UNIVERSAL PAIN MANAGEMENT, PC
Intake Form

What is the reason for your visit today?

Patient Information

Name (First, Middle, Last)		Date of Birth	Age	Social Security #	Birth Gender ☐ M ☐ F
Mailing Address	Apt #	City, State ZIP			
Email Address		Phone no: Home:		Cell:	
Primary Care Provider / Referring Provider		☐ None ☐ Doctors Care is my primary care provider			
Preferred Language		Race ☐ Black or African American ☐ Asian ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ American Indian/Alaska Native ☐ Prefer not to answer			
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino					

Emergency Contact

Contact Name	Phone Number	Relationship to Patient

Guarantor/Responsible Party (person responsible for payment)

Legal Name of Responsible Party (First, Middle, Last)	Social Security #
Email Address (if different from the patient email above)	Date of Birth

Preferred Pharmacy

Pharmacy Name	Phone no:

Medical Insurance (please present your ID and insurance card to the receptionist)

PRIMARY Insurance Company Name	Policy Number/Member ID	Group Number
Insured Name	Insured Date of Birth	Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent
Insurance Company Address (usually on back of insurance card)		Phone

SECONDARY Insurance Company Name	Policy Number/Member ID	Group Number
Insured Name	Insured Date of Birth	Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent
Insurance Company Address (usually on back of insurance card)		Phone

☐ **Self pay**

Please continue to the next page.

New Patient Information and Consent

Accident/Injury Information Worker's compensation ☐ No Fault Insurance ☐ Not Applicable ☐

Where did the injury occur? (example: park) _____

Were you struck by an object? ☐ Yes ☐ No If Yes, what type of object? _____

Date of accident: _____ Claim no: _____ WCB no: _____

Employer's name & address: _____

Insurance carrier name: _____ Adjuster's name: _____

Lawer's name and phone number: _____ Covered body parts:

Authorization for Release of Information (HIPPA)

May we leave testing results or referral info in email or voicemail? ☐ Yes ☐ No

Who may receive information on your behalf regarding testing or referrals? Name: _____

Financial Agreement

1. Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, and credit cards.
2. It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
3. We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
4. If we have a contract with your insurance company we will bill your insurance company first, less any co-payment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.
5. If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
6. Please understand some insurance coverages have Out-of-Network benefits that have co- insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.

I have read the financial policies contained above, and my signature below serves as acknowledgment of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

I have received a copy of the Notice of Privacy Practice and Financial Policy Notice. ☐ Yes ☐ No Initial _____

X _____ _____

Patient or Authorized Person's Signature Date

FOR INTERNAL USE ONLY

Patient's ID: _____ Co-Pay Collected: $ _____

Universal Pain Management, PC

OPIOID CONTRACT

1. A single physician will be prescribing the medication for you. Once the physician is designated, only that physician is able to decide whether or not to switch your medications.
2. A single pharmacy will provide the medication prescribed to you by the physician. You must elect a pharmacy and stay with that pharmacy, unless otherwise changes, you are responsible to let the physician and the staffs know what pharmacy you chose.

