INTERVENTIONAL
PAIN CONSULTANTS

3799 Route 46, Suite 301 Parsippany, NJ 07054
P: 973-335-1440 F: 973-335-1446

Date:_____ Name: _____

Date of Birth: _____ Sex: _____ Height: _____ Weight: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Who referred you to this office?: _____

Primary Care Provider: _____ City: _____

Cardiologist/Pulmonologist: _____ City: _____

Pharmacy:_____ City: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____

Email:_____

Emergency Contact: _____ Phone #: _____

Primary Medical Insurance: _____

ID#: _____ Claim/Grp#: _____

Subscriber: _____ Date of Birth: _____

Secondary Medical Insurance: _____

ID#: _____ Claim/Grp#: _____

Subscriber: _____ Date of Birth: _____

Is this related to an accident or work injury? ☐ Yes ☐No

☐ Motor Vehicle Accident ☐ Workers Compensation

Date of Accident [if applicable]: _____

Insurance Company: _____ Claim #: _____

Case Manager/Adjuster: _____ Phone #: _____

Is there litigation related to this injury? ☐ Yes ☐ No

Attorney's name: _____ Phone #: _____

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Name: _____ Date of birth: _____

Is there any possibility that you could be pregnant? ☐ Yes ☐ No

Do you have obstructive sleep apnea? ☐ Yes ☐ No Do you use a CPAP machine? ☐ Yes ☐ No

What is the reason for today's visit? _____

_____

When did it start? _____

_____

Please select the number that represents your pain today:

0 1 2 3 4 5 6 7 8 9 10

Review the words below that are commonly used to describe pain and indicate the highest severity you have experienced in the past week.

	None	Mild	Moderate	Severe
Throbbing/Aching				
Shooting				
Stabbing/Sharp				
Cramping				
Hot / Burning				
Tender				
Tiring/Exhausting				

What makes the pain worse? ☐Sitting ☐Lying Down ☐Walking ☐Standing ☐Heat ☐Cold

What makes the pain better? ☐Sitting ☐Lying Down ☐Walking ☐Standing ☐Heat ☐Cold

What treatments have you had for this problem and when?

☐Physical Therapy_____ ☐Chiropractic Treatments _____ ☐Medications_____

☐Anti-Inflammatory_____ ☐Nerve Blocks/Injections_____ How Many? _____

Have you had any diagnostic imaging for this problem and when?

☐MRI_____ ☐CT Scan_____ ☐XRays_____ ☐EMG_____ ☐Ultrasound_____

Does/Did anyone in your family have a history of chronic pain, disability, or illness? If yes, please explain:

_____

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Previous Hospitalizations/Surgeries	Year

Please check off if you have any current problems in any of the following areas:

□ General Wellness	□ Headaches	□ Nausea	□ Stomach/Digestion
□ Ears/Nose/Throat	□ Psychiatric	□ Neurological	□ Skin
□ Blood/Lymph	□ Thyroid/Endocrine	□ Trouble Sleeping	□ Reproductive/Urinary
□ Memory	□ Dizziness	□ Ringing in Ears	□ Muscles/Joint/Bones
□ Eyes	□ Fatigue	□ Chest Pain	□ Heart Problems
□ Cancer	□ Diabetes	□ Blood Pressure	□ Kidney Problems
□ Convulsions	□ Hypertension	□ Asthma	□ Liver Problems
□ Stroke/TIA			

If any of the above are check, please explain: _____

_____

Use of alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of tobacco: ☐ Never ☐ Previously but Quit ☐ Daily: _____# of packs

Use of drugs: ☐ Never ☐ Use Type/Frequency: _____

Work/School Status: ☐Full Time ☐Part Time ☐Unemployed ☐Retired ☐Workers Comp

Current Job: _____ Job Title: _____

Is your pain from a work-related injury? ☐ Yes ☐ No Returning to work? ☐ Yes ☐ No

Job requirements (check all that apply)

☐ Work at a constant rate	☐ Work outdoors	☐ Indoors and Outdoors
☐ Use hand tools	☐ Use power tools	☐ Operate Computer
☐ Climb stairs	☐ Climb ladder	☐ Bend
☐ Grasp	☐ Reach	☐ Push _____lbs
☐ Pull _____ lbs	☐ Carry _____lbs	☐ Lift _____ lbs
☐ Stand	☐ Sit	☐ Walk

Are you receiving any of the following?

☐ Workers Compensation ☐ No Fault Auto Wage Reimbursement ☐ Long Term Disability

☐ Short Term Disability ☐ Social Security Disability ☐ Retired/Pension

☐Litigation ☐Other: _____

Patient Signature: _____ Date: _____

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Medication List

Please list all current prescription and non-prescription medications or supplements or check the following options.

