GERSHON PAIN SPECIALISTS
YOUR PATH TO PAIN RELIEF

PATIENT INFORMATION

Patient Name: Date of Birth: Social Security #:

Mailing Address:

City: State: Zip Code:

E-mail for Patient Portal:

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

Spouses Name: Date of Birth: Social Security #

How did you hear about our practice? Referring Doctor:

Sex(please check one): ☐ M ☐ F Race: Ethnicity:

Marital Status: (please check one) ☐ Married ☐Single ☐Divorced ☐Widowed ☐Other

OCCUPATION INFORMATION

Employer Name: Occupation: Phone #:

Employer Address:

EMERGENCY CONTACT INFORMATION(*someone not living in the same household*)

Name: Relationship:

Home Phone #:( ) Cell Phone #: ( ) Work Phone #: ( )

INSURANCE INFORMATION: IT IS YOUR RESPONSIBILITY TO KNOW IF YOU NEED A REFERRAL.

Primary *Insurance Carrier*: Name of Policy Holder:

ID Number: Group # Relationship to Insured:

SS# of Policy Holder: D.O.B of Policy Holder:

Secondary *Insurance Carrier*: Name of Policy Holder:

ID Number: Group # Relationship to Insured:

SS# of Policy Holder: D.O.B of Policy Holder:

Image/recording policy: In order to comply with the regulations that protect the privacy of our patients and associates(HIPAA), it is Gershon Pain Specialists policy that no image or recording may be collected within our office without the express written permission of Administration.

Patient Signature: **Date**:

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AUTHORIZATION FOR TREATMENT & ASSIGNMENT OF BENEFITS

This will authorize the treatment of myself as well as filing of any insurance in force for all charges, which include anesthesia and pathology, if applicable and the direct payment to Gershon Pain Specialists of any amount due on my claim under the above stated policy. I understand that my insurance policy is a contract between me and my insurance company and that I am financially responsible to Gershon Pain Specialists for non-payment of any charges not covered by insurance. I understand and agree to pay in full any balance due after an insurance payment or to make payment arrangements with Gershon Pain Specialists. In consideration of services rendered, the undersigned patient, spouse, and/or responsible party agrees to pay all cost of collections including attorney's and/or collection agency's fees up to 33.3% plus court cost and any interest allowable by law, if incurred. I hereby authorize the release of any medical information necessary to process claims.

Patient Signature: **Date**:

DEEMED CONSENT FORM

I understand that the laws of Virginia provide if my physician or any person employed by or under the direction and control of my physician(s) is directly exposed to my body fluids in any manner which many according to the then current guidelines for the Center of Disease Control transmit the Human Immunodeficiency Virus (HIV) or Hepatitis B or C viruses that I am deemed by law to have consented to testing for infection with HIV or Hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person(s) who is exposed to my bodily fluids.

Patient Signature: **Date**:

ACKNOWLEDGEMENT OF HIPAA PRIVACY PRACTICES & OFFICE POLICY

1. _____ (initial) I hereby acknowledge that I have had the opportunity to review a copy of the Notice of Privacy Practices. Please list anyone you are authorizing to have access to your medical record below:

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

2. _____ (initial) I hereby acknowledge that I understand there is a **$150.00** cancellation fee for procedures not cancelled within 72 hours, and a **$25.00** fee for **No Show** office visits.

3. _____ (initial) I hereby acknowledge that I understand there is a **$50.00** charge for each check that is returned for insufficient funds. If any balance is not paid in full within 3 business days, an additional **$55.00** fee will be added, and we will forward your returned check to the Commonwealth Attorney-City of Virginia Beach for prosecution.

4. _____ (initial) I authorize Gershon Pain Specialists to leave testing reminders or results on my answering machine.

5. _____ (initial) I understand that Gershon Pain Specialists utilizes the Prescription Monitoring Program and routinely monitors controlled medication prescriptions. I also understand that Gershon Pain Specialists will report all controlled substance violations to law enforcement.

6. _____ (initial) I understand that it is the policy of Gershon Pain Specialists to provide and mandate urine Monitoring for all patients who are prescribed scheduled medication.

