NJ Pain, Spine & Sports Associates

2090 Route 27, Suite 103
North Brunswick, NJ 08902
Tel: (732) 565-3777

288 North Broad Street, Suite 1A
Elizabeth, NJ 07208-3711 Fax
Fax: (609)228-7269

100 Village Ct., Suite 102
Hazlet, NJ 07730
Tel: (732) 800-7246

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

SS #: _____ Birth Date: _____ Sex: _____ Marital Status: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Student: ☐ Full Time ☐ Part Time ☐ Not Student

Employer: _____ Employment: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Retired ☐ Self Employed

How did you hear about us? _____

Referring MD: _____ Referring MD Phone: _____

Primary Care Physician: _____ PCP Phone: _____

SPOUSE INFORMATION / RESPONSIBLE PARTY

Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Sex: ☐ Male ☐ Female Date of Birth: _____ SS#: _____

Employer: _____ Employer Address: _____

ATTORNEY INFORMATION

ATTORNEY NAME: _____ **PHONE #:** _____

ADDRESS: _____

I acknowledge and understand that a $40 fee for <u>NO SHOW / NO CALL</u> will be billed to my account.

_____ _____

Signature **Date**

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Patient Name: _____ DOB: _____ Today's Date: _____

INSURANCE INFORMATION

Coverage Type: □ Primary

Insurance Company: _____ Subscriber Name: _____

Subscriber Relationship to Patient: _____ Subscriber DOB: _____

Insurance ID #: _____ Effective Date/ DOL: _____

Coverage Type: □ Secondary

Insurance Company: _____ Subscriber Name: _____

Subscriber Relationship to Patient: _____ Subscriber DOB: _____

Insurance ID #: _____ Effective Date/ DOL: _____

Patient Affirmation

I certify that above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges whether covered by insurance. I authorize treatment by the physician at NJPSSA

_____ _____

Signature Date

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ASSIGNMENT OF BENEFITS

Patient Name: _____ Date of Loss (if applicable): _____

Patient Address: _____

1. I _____, the undersigned, hereafter referred to as "the patient" do hereby assign all of my right and interests to Faheem Abbasi LLC, DBA NJ Pain, Spine & Sports Associates, hereafter referred to as the "the medical provider" to pursue and obtain payment on my behalf. This assignment shall include but is not limited to, all rights available to me pursuant to the guidelines under the State of New Jersey.
2. I assign to the medical provider all my right and benefits under the insurance contract for payment for services rendered to me. However, upon consent of both parties, same shall be revocable.
3. I hereby authorize and request that payment of benefits by my primary insurance company and my secondary insurance be made directly to the medical provider for services furnished to me or my dependent. I understand that my insurance company(s) may only cover a portion of the total bill. I further understand that I may be responsible for all charges including but not limited to copay and deductibles not covered by my insurance carrier(s).
4. If the insurance carrier fails to forward the check to the medical provider, I will endorse and sign the check to the medical provider with (5) days of receipt of same.
5. I authorize the medical provider to disclose all written document to the above-named insurance company(s) and/or its designated representatives at the determination of the medical provider. Such disclosure shall be for reimbursement purposes for those services received. I hereby release the medical provider, its officers, agents, employees, and clinical staff associated with my case from the liability that may arise because of disclosure of information to the above name insurance company(s) or their designated representatives.
6. 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.
7. I, the patient authorizes my bodily injury attorney to pay directly to the medical provider any monies due on my account or have same deducted from my settlement made on my behalf. I authorize medical provider to obtain a letter of protection to cover my portion of medical monies owed. In the case I receive no reward when my case settles, I understand I will be responsible for any services rendered to me due to that accident.
8. I, the patient, do hereby acknowledge that I will not file suit and/or arbitration for the payment of the above providers' medical bills unless I am requested to do so by the medical provider. I understand that the above referenced medical provider has an attorney and will collect payment on my behalf from the insurance carrier through the arbitration process in place by the state of New Jersey or the state under which my policy was purchased.
9. I the patient understand the medical provider will file appeals on my behalf for any denied services. I will comply with any requests made by the medical provider or carrier regarding these appeals.
10. I understand as the patient I am required to notify the medical provider of any change in my insurance coverage. This assignment of benefits will apply to any new insurance carriers introduced during my treatment. If failure to provide the correct insurance information results in non-payment I understand I will be responsible for services.
11. I the patient understand if I do not pay any monies assigned to my responsibility my account may be forwarded to collection. Furthermore, I understand if my account is forwarded to collection, I may be responsible for an additional 30% of the charges owed.
12. This assignment of benefits is applicable to all locations of the medical provider.