☐ I brought a copy of my medication list (please provide the list to the front desk receptionist)
☐ Not currently taking any medications

Medication Name	Dosage	# of times dosage taken per day

Allergies

Are you allergic to latex (please circle)? YES NO

Please list all known allergies or check the following options, whichever applies

☐ I brought a copy of my allergy list (please provide the list to the front desk receptionist)
☐ No known allergies

Medication allergy	Please describe allergic reaction severity & symptoms

Interventional Pain Consultants - SOAPP

Name: _____ Date: _____

The following are some questions given to all patients at the Pain Management Center. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you have mood swings?	0 1 2 3 4
2. How often do you smoke a cigarette within an hour after you wake up?	0 1 2 3 4
3. How often have you taken medication other than the way that it was prescribed?	0 1 2 3 4
4. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0 1 2 3 4
5. How often, in your lifetime, have you had legal problems or been arrested?	0 1 2 3 4

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

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Practice Policies

Thank you for choosing Interventional Pain Consultants. We are committed to the treatment of your pain and in order to provide your care, we require your compliance with our policies. Your clear understanding of our policies is important to our professional relationship.

We will bill your primary insurance company directly if a copy of both sides of your insurance card is provided at the time of service as well as required demographic information necessary to file your claim. If you fail to provide the necessary demographic information to file your claim, you will be responsible for payment in full at the time of service. You are required to notify us when any demographic information changes. You are required to provide a copy of your insurance card if your coverage changes. If payment is not received from your insurance company in 60 days, you will be expected to assist in the resolution of the open claim. If the claim continues to be unpaid after 120 days, we reserve the right to bill you directly. It is in your best interest to ensure that the correct insurance information is provided at the time of service.

If your insurance requires a referral, it is your responsibility to obtain the necessary referral for your visit or procedure and have a copy of this referral sent to our office prior to your visit or procedure. If you do not have a referral from your primary care physician at the time of a visit, you will be given the option to reschedule your appointment.

Authorization to Release Information and Assignment of Benefits

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, Blue Shield, HMO's and commercial insurance to Interventional Pain Consultants and to Morris Anesthesia Group if anesthesia is administered for procedures at a surgery center or hospital. I understand that I am fully responsible for all charges whether or not they are covered by said insurance. I hereby authorize assignee to release any information necessary to secure payment on my behalf.

Consent of Treatment

I understand that the practice of medicine is not an exact science, many things are not predictable, and no guarantees or promises can be made to me by the doctors or assistants. I understand that I maintain the option to terminate my consent to treatment at any time, but such termination must be in writing.

Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and doctors on time. **If a patient is 15 minutes past their scheduled time, we will have to reschedule the appointment.**

To ensure you are seen in a timely manner, please remember to book your next appointment prior to leaving the office.

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Cancellation / No Show Policy for Doctor Appointments

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not canceled at least 24 hours in advance you will be charged a one hundred and twenty five ($125.00) fee; this will not be covered by your insurance company.

Cancellation / No Show Policy for Surgery

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office. **If a surgery is not canceled at least 48 hours in advance you will be charged a one hundred and fifty ($150.00) fee; this will not be covered by your insurance company.**

Disability Forms, Reports, Etc.

Request for completion of disability forms, reports or other paperwork will require a minimum fee of $15.00, paid in advance, related to the amount of preparation involved. If you have not seen your physician recently, you may be required to see your physician before the form can be completed. Please allow five business days for completion.

Medication Policy

In the course of your treatment , you may receive pain medications. Please be aware all physicians are required by federal law to follow stringent policies related to the use of prescription medications, particularly narcotics. The goal of treatment is to help patients become less dependent on pain medication. Therefore all patients must make arrangements to obtain refills prior to the weekend or prior to their medications running out. Medication refills will NOT be made during the weekend, which begins on Fridays at 12pm and ends on the following Monday at 8:30am. Our policy is to NOT provide refills by phone. Please make sure to call at least two days prior to your last dose in order to make an appointment to refill your medication. Do not wait until the day you run out as our physicians need time to review your refill request. Patients receiving chronic medication management will be required to sign a separate narcotic agreement.

My signature indicates that I have read, understood, and agree with the above statements, terms, and conditions.

Patient Name: _____

Patient or Representative Signature: _____

Date: _____

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Authorization for Release of Information to Family Members

Name of Patient: _____

Date of Birth _____/_____/_____

Interventional Pain Consultants is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions. You have the right to revoke this consent, in writing, at any time except where we have already made disclosures in reliance on your prior consent.

I authorize IPC to release my records and any information requested to the following individuals.

1. _____ Relation to patient: _____
2. _____ Relation to patient: _____
3. _____ Relation to patient: _____
4. _____ Relation to patient: _____
5. _____ Relation to patient: _____

Authorization Regarding Messages (please check all that apply)

☐ I authorize you to leave a detailed message on my home or cell number regarding appointments

☐ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information

☐ I authorize you to leave a message with anyone who answers the phone

☐ Messages may only be left with _____

_____ _____
Patient Name (PLEASE PRINT) Date

_____
Patient Signature

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3799 Route 46 Suite 301
Parsippany, NJ 07054
Phone: 973-335-1440 Fax: 973-335-1446

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date: _____

Patient name: _____ Date of birth: _____

To: _____

I hereby authorize you to transfer or make available all my medical records or reports relating to my care to the following provider:

_____

_____

_____

Patient Signature: _____ Date: _____

Please be advised, records will be sent within 31 (thirty-one) days from the date signed.

Office representative: _____

Patient phone number: _____

Date records were picked up: _____