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AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below.
I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. I understand if my record contains information related to substance abuse, HIV, and/or mental health, the information will be released with my medical record.

Patient Name: _____

Last 4 digits of SS#: _____ Date of Birth: _____/_____/_____ Account #_____

Person/Organizations providing information:

_____
_____
_____
_____

Person(s)/Organization(s) receiving information:

_____
_____
_____
_____

Information to be disclosed, covering the period of health care: From_____ To_____

○ Complete Health Record **OR, select from the following:**
○ Office Notes ○ Pathology Reports ○ Procedure Reports ○ Laboratory Tests ○ Diagnostic Testing
○ Other (please specify)_____

This information is to be disclosed for the purpose of:_____.

The patient of the patient's representative must read and initial the following statements:

a. I understand that unless earlier revoke, this authorization will expire 5 years from the date of signed below._____
b. I understand that I may revoke this authorization at any time by notifying **GPS** in writing. If I do, it won't have any effect on any actions **GPS** took before it received the revocation**.** _____
c. I understand that **GPS** cannot require me to sign this authorization as a condition to receive treatment from **Gershon Pain Specialists** except:
    i. When Gershon Pain Specialists provides me with research-related treatment; or
    ii. When Gershon Pain Specialists provides me with health care solely for the purpose of creating protected health information for disclosure to someone else. _____

Gershon Pain Specialists, it's employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. Please be aware there is a charge for obtaining your records.

_____
Signature of Patient or Representative Date

_____
Print Name Relationship to Patient

1133 First Colonial Road, Virginia Beach, VA. 23454 ● Ph: (757) 496-2050 ● Fax: (757)689-4357

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PATIENT QUESTIONAIRE

Name: _____

Age: _____ Referring Provider: _____

Where is your pain located? _____

Does the pain radiate throughout your body? If so, where? _____

What makes your pain better? _____

What makes your pain worse? _____

When did your pain begin? _____ Who have you seen for this? _____

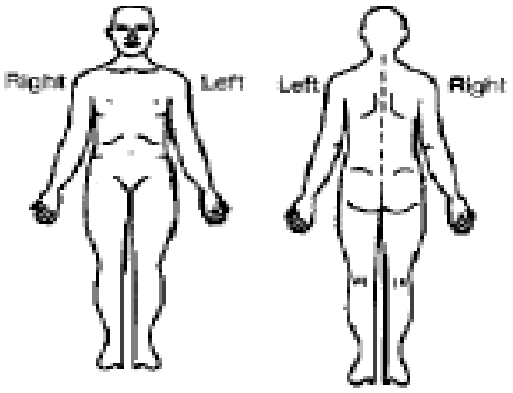
What treatments/tests have you undergone for this pain? _____

_____

Is your pain constant or intermittent?_____

Please describe your pain:(check all that apply)

- Numbness
- Weakness
- Tingling
- Pins & Needles
- Sharp
- Pulsating
- Dull
- Pressure
- Deep
- Aching
- Throbbing
- Stabbing
- Stinging



How severe is your pain?

0- No Pain
1-2 Mild Pain, requires no medication
3-4 Mild/moderate pain, requires mild medications
5-6 Moderate pain, requires stronger medications
7-8 Moderate/Severe, constant pain, requires narcotic or ER visit
9-10 Severe, constant pain, requires admission to hospital

Past Medical History: Please list any medical problems that you are being treated for or have been treated for in the past:

Please list your surgical history:

Do you have any allergies to medications? Y/N
If so, please list:_____

Social History:
Do you use Nicotine Products? Y/N

Do you drink alcohol? If so, how many drink per week?_____

Do you or your family have a history of illicit drug or prescription overuse/abuse? Y/N

Do you have children? Y/N If so, how many_____

Marital Status: (please check one) ☐ Married ☐Single ☐Divorced ☐Widowed ☐Other

OCCUPATION INFORMATION

Employer: Occupation: Phone #:

PHARMACY

Name: Phone Number:

Address: City: State: Zip Code: