PHONE
856-691-2211

MID-ATLANTIC
*Pain Specialists*

FAX
856-839-4128

# M.A.P.S.

*"Your roadmap to recovery"*

## PATIENT INFORMATION:

First Name:_____ Last Name:_____ Sex: M F (circle)

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

Home Phone:_____ Cell Phone:_____ Email:_____

Date of Birth:_____ SS#_____ Referred by:_____

Primary Care Physician:_____ Phone:_____ Address:_____

Pharmacy:_____ Phone:_____ Address:_____

**INSURANCE INFORMATION:**

**Primary Insurance:**_____ Policy/ID#_____

Group #_____

Policy Holder Name:_____ Date of Birth:_____

**Secondary Insurance:**_____ Policy/ID#_____

Group#_____

Policy Holder Name:_____ Date of Birth:_____

**If Accident Related: Auto or W/C (circle)**

**Auto Insurance Carrier:**_____ Policy Number:_____

Claim#_____ Adjuster Name:_____

Claims Billing Address:_____

**Worker Comp Insurance Carrier:**_____ Policy Number:_____

Claim#_____ Adjuster Name:_____

Claims Billing Address:_____

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**Patient Name:** _____ **DOB:**_____

**Our Commitment to You**

- We will provide you with the most appropriate care in the most time-efficient fashion.
- We will treat you with respect and professionalism.
- We will always do our best to keep your scheduled appointment and to minimize any wait time you may incur. However, due to circumstances beyond our control, there may times that we must reschedule your appointment with short notice.
- In order to give you as much as notice as possible, we request an active phone number so that we can reach you during the day, such a business number or cell phone. We will do our best to move your appointment to an earlier time or date if we have a cancellation in our office schedule.

**General Information**

- Our office hours are very limited so it is very important that you keep your scheduled appointment.
- If you have an emergency and cannot keep your appointment, you must contact our office no later than 24-48 hours prior to your scheduled appointment time/date.
- You will be charged a $25 NS FEE for office visits and $75 for procedures if your appointment is not kept or cancelled 24-48 hours prior to your scheduled time.
- In order to treat you effectively and efficiently and within HIPAA guidelines, we require a registration and several other forms to be completed by you.

**After Hours Policy**

- If you have an urgent medical problem after regular business hours (8:00 AM to 5:00 PM Monday – Friday) or over the weekend, you do one of the following
    1. Contact your primary care physician
    2. Go to an urgent care facility
    3. Go to the emergency department of the nearest hospital

It is permissible that you obtain medications from these physicians for any acute pain or new injury that you have. It is your responsibility to contact us within the next two business days to inform us of any changes, additions or deletions made to your narcotic regimen. All non-narcotic changes should be reported at your next office visit.

**Medication Policy**

- It is important for your health that you follow directions carefully on all medications that we prescribe. In addition, we must be informed of all other medications, prescriptions or over the counter.
- We WILL NOT refill controlled medications in advance of their refill date. We WILL NOT mail prescriptions.
- Opioid medications (narcotics) WILL NOT be prescribed at the first visit.
- Opioid medications will ONLY be prescribed at the time of your appointment.

**Financial Policy**

- We expect that you have an understanding of your responsibilities under your insurance contract with respect to referral and pre-authorization requirements as well as your deductible, co-pays, and coverage limits.
- In order to achieve your maximum allowable benefits, we need your assistance and your understanding of our payment policy.
- Payment is due in **FULL** at the time of service, **(including co-pays and/or deductibles)** unless you have made payment arrangements in advance with the Practice Administrator.
- If you have insurance coverage with one of the plans with which we participate, we will bill your insurance company along the guidelines of our contract.
- Returned checks will be subject to an additional **non-sufficient fund fee. Checks are not accepted for co-pays.**
- We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Please realize that your insurance is a contract between you, your employer (if employed), and the insurance company.
- You will be required to show a copy of your insurance card at the time of service. If you do not have your insurance information or we are unable to verify your coverage, you will be required to pay for services rendered that day. If your insurance coverage terminates or changes, you are responsible for notifying us of this change immediately so that we can assist you in receiving your maximum reimbursement.

