ Date _____ **Valid for 90 days

Signature of witness _____ Date _____ **Valid for 90 days



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AUTHORIZATION

I understand that, under the **Health Insurance Portability & Accountability Act of 1996 (“HIPAA”)**, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used by **Interventional Pain Medicine of NJ**.

- o Conduct, plan, and direct the treatment, examination and follow-up rendered to me or my child among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- o Obtain payment from third-party payers.
- o Conduct normal healthcare operations such as quality assessments and physician certifications.

I am aware of or have received a copy of the Notice of Privacy Practices under the 1996 HIPAA Act for protected health information.

I acknowledge all this information.

Signature _____

Date _____

Please print your name: _____