NJAPMC - PARSIPPANY

1081 Parsippany Blvd, Suite 102

Parsippany, NJ 070541291

PATIENT INFORMATION

NAME:_____ SEX:____ AGE:_____ DOB___/___/____

ADDRESS:_____ CITY: _____

SOCIAL SECURITY NUMBER:_____ MARITAL STATUS: M S D W

HOME PHONE: ( )_____ OTHER PHONE: ( )_____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

PHONE:( )_____ EMAIL: _____

REFERRING DOCTOR: _____ PHONE: ( ) _____

EMPLOYER: _____ OCCUPATION: _____

RACE: American Indian/Alaska Native
Asian
Black/African American
Native Hawaiian
Pacific Islander
White/Caucasion
Other:_____

ETHNICITY: Hispanic/Latino
Non Hispanic/Latino
Other: _____

HEIGHT_____ WEIGHT_____

INSURANCE INFORMATION

(primary)

INSURANCE CARRIER:_____ PHONE: ( )_____

INSURANCE ID#: _____ GROUP#:_____

NAME OF INSURED: _____ RELATIONSHIP_____

DOB___/____/____

(secondary)

INSURANCE CARRIER: _____ PHONE:( )_____

INSURANCE ID#: _____

IS THIS VISIT RELATED TO A WORKMANS COMPENSATION/MOTOR VEHICLE ACCIDENT: Y / N

INSURANCE: _____PHONE:_____ DOA: ____/____/____

CLAIM #:_____ ADJUSTER: _____

Assignment of Benefits: I assign Pain and Neuropathy Center of PA, all my rights and benefits under any/all insurance carrier payments to any/all services rendered. I also authorize all information regarding my benefits regarding claims submitted by New Jersey Advance Pain Management Center to file insurance claims on my behalf for all services rendered to me. I also direct any/all insurance carriers listed to make payment directly to New Jersey Advanced Pain Management Center. This assignment has been explained to my full satisfaction aqnd with my signature, I allow this assignment of benefits.

PRINT PATIENT NAME: _____ DATE: _____

SIGNATURE OF PATIENT:_____ DATE: _____

PATIENT INITIAL FORM

PATIENT'S NAME: _____ Age: _____ Date of Birth: _____
PRIMARY CARE PHYSICIAN: _____ PHONE: _____
REFERRED BY: _____

DESCRIBE IN DETAIL HOW THE PAIN STARTED:

_____

_____

WHERE IS YOUR PAIN LOCATED? ☐NECK ☐UPPER BACK ☐LOW BACK ☐ARM ☐LEG ☐SHOULDER ☐KNEE ☐HIP ☐CHEST WALL ☐HEADACHE ☐ABDOMEN
☐OTHER: _____

WHEN DID PAIN BEGIN: _____

RATE YOUR PAIN: no pain (-) 1 2 3 4 5 6 7 8 9 10 (+) worst pain

How much time during the day are you in pain? ☐ few hours ☐ less than 1/3rd of time ☐2/3rd of time ☐ all the time

Describe your pain: ☐ sharp ☐ burning ☐ achy ☐ knife like ☐ pressure ☐ heavy ☐ twisting ☐ throbbing ☐ pulsating ☐numbness ☐ weakness ☐ other: _____

What makes your pain worse? ☐ walking ☐ standing ☐ sitting ☐ bending ☐driving ☐ coughing ☐ sneezing ☐ twisting ☐ other: _____

What makes your pain better? ☐ heat ☐ ice ☐ lying down ☐ sitting ☐ standing ☐ walking ☐ bending ☐ medication ☐ other: _____

Are you or have you ever received treatment for your pain? ☐ yes ☐no
If so what Type? ☐ spinal injections ☐ physical therapy ☐ chiropractic ☐medication ☐ massage ☐acupuncture ☐ other: _____

What medications have you tried to treat this pain? _____
How much relief do/did u get from medications? _____
Duration of relief: _____ **side effects:** _____