**Billing Policy**

I understand that the practice will file all claims for services rendered to my insurance carrier for your primary insurance plan. Copays are due at the time of your appointment and there are NO exceptions. We accept most insurances; however, it is your responsibility to ensure we participate with your plan. You must present your current active insurance at the time of your visit. We **do not** back bill. **It is ultimately the patients' responsibility to understand their health coverage. Your employer should have a copy of your Benefits Guidebook or call your insurance company if you need detailed information about your coverage.**

**I acknowledge that I am responsible for any balances that may be due to Mid-Atlantic Pain Specialists due to any/all of the following:**

- Co-insurance, copays and yearly deductibles
- Non-covered services
- Out-of-network charges
- Terminated Coverage
- No insurance coverage
- No referral obtained from primary care physician
- Failure to respond to insurance carrier correspondence (COB)

I understand that I will receive a statement for any balance due after my carrier has processed the claim.

I understand and am agreeable that the balance of my statement will be paid in full to Mid-Atlantic Pain Specialists within 30 (thirty) days. If I am unable to pay the entire amount, I am responsible to immediately, upon receipt of the statement, call the office at (856) 896-2814 to arrange a payment plan.

I understand that failure to pay my balance and/or arrange payments and follow that payment agreement will result in collections agency action, including payment of 35% collection agency fee, and/or discharge from the practice.

**I HAVE READ, UNDERSTAND and AGREE to this Financial/Billing Policy. I GUARANTEE payment of all charges incurred for this account. I hereby assign benefits to Mid-Atlantic Pain Specialists for all claims submitted to my insurance on my behalf. I further agree to pay any attorney fee, court costs and related collection fees incurred.**

_____ _____

**Patient Signature** **Date**

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OPIOID (NARCOTIC) AGREEMENT

I UNDERSTAND THAT IN ORDER TO RECEIVE CARE FOR THE TREATMENT OF Pain at Mid-Atlantic Pain Specialists, I MUST comply with the following rules:

1. I UNDERSTAND that narcotic and controlled drug prescriptions are MY RESPONSIBILITY once they are placed in my hand. I UNDERSTAND that if anything happens to this prescription (i.e., It is lost, stolen, flushed down the toilet, etc.) I am personally responsible, and physicians, physician's assistants and/or nurse practitioners WILL NOT rewrite the prescription until the designated time is given.
2. Your narcotic and controlled drug prescription WILL NEVER be refilled after hours or on the weekends.
3. All controlled substances should be obtained at the SAME PHARMACY. Should the need arise to change pharmacies our office must be informed.
4. I WILL take medications as a dose and frequency prescribed. Any changes in the dose or frequency will be discussed with my physician, physician's assistant and/or nurse practitioner at Mid-Atlantic Pain Specialists. If my medications are prescribed every eight-hour basis, I WILL take these medications every eight hours. I UNDERSTAND that if I use more than the allowed amount or use up my medication before my appointment date, NO MORE PILLS WILL BE GIVEN.
5. I UNDERSTAND that narcotics and controlled drug prescriptions WILL NOT be given the date of the original appointment time.
6. I UNDERSTAND that if I come in at an earlier date for an appointment, my medication WILL NOT be given the date of the original appointment.
7. I WILL receive prescriptions at the interval determined by physicians, physician assistant's and/or nurse practitioners at Mid-Atlantic Pain Specialists.
8. I WILL NOT receive controlled substances for the treatment of pain from any source other physician, physician's assistant and/or nurse practitioner at Mid-Atlantic Pain Specialists.
9. I Will communicate with my primary physician that I am treated at Mid-Atlantic Pain Specialists for the controlled prescribing of pain medications. I understand that Mid-Atlantic Pain Specialists has the permission to discuss all diagnostic and treatment details with the dispensing pharmacists or other professionals who provide your health care.
10. I WILL consent to random drug testing. I will NOT use any illegal substances (cocaine, heroin, crystal methamphetamine, PCP, ecstasy, ketamine, etc.) or any controlled substances which are not prescribed in our practice while being treated with mid-Atlantic Pain Specialists.
11. I WILL safeguard my prescribed medications. I understand that these medications maybe lethal or hazardous to a person that is not tolerant to its affects, especially a child.
12. I WILL comply with my scheduled appointments.