   Name of Pharmacy: _____, Phone: _____
3. You are expected to notify our office of any old/new medical condition and/ or medications you take, and any adverse effects you experience from any medications you take.
4. You must notify your physician if additional medications are prescribed to you by another health care provider (ex. ER, Hospital, Family Doctor).
5. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacist or other professionals who provide your healthcare for purposes of maintaining accountability.
6. Refill prescriptions for Schedule ll opioids will be rewritten every 30 (thirty) days or about the same day of each month. You must come to the office for re-evaluations every month (30 days).
7. Controlled substances will NOT be called in to the pharmacy. You must personally pick up your prescription drug personally on your scheduled date of appointment.
8. You may NOT share, sell, or otherwise permit others to have access to the medications prescribed to you.
9. Lost medications or duplicate prescriptions will not be replaced. Specific documentation will be required in order to obtain further prescriptions before monthly refill date (ex. Police report).
10. Unannounced urine, serum toxicology, and/or pill count will be requested. Your cooperation is required. Presence of unauthorized/illegal substances may prompt referral for assessment for addictive disorder and possible discharge from our office.
11. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependencies and shoulder be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. Medications/Prescription SHOULD NOT be left where others might see or have access to.
12. Original containers of medication should be brought in on each visit.
13. Since the drug may be hazardous or lethal to a person who is not tolerant to their effects, especially children. You must keep medications out of the reach of children and locked away safely.
14. Early refills of medications will generally NOT be given.
15. Prescriptions may be issued early if the patient or the physician will be out of town when a refill is due. However, these prescriptions will have instructions for the pharmacist that they may NOT be filled prior to the appropriate date.
16. If the responsible legal authorities (ex. police officers) have questions concerning your treatment (ex. You were obtaining medications at several pharmacies) all confidentiality is waived and these authorities may be given full access to our records of controlled substance administration.
17. Any breach of the contract will result in permanent discharge from the practice, and a referral to a substance abuse specialist/ detoxification program will be given.
18. Renewals are contingent on keeping scheduled appointments. You must comply with all other components of the treatment program (including, but not limited to, physical therapy, behavior management, Psychologist/psychiatrist).
19. It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit.
20. You are aware that the use of opioid medications have certain risks and associated with, including, but not limited to: sleepiness, drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, decreased breathing

rate, decreased reflex or reaction time, physical dependence, tolerance to analgesia, addiction, and possibility that the medicine will not provide complete pain relief.

21. I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include, but are not limited to: using heavy equipment, driving a motor vehicle/motorcycle, working in unprotected heights, and being responsible for another individual who is unable to care for himself or herself.
22. You understand that opioid medications SHOULD NOT be used with alcohol.
23. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understood, and accept all of its terms.
24. I am aware that certain other medications such as Nalbuphine (Nubain), Pentazocine (Tatwin), Buprenorphine (Suboxene), and Butorphanol (Stadol) may reverse the action of the medicine I am using to control my pain. Taking any of these other medications while I am taking my pain medications can cause symptoms like withdrawal. I agree not to take any of these medications and to tell my doctors that I am taking an opioid as my pain medicine and cannot take any of the medicine listed above.

- I have been informed of the risk of developing tolerance, or an addiction to opioids. I have been informed of the risk of depression and suicidal ideation from narcotics. It is understood that failure to adhere to these policies will result in cessation of therapy with controlled substance prescribing by the physician or referral for further specialty assessment.
- I am giving permission to the office of the prescribing physician to contact my pharmacy directly, at the discretion of the physician, to review and evaluate my medications. My signature below grants the pharmacy permission to release such requested information.

I, _____ understand all of the above and will comply.

Patient's Signature: _____ Date: _____

Witness's Signature: _____

NO CALL / NO SHOW POLICY

In an effort to provide effective and efficient treatment to all of our patients, it is the policy of this office that all appointment cancellation is made at least **24 hours** prior to your scheduled appointment time.

If an appointment is not cancelled or patient fails to show up for appointment in Universal Pain Management, PC office reserves the right to charge patient a **$30 fee** per occurrence.

No Show fees will be billed to the patient .This fee is not covered by insurance, and must be paid prior to your next appointment.

Thank you for your anticipated cooperation.