PatientSignature_____Date _____

Patient or Guardian's Name _____

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Narcotic Medication Agreement & Consent Form

You have agreed to receive narcotics for the treatment of your pain from Dr. F. Abbasi, ("Pain Physician"). It is important that you understand the risks and your responsibilities that go along with this treatment. Please read and initial each statement to signify your understanding. If you have any questions regarding this information or our policy regarding the prescribing of narcotics, please request clarification.

I, _____ understand that:

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatments, administration of anesthetics and performance of diagnostic and/or surgical procedures. I understand that I am under the care and supervision of the attending Pain Physician and it is responsibility of the staff to carry out the instructions of Pain Physician.

RELEASE OF INFORMATION: The Physician may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the physician or to the patient or to the Health Care Financing Administration and/or the patient's attorney, for all or part of the physician's charges, including but not limited to, patient insurance companies, worker's compensation carriers, welfare funds, or the patient's employer if a worker's compensation case.

____ Any medical treatment is initially a trial and that continued prescription of narcotics is based on evidence of benefit. I understand that the goal of using narcotics is to increase my functional level and decrease my pain. If these goals are not achieved, the medication will be stopped.

____ I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: Sleepiness or drowsiness, constipation, nausea, itching, vomiting, lightheadedness, dizziness, confusion, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, kidney or liver disease, sexual dysfunction, physical or psychological dependence, tolerance to the pain-relieving effects, addiction, withdrawal, and the possibility that the medicine will not provide complete relief.

____ The overuse or misuse of narcotic medication can result in serious health risks including respiratory depression (stopping of breathing) or even death.

____ This medication will be strictly monitored, and my medications should be filled at the same pharmacy. Should the need arise to change pharmacies, our office must be informed. The pharmacy name and the location of the pharmacy that I have selected is:

Pharmacy _____ Phone# _____

____ I cannot receive medication by phone, nor may I call the office to have a prescription called in. Early refill requests will not be honored.

____ I am responsible for making & keeping schedule appointments. I also understand that it may take up to 2 weeks to make a regular follow up appointment.

____ I will take the narcotics medication *only as prescribed*. Any change must first be discussed and agreed upon with my Pain Physician.

____ I agree that only my Pain Physician will prescribe narcotic medication. I will *not* obtain or use narcotic or other controlled substances from any other sources. I will instruct my other physicians to confer with Pain Physician for any changes or need for additional narcotics medication. If it is brought to the attention of the clinic that other providers are prescribing medications for me, Pain Physician reserve the right to discontinue prescribing medications and/or discharge me from clinic.

Narcotic Medication Agreement (Continued)

____ I will inform my Pain Physician of any changes in my medical condition, any changes in ***any*** prescription and/or over the counter medication (including herbals and supplements) that I take and of any adverse effect that I may experience from any of the medications that I take.

_____ I agree to tell my Pain Physician my complete personal drug/medication usage and history.

____ I will not use any illegal "street drugs" or alcohol while receiving medications from my Pain Physician. Examples include, but are not limited marijuana, cocaine, & amphetamines ("speed").

____ I will communicate fully and honestly with my Pain Physician about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

____ Routine blood work and periodic drug screens may be a part of my treatment plan. I agree to have them done when my physician requests it.

____ The prescribing physician has my permission to discuss all diagnostic and treatment details to obtain prescription history with dispensing pharmacies, my insurance company, pharmacy benefits companies, or other professionals who provide my health care for the purpose of maintain accountability.

____ It is a felony to obtain narcotic under false pretenses. This could include getting medication from more than one doctor, misrepresenting myself to obtain medication, using them in a manner other than prescribed, or diverting the medications in any other way (i.e., selling).