13. I UNDERSTAND that there is a possibility of impairment of thought processes, especially if this narcotic is combined with a sedative, a sleeping pill, tranquilizer or alcohol.
14. I UNDERSTAND the possible adverse effects and dependencies associated with these medications. Overdose of medication may result in injury or possible death. Other side effects may include, but are not limited to constipation, difficulty in urination, fatigue, drowsiness, nausea, itching, loss of appetite, confusion, sweating, flushing sexual dysfunction, and or depressed respiration.
15. I UNDERSTAND that if I plan to become pregnant or become pregnant, I have to inform the physician, physician's assistant, and/or nurse practitioner at Mid-Atlantic Pain Specialists. I UNDERSTAND that if I become pregnant, a child WILL likely be physically dependent at birth if I continue narcotics.
16. You are expected to INFORM OUR OFFICE of any new medications or medical conditions, and any adverse effects you experience from any of the medications that you take.
17. I UNDERSTAND that changing a date, quantity or strength of medication or altering a prescription in any way, shape or form is against the law. Forged signatures are also against the law. If there is a violation this will be reported to the patient's pharmacy, local authorities and DEA.
18. I realize that it is MY RESPONSIBILITY to keep others and myself from harm, including safety of driving and the operation of machinery.
19. I UNDERSTAND that if I violate this contract, all medications from Mid-Atlantic Pain Specialist WILL thereafter CEASE.
20. I UNDERSTAND this mode of treatment will be stopped if any of the following occurs:

    a) I giveaway, sell, or misuse the drugs or use other people's drugs or illegal substances
    b) I am non-compliant with any of the terms of this agreement
    c) I disrespect or harass any of Mid-Atlantic Pain Specialists staff.
21. I UNDERSTAND that extended-release opioid medication will be prescribed for cancer related pain and hospice patients only according to the current prescribing recommendations.

YOU ARE INFORMED that you have the right and power to sign and be bound by this agreement, and that you have read, understand and accept all of its terms.

_____ _____

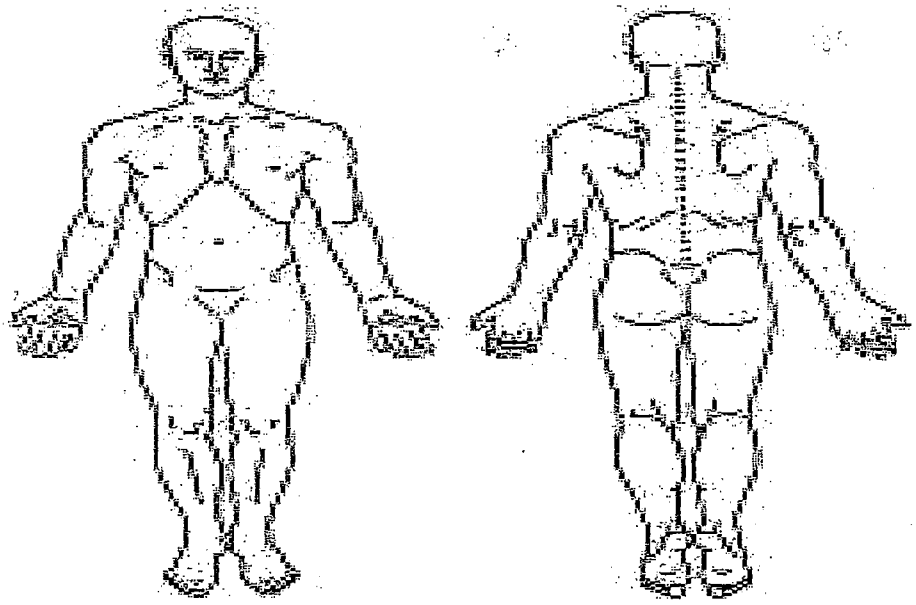
Patient's Signature Date

**Patient Intake/ Medical History** ❑ Right handed ❑ Left Handed

**Patient Name:** _____ **DOB:** _____ **Date:** _____

**Height:** _____ **Weight:** _____ **Male:** _____ **Female:** _____

**Chief Complaints:** (please circle pain location(s))



**Current Pain Level** (please circle) **0 1 2 3 4 5 6 7 8 9 10**

**Does the pain radiate?** (Please circle) Right Arm/Leg Left Arm/Leg ❑ **No Radiation**

**When did the pain start and how was it started?** (MVA or work accident?)

_____

_____

_____

**Describe your pain** (check all that apply)

❑ Dull ❑ Aching ❑Sharp ❑ Shooting ❑Stabbing ❑Throbbing ❑Numbness ❑Burning

Other: _____

**How often is the pain?** ❑ Constant ❑ Frequent ❑ Occasional

**What makes your symptoms worse/exacerbate?**

_____

_____

**What makes the symptoms better?**

_____

_____

**Have you tried Physical Therapy?** ❑ **Yes** ❑ **NO** **If yes, when and how long?**

_____

_____

**Past Surgical History**

Please list all past surgeries:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

**Allergy List**

Please list medication allergies:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Are you allergic to Latex? ❑ YES ❑ NO

