W/C WORKSHEET

Today's Date: _____/ _____/ _____

Social Security Number ----------_____

Date of Birth: _____/ _____/ _____

Name: _____

Home Address:_____

_____

_____

Home Telephone: (_____) - _____- _____

Cell Phone: (_____) - _____- _____

Pharmacy Name: _____

Pharmacy Telephone: (_____) - _____- _____

HISTORY OF ACCIDENT:

DATE OF ACCIDENT: _____/_____/_____

PLACE OF ACCIDENT: _____ REAR ENDED / FRONT ENDED / RT SIDE ENDED / LT SIDE ENDED

TIME OF ACCIDENT: _____

DESCIPTION OF ACCIDENT: _____

_____

_____

LOSS OF CONSCIOUSNESS: YES NO

HOSPITAL: YES NO **WHICH HOSPITAL:** _____

X-RAYS TAKEN: YES NO **ANY FRACTURES;** _____

MEDICATION PRESCRIBED: YES NO **WHICH MEDICATION:** _____

ANY PREVIOS ACCIDENT: YES NO **WHEN:** ___/___/_____

CHIROPRACTOR: _____ **LAWYER:** _____

PRIMARY INSURANCE: _____ **CLAIM/ID #:** _____

SECONDARY INSURANCE: _____ **CLAIM/ID #:** _____

Medical History:

Age: _____Sex: Male / Female

Height: _____ Weight: _____lbs.

Right-Handed / Left Handed

Race: Asian Native Hawaiian or Other Pacific Black or African American White

Hispanic Other: _____

Ethnicity: Not Hispanic or Latin Hispanic or Latin

Language: _____

Email: _____

Please list any medical or psychiatric problems that you see a Doctor for:

_____

_____

_____

Date of last menstrual period: _____/ _____/ _____

Could you be pregnant: Y / N

Please list all surgeries you have had and the dates of the surgeries:

_____

_____

Do you have any allergies to any medications?

_____

_____

What medications do you currently take? _____

_____

Social History:

Do you smoke: Y / N: I smoke _____packs per day for _____years.

Do you drink alcohol: Y / N? If yes, how much? _____

Do you take any illicit drugs? _____

Working: Y / N: If yes, what type of work: _____

Family History

Marital Status: Single Married Divorced Separated Widowed

Any Children: _____ Illnesses in the Family _____

History/Chief Complaints:

Where is the location of your pain?

_____

_____

How long has the pain been present in this area?

_____

_____

Onset (circle): Acute Chronic

Has your pain followed any specific event? If yes, please described:

_____

_____

Were you injured on the job? YES NO

Are you currently involved in litigations? YES NO

Have you stopped working? YES NO

Do you have any of these symptoms associated with the pain? (circle)

Anxiety	**Loss of Sensations**	**Loss of bladder or bowel control**
Depression	**Impotence**	**Other: _____**
Insomnia	**Dizziness**	

How would you describe your pain? (circle)

Sharp	**Shooting**	**Aching**	**Gripping**
Cramping	**Cutting**	**Dull**	**Electrical**
Throbbing	**Numbness**	**Pins & Needles**	**Other: _____**

When is the pain worse? (circle)

Morning	**Afternoon**	**Evening**
Changing Positions	**Coughing**	**Straining**

How frequent do you have your pain? (circle)

Constantly	**About 80-100% of the time**
Often	**About 50%-80% of the time**
Intermittently	**About 25%-50% of the time**

The pain interferes with: (circle)

Appetite	**Work**	**Concentration**
Sleep	**Social Activities**	**Activities of Daily Living**

If the pain limits your activities answer the following questions:

I can't walk more than _____blocks.

I can't sit more than _____minutes.

I can't stand more than _____minutes.

I cant's tolerate lying down more than _____minutes.

The following scale represents a spectrum. The far left represents no pain and the far right represents the worse pain you ever had.

Please mark: X – How much pain you have now

L – When the pain is at its least

W – When the pain is at its worst

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

What makes your pain worse/aggravating factors? _____

What makes your pain better/alleviating factors?_____

What medicines do you take now? _____

_____

What medicines have you tried? _____

_____

Prior treatment you have tried:

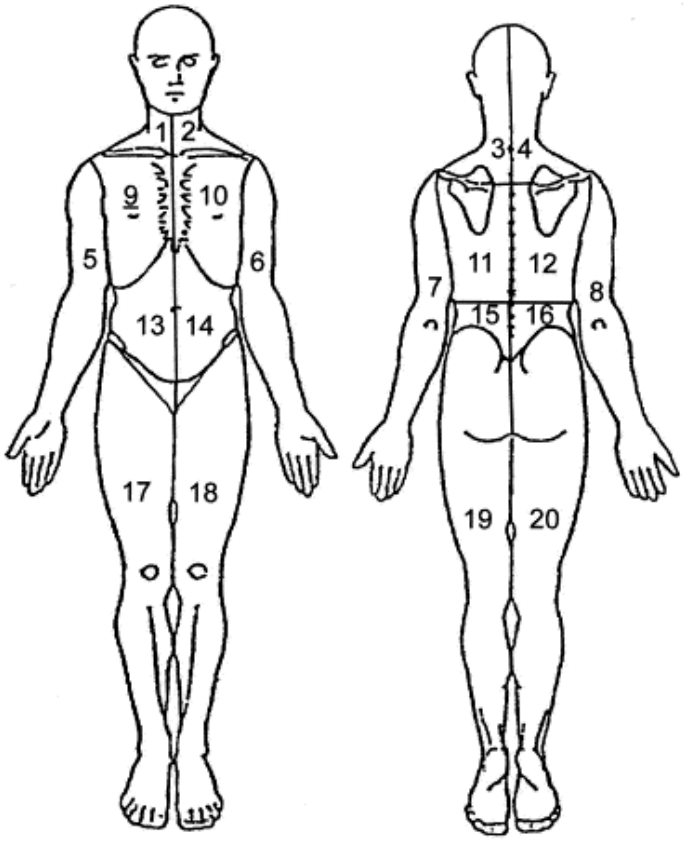
TREATMENT:	DATES:	DID TREATMENT HELP?
SURGERY		
INJECTIONS		
PHYSICAL THERAPY		
CHIROPRACTIC MANIPULATION		
PSYCOTHERAPY		
BIOFEEDBACK		
ACUPUNCTURE		

Please circle the test you have undergone:

X-ray **CT Scan** **MRI Scan** **Bone Scan** **EMG/NCV**

Others: _____

On the drawing please shade in the areas in which you are experiencing the pain:



Patient Signature:

_____ **Date:** _____

ASSIGNMENT OF BENEFITS

Patient Name: _____

Patient Address: _____

Insurance Company: _____

Name of Policyholder: _____

Policy Number: _____

I, the undersigned, 'hereafter referred to as "the patient" do hereby assign all of my rights and interests to the Interventional Pain Management and Ortho-Spine Center, LLC, hereafter referred to as "the medical provider" to pursue and obtain payment from fee above named insurance carrier. This assignment shall assign all of my rights available to me in law and/or equity.

I, the patient, do hereby acknowledge that I have an obligation to comply with and will comply with reasonable requests made of me by the insurance carrier; I, the patient,' do further agree to cooperate with the attorney selected by the medical provider.

I, the patient, do hereby understand and acknowledge that if I willfully refuse to comply with reasonable requests of the insurance carrier, payment of my medical bills may be denied and I will be held responsible for same;

I, the patient, authorized my insurance carrier to pay directly to the medical provider any monies due on my account, or, the same to be deducted from any settlement made, on my behalf if applicable. I further acknowledge that it is my responsibility to endorse over any payments that my insurance carrier pays directly to me for any services rendered.

I, the patient, do hereby understand this provider is out of network with my insurance and I may be billed and liable for any amount(s) which is not covered by my insurance.

I, the patient, do hereby acknowledge that I will not file suit and/or arbitration for the payment for the above provider's medical bills. I understand that the above referenced medical provider has an attorney and will collect payment on my behalf from the insurance carrier.

Further, should a partial payment be made on my behalf for services rendered to, me by the medical provider, I agree to pay this difference or, the balance will be deducted from any settlement made on my behalf, if applicable. If there is no medical coverage, the balance due the medical provider will be paid directly from the proceeds of my settlement, if applicable.