____ I know that narcotic medication will be stopped if any of the following occur:

- I trade, sell, or misuse the medication
- The clinic find that I have broken ***any*** part of this agreement
- I do not go for a blood or urine test ***immediately when asked to.***
- My blood or urine test shows the presence of any illegal drugs.
- My blood or urine test shows the presence or absence of unexpected or expected medications.
- I get narcotics from sources other than mentioned Pain Physician
- Any member of the professional staff of this clinic feels that it is in my best interest that narcotic treatment be stopped.
- Any aggressive or inappropriate behavior towards physicians or staff.
- I consistently missed scheduled appointments.

____ It is understood that failure to adhere to this agreement may result in cancelation of therapy including prescribing of controlled substances by the Pain Physician.

____ I have read the Narcotic Medication Agreement and without question understand all this agreement. By signing this agreement, I affirm that I have read, understand, and accept the terms of this agreement.

Patient Signature _____ **Date** _____

Clinic Witness _____ Date _____

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date: _____

Date of Birth: _____ Phone Number: _____

To release healthcare information of the patient named above to:

Name: NJ Pain, Spine & Sports Associates

Address: 2090 Route 27, Suite 103

City: North Brunswick State: NJ Zip Code: 08902

This request and authorization apply to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

_____ _____ _____

Patient Name (PRINT) **Patient Guardian Signature** Date

_____

Witness Signature

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MEDICAL HISTORY FORM

Patient Name: _____ Today's Date: _____

Have you ever had or been told you have (check all that apply)?

Cardiovascular:
- ☐ Chest pain or Angina
- ☐ Heart Disease
- ☐ MI, Heart Attack, blocked artery
- ☐ Congestive Heart Failure
- ☐ High Blood Pressure
- ☐ Peripheral vascular disease
- ☐ Abnormal Heartbeat
- ☐ Pacemaker
- ☐ Angioplasty or Heart Cath
- ☐ Rheumatic Fever
- ☐ Damaged Heart Valve

Respiratory:
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Emphysema
- ☐ TB
- ☐ Smoking: Now Past Packs per day ———

Neurological:
- ☐ Epilepsy Seizure
- ☐ Fainting spells or Dizziness
- ☐ Stroke _____
- ☐ Headaches / Migraines

Gastrointestinal:
- ☐ Ulcer, Heartburn, Reflux
- ☐ Diverticulitis or Colitis
- ☐ Other _____

Cancer: _____

Metabolic:
- ☐ Diabetes _____
- ☐ Thyroid Disease
- ☐ Adrenal Gland Problem
- ☐ Steroid use _____

Liver/Kidney/Blood:
- ☐ Kidney disease
- ☐ Shunt, Graft, Fistula
- ☐ Dialysis
- ☐ Liver disease
- ☐ Gallbladder
- ☐ Hepatitis (Type _____)
- ☐ Anemia
- ☐ Easy bruising or Bleeding

Other:
- ☐ Chronic numbness or Pain
- ☐ Depression or Anxiety
- ☐ Other nervous problem: _____
- ☐ Anticcegulants (Blood thinner)
- ☐ Back injury / Nerve damage
- ☐ Skin condition
- ☐ Arthritis, Rheumatism
- ☐ Dentures ☐ Partial Plate
- ☐ Glasses ☐ Hearing Aid

ROS: Please check the box if you currently have any of the following
- ☐ Shortness of Breath
- ☐ Swelling or Rash
- ☐ Abdominal pain
- ☐ Cough, Sputum Production, Wheeze
- ☐ Headache(s) How often? _____
- ☐ fever, weight Loss, Sweat
- ☐ Chest pain, Palpitations
- ☐ Change in bowel habits, nausea
- ☐ Pregnant or possibly pregnant
- ☐ Weakness or paralysis of arms or legs
- ☐ Dizziness, Vision Changes, lightheadedness
- ☐ Easy bruising, bleeding, using blood thinner
- ☐ Change in bladder habits (frequency, pain)

Social/ Family History:

Mother: living / deceased Cause_____

Father: living / deceased Cause_____

Usual Diet: _____ Alcohol: drinks per day ____ Other Drug use: _____

Is your injury related to an accident? _____ if yes, please answer question 1-7 otherwise move on to question number 8.