Contrast (DYE) ❑ YES ❑ NO

**Medical History:** (please check all that apply) Check here if none apply _____

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Heart Disease | ___ | ___ | Hepatitis/Liver Disease | ___ | ___ |
| High Blood Pressure | ___ | ___ | Kidney Problems/Stones | ___ | ___ |
| High Cholesterol | ___ | ___ | Thyroid Disease | ___ | ___ |
| Heart Attack | ___ | ___ | Diabetes | ___ | ___ |
| Stroke | ___ | ___ | Anxiety | ___ | ___ |
| Seizures | ___ | ___ | Depression | ___ | ___ |
| Glaucoma | ___ | ___ | | | |
| Asthma | ___ | ___ | Cancer: _____ | | |
| COPD | ___ | ___ | Other: _____ | | |

**Review of Systems** (circle all that apply)

Gen: Weight Loss | Weight gain | Fever | Fatigue | Loss of Appetite | Nausea | Vomiting

Skin: Skin Problem | Rash | Psoriasis | Slow healing | Easy Bruising | Itching

Neuro: Light Headedness/Dizziness | Fainting | Weakness | Tremor | Memory Loss

Eyes: Vision Problem | Blurred Vision | Double vision

ENT: Ear Pain | Hearing Loss | Ear Noises | Nose Bleed | Sore Throat | Hoarseness

Cardio: Chest Pain | Chest Pressure | Irregular Heart Beat | Murmur

Respiratory: Coughing | Difficulty Breathing | Wheezing |

Gastro: Constipation | Diarrhea | Bloody Stool | Stomach Pain | Ulcer

Genitourinary: Painful urination | Frequent urination | Bloody urine | loss of libido | infection

Endocrine: Hyper/hypothyroidism | Parathyroid problems

Hematology: Anemia | Bleeding disorder | Sickle cell disease/trait

Immunologic: Fever | hay fever | Sinus problems | allergies

Musculoskeletal: Back injury | Birth Trauma | Birth Defect | Muscle Pain | Joint Pain | Spinal Trauma

Psychiatric: Suicidal attempts | Suicidal ideation | homicidal | hallucination | Psychosis | other _____

Medication List: Please list all active medications name dosage frequency or provide a list

_____

_____

_____

_____

_____

Family History:

Mother: No conditions ☐ Deceased ☐ Medical Conditions:_____

Father: No conditions ☐ Deceased ☐ Medical Conditions:_____

Social History:

Tobacco Use: ☐ Never ☐ Quit in _____ ☐ Currently # of packs per day _____

Alcohol Use : ☐ Never ☐ Currently Occasional_____ Frequent _____ Daily _____

Illicit Drug Use: ☐ Never ☐ Yes Type_____ Recovery? _____

Occupation: _____ ☐ Unemployed ☐ Disabled

Marital Status : ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Do you have any Children? : ☐ No ☐ Yes How many?: _____

**I certify that the information given on my initial visit intake is correct to the best of my knowledge. I will not hold my doctor or any member of his staff responsible for any error or omission that I may have made in the completion of this paperwork .**

_____ _____

**Patient/Family/Legal Guardian Signature** **Date**

MID-ATLANTIC PAIN SPECIALISTS

HIPAA PRIVACY NOTICE CONSENT FORM

I understand and have been provided with Mid-Atlantic Pain Specialists Notice of Privacy Practices that provides a more complete description of information uses and disclosures. Mid-Atlantic Pain Specialists reserves the right to make changes to their Privacy Notices and revised copies are available. By Signing this form, I acknowledge that I have been afforded the opportunity to consider Mid-Atlantic's Notice of Privacy Practices prior to signing this consent and making healthcare decisions. I also understand and agree to have my digital photo identification taken as part of my electronic health records.

I authorize Mid-Atlantic Pain Specialists to release medical and financial information, including any or all reports, records. Bill for services rendered or opinions found in my medical chart, with respect to treatment to any alternative healthcare giver.

Mid-Atlantic pain Specialists maintains patient medical records on paper, on microfilm and/or electronic media which may be accessible to any physician or healthcare provider participating in my current of future care. Medical records are disclosed according to applicable NJ State and Federal laws, and the provisions of this consent.

HIPAA AUTHORIZATION TO DISCUSS YOUR MEDICAL INFORMATION:

_____Patient Only and/or

You may disclose my medical information to:

_____ _____ _____

Please Print Name Relationship Phone Number

EMERGENCY CONTACT: MEDICAL INFORMATION IS NOT RELEASED TO THIS PERSON.