Patient Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS

Patient Name: _____

Patient Address: _____

Insurance Company: _____

Name of Policyholder: _____

Policy Number: _____

I, the undersigned, 'hereafter referred to as "the patient" do hereby assign all of my rights and interests to the Global Anesthesia Group, LLC, hereafter referred to as "the medical provider" to pursue and obtain payment from fee above named insurance carrier. This assignment shall assign all of my rights available to me in law and/or equity.

I, the patient, do hereby acknowledge that I have an obligation to comply with and will comply with reasonable requests made of me by the insurance carrier; I, the patient,' do further agree to cooperate with the attorney selected by the medical provider.

I, the patient, do hereby understand and acknowledge that if I willfully refuse to comply with reasonable requests of the insurance carrier, payment of my medical bills may be denied and I will be held responsible for same;

I, the patient, authorized my insurance carrier to pay directly to the medical provider any monies due on my account, or, the same to be deducted from any settlement made, on my behalf if applicable. I further acknowledge that it is my responsibility to endorse over any payments that my insurance carrier pays directly to me for any services rendered.

I understand that if I undergo any procedures, Global Anesthesia Group, LLC will be the provider for anesthesia services.

I, the patient, do hereby acknowledge that I will not file suit and/or arbitration for the payment for the above provider's medical bills. I understand that the above referenced medical provider has an attorney and will collect payment on my behalf from the insurance carrier.

Further, should a partial payment be made on my behalf for services rendered to, me by the medical provider, I agree to pay this difference or, the balance will be deducted from any settlement made on my behalf, if applicable. If there is no medical coverage, the balance due the medical provider will be paid directly from the proceeds of my settlement, if applicable.

Patient Signature: _____ Date: _____

Authorization for Release of Medical Information

Patient Name _____Date of Birth _____

Address_____

Records released from/to: Interventional Pain Management and Ortho-Spine Center, LLC

3848 Park Avenue, Suite 101

Edison, New Jersey 08820

Type of information to be released: (check all that apply)

__Medical History, Exams, Reports

__Consultation

__Progress Notes

__Mental Health Records

__X-Ray /MRI / CT Scan

__Laboratory Reports

__Prescriptions

Dates of Treatment; All : _____OR Specific Dates ___-___-___to----------___

Purpose or need for release: _____

Your Rights Regarding this Authorization:

Receive a copy of authorization - Understand that if I agree to sign this Authorization, I will receive a copy of this authorization.

Patient Signature: _____ Date: _____

PAIN CONTRACT

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 such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain. Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is pro-longed. For this reason, the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

1. All controlled substances must come from the physician whose signature appears below, or during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment.) I understand that my physician will be periodically checking the Prescription Monitoring Program to ensure compliance.

2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:

   Name:_____ Phone: _____

3. You are expected to 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.

4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.

5. I have told my prescriber about other medications I am taking and my medical history, including my prior experience with pain medication and other drugs. Throughout my treatment, I will communicate fully with my prescriber about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medication is helping to relieve pain.

6. You may not share, sell, or otherwise permit others to have access to these medications. I will keep the medicine safe, secure and out of reach of others, and will dispose of unused medications in a Project Medicine Drop Box, through a Take-back Program or in a drug disposal pouch.

7. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.

8. Unannounced urine or serum toxicology screens may be requested and your cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorder.

9. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.

10. Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made. Early refills will not be given.

11. Prescriptions may be issued early if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date.

12. If the responsible legal authorities have questions concerning you treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.

13. It is understood 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. Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.

14. It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit. I understand that my course of treatment and progress will be monitored periodically (at least every three months) and a period attempt will be made to stop, taper and/or change my opioid medication to reduce potential for abuse or dependence.

15. **For female patients only**: To the best of my knowledge I am NOT pregnant. If I am not pregnant, I will use appropriate birth control measures during my course of treatment. I accept that it is MY responsibility to inform my physician immediately if I become pregnant. If I am pregnant or am uncertain, **I WILL NOTIFY MY PHYSICIAN IMMEDIATELY**. All of the possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and hold my physician harmless for injuries to the embryo/ fetus / baby.

16. The risks and potential benefits of these therapies are explained in the narcotic education sheet (and you acknowledge that you have received such explanation). Specifically, you may feel sleepy, dizzy and slow to react. If this happens, then you should not drive, use heavy machines or guns, be at unsafe heights, or be caring for someone else.

17. 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.

Physician Name: _____

Physician Signature: _____

Patient Signature: _____

Patient Name: (Printed): _____

Date: _____

SIGNATURE ON FILE

I authorize the use of this form on all my insurance submissions and the release of all of my insurance companies.