1. What Kind of Vehicle Was Involved in Accident? ☐ Truck ☐ Car ☐ Motorcycle ☐ Other
2. Were You a ☐ Driver ☐ Passenger ☐ Pedestrian?
3. If a Passenger, Please Indicate Your Location in the Car _____
4. Was Your Vehicle Moving When the Accident Occurred? ☐ Yes ☐ No Mph? _____
5. Did Your Vehicle Hit Other Vehicle(s)? ☐ Yes ☐ No Where? _____
6. Did Other Vehicle(s) Hit Your Vehicle? ☐ Yes ☐ No Where? _____
7. Describe Accident Including Causes and Surrounding Circumstances

_____

_____

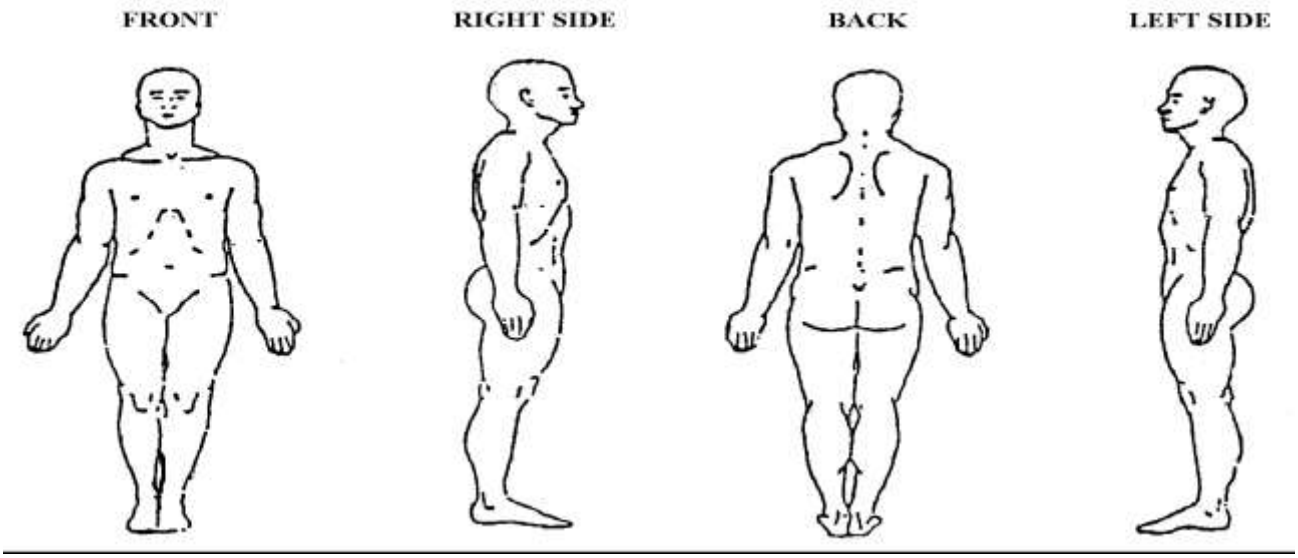
_____

Patient Signature: _____ Date: _____

Reviewed by MD: _____ Date: _____

MEDICAL HISTORY FORM (Continued)

8. Please mark the area(s) in the diagram below where you are having pain:



9. Where is your pain located? _____
10. Does your pain radiate anywhere? ____ Yes ____ No Where? _____
11. When did it start? _____
12. How long have you had the pain? _____
13. Did it start: ____ Gradually ____ Suddenly ____ Not sure
14. How often does the pain occur? ☐ Continuously ☐ Several times a day ☐ Intermittent ☐ Occasionally ☐ Less than daily
15. Has the pain intensity changed since it began? ☐ Getting better ☐ Getting worse ☐ No change
16. How did it start? _____
17. What makes the pain better?
    ☐ Standing ☐ Sitting ☐ Walking ☐ Laying Down ☐ Bending Forward ☐ Arching Backward
    ☐ Coughing/Sneezing ☐ Using Bathroom ☐ Other _____
18. What makes the pain worse?
    ☐ Standing ☐ Sitting ☐ Walking ☐ Laying Down ☐ Bending Forward ☐ Arching Backward
    ☐ Coughing/Sneezing ☐ Using Bathroom ☐ Other _____
19. Check all those that describe your pain:
    ☐ Aching ☐ Burning ☐ Cramping ☐ Tingling ☐ Throbbing ☐ Sharp ☐ Shooting
    ☐ Stabbing ☐ Numb ☐ Heavy ☐ Tender ☐ Splitting ☐ Tiring ☐ Exhausting
    ☐ Sickening ☐ Fearful ☐ Punishing ☐ Cruel
20. What is your current level of pain on a scale from 0 to 10, with 0 being no pain and 10 being severe? _____
21. What tests have been done?
22. ☐ MRI ☐ CT ☐ X-ray ☐ EMG ☐ Other _____
23. What treatment have you tried for your pain?
    ___ Exercise ___ Massage ___ Chiropractor ___ Acupuncture ___ Brace ___Physical Therapy
    ___ Warm pack ___ Ice pack ___ Nerve block ___ Psychologist ___ Psychiatrist ___ Surgery

Patient Signature: _____ Date: _____

Reviewed by MD: _____ Date: _____

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MEDICAL HISTORY FORM (Continued)

Patient Name: _____ Today's Date: _____

Previous Medications Tried (Circling all that apply)

NSAIDS
- Aspirin
- Ibuprofen
- Advil
- Motrin
- Naprosyn

Relaxation
- Flexeril
- Valium
- Xanax
- Ativan
- Librium

Sleep Medicines
- Ambien
- Restoril
- Benadryl
- Halcion

Pain Medication
- Neurontin
- Klonopin
- Dilantin
- Baclofen
- Ultram
- Prozocin
- Mexitil
- Prazocin

Antidepressants
- Elavil
- Amityptilline
- Prozac
- Effexor
- Zoloft
- Deseryl
- Paxil
- Pamelor
- Serozone
- Desipiramine
- Remeron

Narcotics
- Vicodin
- Darvocet
- Tylenol 3
- Tylox
- Codeine
- Percocet
- Percodan
- MS Contin
- Cxycontin
- Demerol
- Morphine
- Methadone
- Dilaudid

Please list if you have any **Allergies**:

Allergies	Reaction

Please list all previous **Surgeries**:

Surgeries	Date

Medications you take at home (including pain medicines)

Medicine	Dose	How often	Last dose

Patient Signature: _____ Date: _____

Reviewed by MD: _____ Date: _____

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NOTICE OF PRIVACY PRACTICE RECEIPT

I acknowledge that I was offered the Notice of Privacy Practices of the medical practice named at the top of the Page.

Print name of patient: _____ Date: _____

Signature of patient: _____ SSN: _____

For personal representative of the patient (if applicable):

Print name of personal representative: _____ Date: _____

Signature of personal representative: _____ Relation to patient: _____

For practice use only:

Signature of practice employee: _____ Date: _____

The following is an authorization for miscellaneous services this office uses. We will make every effort to abide by your instructions. Please provide the following information:

Appointment Reminder/Test Results (laboratory, x-rays, etc.):

If we need to contact you regarding an appointment or lab results, we will make every effort to reach you personally. If we cannot reach you personally, we will only leave a message asking you to call our office during regular business hours. Please check all items below that apply to you.

May we send an appointment reminder card to your home address? ☐ Yes ☐ No

May we call to remind you of an appointment or regarding test results? ☐ Yes ☐ No

Please call me at the following number(s):

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email address: _____

If we get an answering machine/voicemail, may we leave a message? ☐ Yes ☐ No

If we get a family member, may we leave a message? ☐ Yes ☐ No

Policy for discussing your medical information with family members:

Our office will never discuss your medical information with a family member unless you have authorized us to do so. Please indicate the family members authorized to discuss your medical care by checking all items that apply to you and providing the name(s) where applicable.

- ☐ Spouse _____
- ☐ Parent(s) _____
- ☐ Child(ren) _____
- ☐ Sibling(s) _____
- ☐ Other(s) _____

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APPOINTMENT REMINDER BY TEXT CONSENT FORM

I, _____, authorize New Jersey Pain, Spine & Sports Associates to send Appointment Reminders electronically via text message to my mobile phone. I understand that this service is offered free of charge. However, standard text messaging rates from my mobile carrier may apply.

PATIENT NAME	MOBILE#	MOBILE CARRIER

Patient Signature: _____ Date: _____

OR

Parent/Legal Guardian Signature: _____ Date: _____