(HOWEVER, THIS PERSON CAN BE THE SAME AS YOU HIPAA AUTHORIZED CONTACT)

_____ _____ _____

Emergency Contact Relationship Phone Number

I acknowledge that I have received a copy of Mid-Atlantic Pain Specialists Notice of Privacy Practices, Patients' Rights & Responsibilities and Patient Notices.

_____ _____

Signature of patient or legal guardian Date

# Authorization and Consent

I request that payment of authorized Medicare Benefits be make either to me or on my behalf to Mid-Atlantic Pain Specialists for any services furnished me by Mid-Atlantic Pain Specialists. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to myself or to the party who accepts assignment.

I request that payment of authorized Medigap Benefits be make on my behalf to Mid-Atlantic Pain Specialists for any services furnished me by Mid-Atlantic Pain Specialists. I authorize any holder of medical information about me to release to my insurance carrier any information needed to determine these benefits payable for related services.

Authorization to release information and payment request. I certify that the service(s) covered by this claim has been received and I request that payment for these services be made on my behalf. I authorize any holder of medical or other information about me to release to the Division of Medical Assistance and Health Services or it's authorized agents any information needed for this or a related claim.

Assignment of Insurance benefits: I irrevocably assign all payments to Mid-Atlantic Pain Specialists for medical insurance benefits including any Major Medical Benefits otherwise payable to me under the terms of my policy but not to exceed the balance due to Mid-Atlantic Pain Specialists for services performed during this period of treatment. In making this assignment, I understand and agree that I am financially responsible to the above party for charges not paid under this insurance policy. I permit a copy of this authorization to be used in place of the original.

Release of Information: Mid-Atlantic Pain Specialists may disclose any or all parts of the clinical record to me (our) insurance company(s) or employer (s) for purposes of satisfying charges billed by Mid-Atlantic Pain Specialist. I further understand that it may be necessary for Mid-Atlantic Pain Specialists to contact my (our) past present employer (s) in regards to this claim. This authorization does not cover 3rd party liability claims.

Guarantee of Account: Mid-Atlantic Pain Specialists, For and in consideration of services rendered by Mid-Atlantic Pain Specialists to the below named patient, the undersigned (jointly and severally, if more than one) guarantees payment of all charges incurred for said patient in accordance with the policy of payment of such bills. There will also be added 35% collection and reasonable attorney fee if your account goes to a collection agency.

THE UNDERSIGNED CERTIFIES THAT EACH HAS READ AND UNDERSTANDS THE ABOVE TERMS AND CONDITIONS.

_____ _____ _____

Patient's Name Patient's Signature Date

# PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

2466 e. Chestnut Ave Suite 2 Vineland, NJ 08360

Medical Records Department

Phone (856) 896-2814 – Fax (856) 691-2230

Patient Name:_____DOB:_____Last 4 of SS#_____

Address:_____City_____State_____Zip Code_____

I hereby authorize Mid-Atlantic Pain Specialists to release/obtain my protected health information to/from the following:

| Release to: | Obtain From: |
|---|---|
| Name:_____ | Name:_____ |
| Fax:_____ | Fax:_____ |
| Name:_____ | Name:_____ |
| Fax:_____ | Fax:_____ |

For the purpose of: __ Ref to Specialist __Change of Doctor __Insurance__Workers Comp

__Disability__Continuing Care__Legal Investigation__Personal File

Please send:

___Entire Medical Record Or Specific Items Only

(please list):_____

**Our medical records department has 30 days to release any medical records**

I understand that these medical records may or may not contain information pertaining to psychiatric counseling or testing, alcohol or drug abuse counseling or testing and/or HIV/ARC testing. I do expressly and voluntarily authorize the disclosure of the said medical records to the person (s) and /or entity (ies) as stated above. This authorization/consent will remain in effect for a period of on (1) year from the date stated below unless revoked in writing by the person to which it pertains (or his/parent, legal guardian or legally authorized agent), to the medical records department. These medical records are being disclosed under the provisions of the applicable New Jersey and Federal Law. Please note that there may be a charge incurred with releasing these records.

Note: There will be a charge for copies or the transfer of your records. The charge of $1.00 per page with a minimum of $10.00 and a maximum of $100.00, plus postage if applicable, in compliance with guidelines set forth by the NJ Administrative Code Title 13:35-6.5 4.

_____ _____

Patient or Legally Authorized Agent Date