List all medical problems: _____

Allergies: ☐ Yes ☐ No **If yes list them:** _____

Latex Allergy: ☐ Yes ☐ No

Previous surgeries: _____

_____

REVIEW OF SYSTEMS

Musculoskeletal: ☐ Spasms/cramps ☐ Back/Neck/Joint Pain ☐ Sore Muscles
☐ Balance Problems

Neurological: ☐ Weakness ☐ Numbness ☐ Memory loss ☐ Pain in limb ☐ Sexual Dysfunction
☐ speech changes

Gastrointestinal: ☐ Bowl or bladder incontinence ☐ Choking ☐ Abdominal Pain

Respiratory: ☐ Shortness of breath ☐ chest pain ☐ Dizziness ☐ Fainting

Psychological: ☐ Depression ☐ anxiety ☐ irritability ☐ suicidal ☐ substance abuse

Genitourinary: ☐ pain with urination ☐ urgency ☐ hesitancy ☐ blood in urine

Special Senses: ☐ double vision ☐ blurred vision ☐ blindness ☐ hard of hearing

Recent weight changes: ☐ Yes ☐ No

FAMILY HISTORY

Is there any history of you/family (mother/father/grandparents) having had the following:
☐ heart attack ☐ heart failure ☐ high blood pressure ☐ stroke ☐ kidney disease ☐ cancer
☐ bleeding problems ☐ diabetes ☐ liver ☐ Other: _____

PERSONAL/SOCIAL HISTORY

Hobbies: _____ Hours of sleep per night: __ Trouble falling asleep: Y/N
Do you Smoke? ___ per day I consume ___ alcoholic beverages per ☐ day ☐ wk ☐ month
History of substance/illicit drugs: Y/N

PRINT NAME: _____

New Jersey Advanced Pain Management Center

ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE AND DESIGNATION OF DISCLOSURE

I. Acknowledgment of Privacy Practice Notice
I have received a copy of the New Jersey Advanced Pain Management Center Notice of Privacy Practices.

Patients Name: _____ Date of Birth:_____/____/_____

Signature of Patient, Parent/Guardian: _____ Date: _____

II. Designation of certain relatives, close friend, and other caregivers

I agree that New Jersey Advanced Pain management Center may disclose certain health information to the family member, close friend, attorney, or other caregivers because such person is involved in my health care. In that case, New Jersey Advanced Pain Management Center 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 also understand that my insurance carriers are entitled to my medical record for health care operations or for payment of any/all claims.

I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of New Jersey Advanced Pain Management Center. 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: _____ Relationship: _____

Print Name: _____ Relationship: _____

New Jersey Advanced Pain Management Center

DISCLOSURE OF FINACIAL INTEREST IN MEDICAL PRACTICE

Public law/rule of the State of New Jersey/Board of Medical Examiners mandates that a physician, podiatrist and all other licensees of the Board of Medical Examiners inform patients of any significant financial interest held in a health care service.

Accordingly, take notice that practitioners in this office do have a financial interest in the following health care service(s) to which patients are referred:

Spine and Welness Center of New Jersey
Suite 203
7 Ridgedale Avenue
Cedar Knolls, New Jersey 07927

Morris County Surgical Center
3695 Hill Road
Parsippany, New Jersey 07054

You may of course, seek treatment at a healthcare service provider of your own choice. A listing of alternate health care service providers can be found in the classified section of your telephone directory under the appropriate heading.

Additionally, please take note that the services may be considered to be, and reimbursed at, and "out-of-network" level by your insurance company. Please speak with the office administrator for more information.

Please sign below to acknowledge that I have informed you of the ownership interest in the above entities prior to or at the time I referred you to the above entity.

Patients Name: _____ Date: _____
Patients Signature: _____ Date: _____

New Jersey Advanced Pain Management Center

RELEVANT OFFICE POLICY AND AGREEMENT

Dear valued patient,

Welcome to New Jersey Advanced Pain management Center for your health care. In order to provide the best possible care for you and avoid any confusion, please take a little time to read "PAYMENT AUTHORIZATION AND INFORMATION RELEASING AGREEMENT", "FINANCIAL POLICY", "NOTICE OF PRIVACY PRACTICE" AND "CACELLATION POLICY AND PATIENT NO SHOW OR LATE SHOW AGREEMENT".

I. PAYMENT AUTHORIZATION AND INFORMATION RELEASING AGREEMENT

I, patient, hereby authorize the payment of medical benefits to New Jersey Advanced Pain Management Center for services rendered. I also authorize New Jersey Advanced Pain Management Center to release any medical information necessary to complete and process my insurance claims. I understand that I must present my insurance ID, which can be scanned as part of the claim processing information.

I understand that I am financially responsible for any services not covered by my insurance carrier. I agree to pay all collections costs, attorney fees, and other collections costs that may be incurred to enforce the collection of any amount outstanding.

II. FINANCIAL POLICY

New Jersey Advanced Pain Management Center believes that part of good healthcare practice is to establish and communicate a financial policy to our patient. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

1. **PAYMENT** is expected at the time of your visit. We will accept cash, check or credit card. Payment will include any unmet deductible, co-insurance, co-pay amount or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit.

2. **INSURANCE:** We are participating providers with several insurance plans. We will file all of these insurance claims. A list of these insurance plans is available upon request. Please remember that **insurance is a contract between the patient and the insurance company. Ultimately, the patient is responsible for the payment in full.**

If your insurance information is found to be incorrect or invalid, the balance will be transferred to self pay. If you forward the correct insurance information, and your claims are rejected for time filing limits, you acknowledge that the balance will remain self pay. Also, if your insurance requires a referral and you do not have one, you may be asked to reschedule. If you choose to be seen, you agree that the fee for that visit will become self pay as you do not have a referral as required by your contract with your insurance company.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

3. **COPYS** are due at the time of service **as per your contract with your insurance company.** If the copay is not paid at the time of service, you may be asked to reschedule your appointment. Please understand that the contract is between you and your insurance company. Our contract with the insurance company states that we must collect copay at the time of service.

4. **RETURNED CHECKS** will incur a $25.00 service charge. You will be asked to bring cash or a money order to cover the amount of the check plus the service charge. Returned checks that are not settled within 10 days will be forwarded to appropriate enforcement program where you will incur fees and court costs.

5. **ACCOUNTING PRINCIPLES:** Payment and credits are applied to the oldest charge first, except for insurance payments which are applied to the corresponding dates of service.

6. **BILLING STATEMENT:** If you have questions in regard to any of your billing statements, our account receivable staff is available to assist you.

III. NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide to you. You may ask to see and copy that record. There is a service charge for medical record copy. We will not disclose your record to others (except your treating or referral physician) unless you direct us to do so, or unless the law authorizes or compels us to do so. By the signature below, you acknowledge receipt of the Notice of Privacy Practices.

IV. CANCELLATION POLICY AND PATIENT NO SHOW OR LATE SHOW AGREEMENT

I, patient, understand that it is very important that I attend the scheduled appointment for my health reason and scheduling for New Jersey Advanced Pain Management Center as well. Any necessary cancellation should be made in advance at least 24 hours prior to that appointment.

Should any cancellation with less than 24 hours' notice or no show for my appointment, I agree that New Jersey Advanced Pain Management Center **will bill me personally (not an insurance company) $30.00** for the missed or canceled appointment.

I understand that I may be asked to reschedule my appointment if I am late 15 minutes for my appointment.

I have read and understand all above completely, and I agree to be bound by the terms.

Signature of patient or authorized representative: _____

Date: _____

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○

The SOAPP®-R was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

PainEDU
Improving Pain Treatment Through Education

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

Please include any additional information you wish about the above answers.
Thank you.