Patient's Name: _____

Patient's Signature: _____ Date: _____

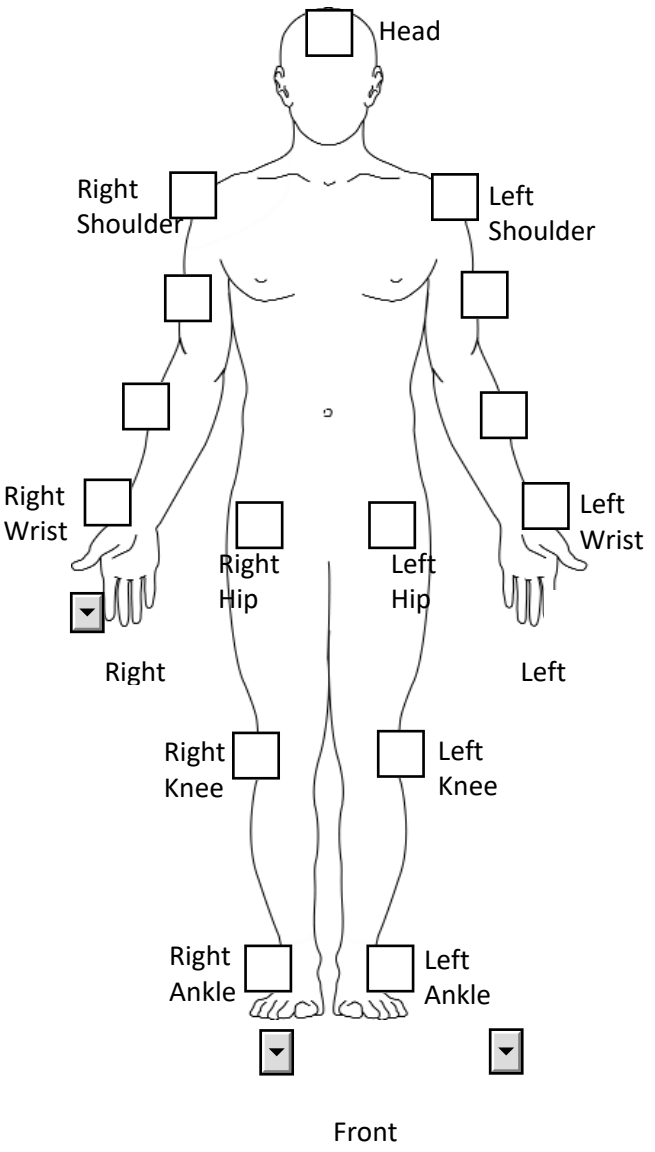
PATIENT PAIN DRAWING

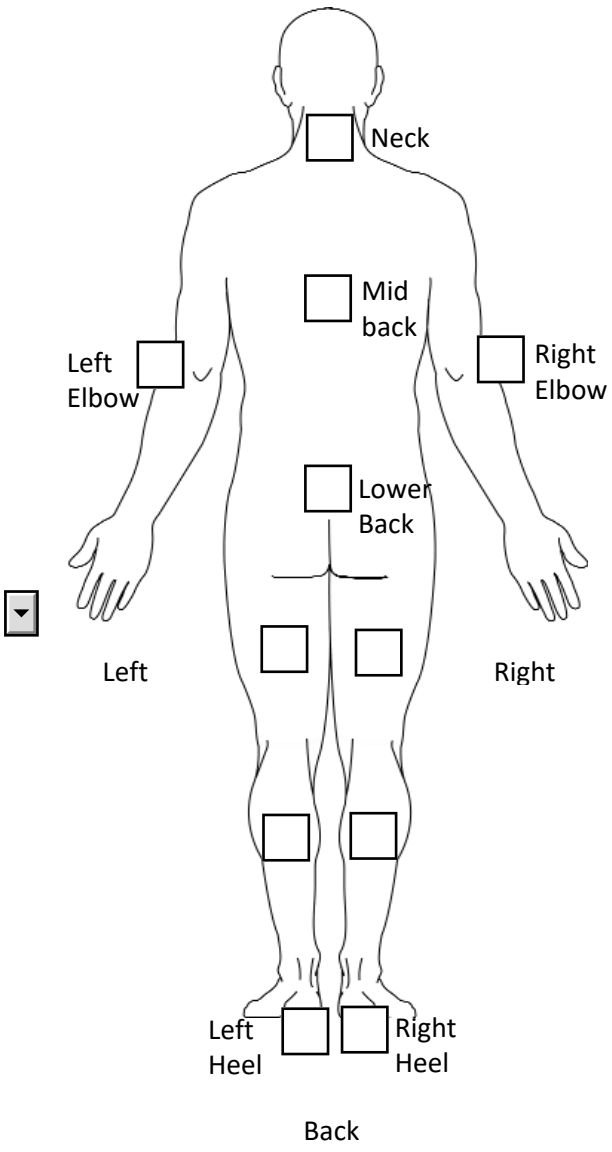
Name: _____, Date: _____

Where is your pain now?

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation. Include all affected areas.