I understand that I am responsible for my bill(s) and authorize Interventional Pain Management and Ortho-Spine Center, LLC to act as my agent to obtain and secure payment from my insurance companies.

I further authorize payment directly Interventional Pain Management and Ortho-Spine Center, LLC and permit a copy of the authorization to be used in place of the original.

In doing so, I waive my rights to petition as long as the information submitted by this office is true and has not been falsified.

Our office will attempt, by assisting you with the completion of your insurance claim form. However, each patient, not the insurance company, is responsible got collecting your insurance claims for negotiating a settlement on a disputed claim.

Due to increasing complexity of insurance policies with regard to second opinions, pre-certifications, etc, for hospital stays and surgeries, office based procedures, lab work and x-rays, you should notify your insurance company before being admitted or treated. This will help you avoid any unnecessary denials for failing to follow obligations of your insurance policy.

We cannot be responsible for any loss of benefits. It is your responsibility to follow your policy.

Patient Signature: _____ **Date:** _____

ACKNOWLEDGEMENT OF HIPPA PRIVACY NOTICE AND DESIGNATION OF DISCLOSURE

I. Acknowledgment of Practice's Notice of HIPPA Privacy:

Patient Name: (Printed): _____

Patient Signature: _____

Date: _____

II. Designation of Certain Relatives, Close Friends and Other Caregivers:

A. I agree that the Practice may disclose certain information to a family member, close personnel friend or caregiver since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care. I wish to be contacted in the following manner.

(Check that apply): Telephone, Written and Fax Communication

Home Telephone Number:

_____Ok to leave message with detailed information
_____Leave message with call back numbers only

Written Communication:

_____Ok to mail to my home address
_____Ok to mail to my work/office address

B. I designate the following persons listed below as persons involved with my heath care or payment relating to my health care for the purpose of the practice making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

Print Name:_____ Last 4 digits of SS# _____

Print Name:_____ Last 4 digits of SS# _____

C. The following person (s) are not authorized to receive my Patient Health Information:

Print Name:_____ Print Name:_____

_____ _____
Signature of Patient/Parent/ Guardian Date

III. The privacy rule generally requires healthcare providers to take reasonable steps to limit the use of, and requests for, Patient Health Information to the minimum necessary to accomplish the intended purpose. The provisions do not apply to uses or disclosures made pursuant to an authorization requested by the patient/parent/ guardian. Healthcare entities must keep a record of Patient Health Information disclosures. Information provided below will constitute an adequate record. Use and disclosures for Treatment, Payment, and Health Care Operations may be permitted without prior consent.

Date of Disclosure Disclosed to whom address/fax # Description of Disclosure Date of Service

1._____

2._____

NOTICE OF PRIVACY PRACTICES

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information.

If you would like a copy of our full Notice of Privacy Practices, please request this from our front desk.

I HAVE BEEN ADVISED THAT IF I REQUEST A COPY OF THE UPDATED HIPPA POLICY ONE WILL BE FURNISHED TO ME

Patient Signature: _____ **Date:** _____

DISCLOSURE OF OWNERSHIP

This letter serves as proof that I have been informed prior to my surgery/procedure that the physicians who perform procedures/services at:

Park Avenue Surgery Center
3848 Park Avenue
Edison, NJ 08820

Springfield Surgery Center
105 Morris Avenue
Springfield, NJ 07081

may have an ownership interest in the ambulatory surgery center at which I am scheduled. I have been provided a list of physicians who have a financial interest or ownership in the Center. The physician has given me the option to be treated at another facility/Center, which I have declined. I wish to have my procedure/services performed at the facility which I have been scheduled at.

PATIENT NAME (PRINT): _____

PATIENT SIGNATURE:_____

DATE: _____

Patient Certification

I, _____(Patient Name), hereby certify that:

1. I require transportation in order to receive medical treatment at the "ASC" (circle one)

   Springfield Surgery Center

   Park Avenue Surgery Center

2. I do not have access to any other reliable and affordable means of transportation.

3. I understand that the drivers providing the transportation are independent contractors who are employed by an outside transportation company and are not employed by ASC or any physician that performs services at ASC.

_____

Patient Signature:

_____

Date

_____

Treating Physician