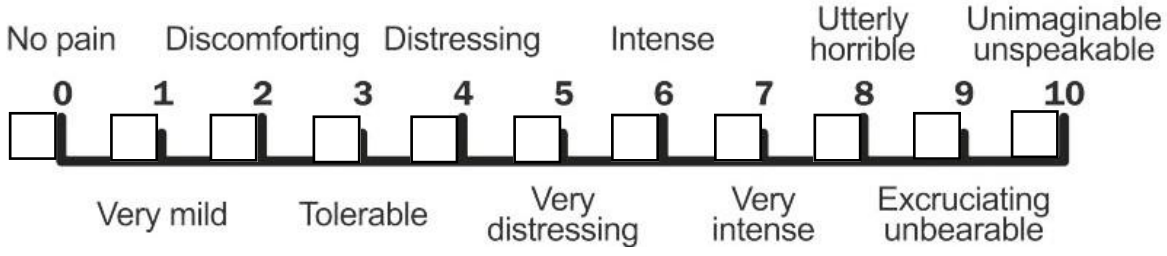
Aching	**Numbness**	**Pins & Needles**	**Burning**	**Stabbing**
^^^	===	ooo	xxx	///





How bad is your pain now?

Please select a number:



PATIENT HISTORY QUESTIONAIRE

Name: _____, Occupation: _____, Date of Birth: _____

1. When did your present pain start?

_____

Are you still working? ☐ Yes ☐ No
Last day on job _____

Do you plan to return to regular job in 6 months?
☐ Yes ☐ No

2. How did the pain start?

☐ Suddenly
☐ Gradually
☐ Lifting
☐ Twisting
☐ Fall
☐ Bending
☐ Pulling
☐ Injured at work
☐ Injured in auto accident
☐ Hit from behind
☐ Injured during sports
☐ No apparent cause

3. What activities make the pain worse?

☐ Exercise (during)
☐ Exercise (after)
☐ Sitting
☐ Standing
☐ Walking
☐ Bending forward
☐ Bending backward
☐ Coughing
☐ Sneezing
☐ Stairs climbing

4. What reduces the pain?

☐ Lying down
☐ Sitting
☐ Standing
☐ Walking
☐ Manipulation
☐ Pain pills
☐ Injections for pain
☐ Muscle relaxant pills
☐ Physical therapy
☐ Nothing
☐ Aspirin or anti-inflammatory pills

5. How long have you had this pain?

_____

6. Have you had any of these diagnostic studies?

☐ X-rays Date: _____
☐ CT Scan Date: _____
☐ MRI Date: _____
☐ EMG Date: _____
☐ Ultrasound Date: _____
☐ Injections Date: _____

7. Have you been hospitalized for your pain problem?
☐ Yes ☐ No

8. Height and weight:

Height: _____ ft _____ inches
Weight: _____ pounds / kgs

9. Lists of surgeries you had so far:

_____
_____
_____

10. What medications are you currently taking?

_____
_____
_____

11. Do you have any of the following conditions?

☐ Diabetes ☐ Cancer ☐ Gout
☐ Heart disease ☐ Epilepsy ☐ Arthritis
☐ Hypertension ☐ Stomach problems
☐ Thyroid disease ☐ Other _____

_____

12. Do you have allergies?
☐ No ☐ Yes: _____

13. Do you smoke? ☐ No ☐ Yes

14. Do you drink alcohol? ☐ No ☐ Yes

15. Family medical history: _____

What other types of doctors or health care providers have you seen for this condition?

_____
_____

Do you have any additional information that would be helpful in understanding your problem?

_____
_____

Last grade completed in school? _____

Please check if appropriate:
☐ On workman's compensation
☐ Receiving disability income
☐ Legal proceeding pending
☐ Report should be sent to referring doctor or PCP

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ ☐ **Alcohol/Drug Treatment**

_____ ☐ **Mental Health Information**

_____ ☐ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

Universal Pain Management, PC
25-03 27th St, Astoria, NY-11102
Phone: (718) 687-2010 Fax: (718) 517-2410

WORKERS COMPENSATION, NO-FAULT AND PERSONAL INJURY CLAIMS

I, _____ am aware that I have an open claim for the body parts I am receiving treatment for, and therefore cannot use my private insurance for the treatment of those body parts. If I fail to comply with this federally mandated rule, I will be responsible to the payment for the treatment.

Patient's Signature: _____ Date: _____