SPINE & PAIN CENTERS
OF NEW JERSEY & NEW YORK

Thank you for making an appointment to see a doctor at Spine & Pain Centers. This appointment does not guarantee that he will agree to take you as a patient. Our doctor will evaluate your condition at the initial visit and determine if further treatment is necessary. Narcotics will not be prescribed until you have been cleared by our team of specialist. To aid our doctor in determining the best course of treatment, please bring the following information to your first appointment.

INSURANCE ID CARD AND REFERRAL IF NECESSARY

WORKER'S COMP OR AUTO-PIP CLAIM INFORMATION IF APPLICABLE INCLUDING INSURANCE COMPANY ADDRESS, CLAIM NUMBER AND DATE OF ACCIDENT, ADJUSTER/CASE MANAGERS NAME AND PHONE NUMBER AND YOUR ATTORNEY'S NAME, ADDRESS AND PHONE NUMBER

MRI, CT SCAN OR X-RAY FILMS AND REPORTS
(EVEN IF THE FILMS ARE 2 TO 3 YEARS OLD)

A **LIST OF ALL MEDICATION** THAT YOU ARE CURRENTLY TAKING

COMPLETED PATIENT FORMS (attached)

NAME AND ADDRESS OF YOUR **REFFERING AND PRIMARY CARE DOCTOR**

IF YOU HAVE ANY QUESTIONS REGARDING YOUR APPOINTMENT, PLEASE CALL 732-345-1180

SPINE & PAIN CENTERS
OF NEW JERSEY & NEW YORK

Anil Sharma, MD Charles Daknis, MD

Date:_____

Patient Information

Last Name:_____First Name:_____M:_____

Sex: Male / Female Date of Birth:_____ Social Security:_____

Marital Status: Single / Married / Divorced / Widowed Preferred Language: English / Other_____

Race: White / African American / Other_____ Ethnicity: Hispanic / Non-Hispanic

Address:_____Town:_____ State/Zip:_____

Home Phone _____Cell Phone_____Work Phone_____

E-Mail Address_____Preferred Contact: Home / Cell / Work / E Mail (circle one)

Emergency Contact Name:_____ Phone:_____

Referring Doctor:_____**Primary Care Doctor**:_____

Employer/School:_____Occupation:_____

Pharmacy Name, Address, Phone:_____

Primary Insurance Information

Type: Health Insurance Workers Comp Auto/PIP Accident None/Self-Pay

Subscriber's Name:_____**Date of Birth**:_____
Address:_____SS#_____
Insurance Company:_____**Date of Accident**:_____
Address:_____Phone#_____
Group/Claim #_____Policy/ID#_____
Case Manager:_____Phone #_____

Secondary Insurance Information

Type: Health Insurance Workers Comp Auto/PIP Accident None/Self-Pay

Subscriber's Name:_____**Date of Birth**:_____
Address:_____SS#_____
Insurance Company:_____**Date of Accident**:_____
Address:_____Phone#_____
Group/Claim #_____Policy/ID#_____
Case Manager:_____Phone #_____

INITIAL PATIENT INTAKE

PATIENT NAME:_____ **DOB**__/_____/_____ **DATE:** _____

Chief Complaint:_____

Is Your Pain From an Auto or Worker Comp Accident? **YES / NO**

Initial Pain Level (0-10): 0 1 2 3 4 5 6 7 8 9 10 **How often is your pain present?** Occasional Frequent Constant

What makes symptoms worse?

Walking_____ Standing _____ Sitting_____ Lying Down_____

What makes symptoms better?

Walking_____ Standing_____ Sitting_____ Lying Down_____

Medical History:

- **Patient Medical History:**

			Previous Hospitalizations/Surgeries	**When?**
Diabetes	No	Yes		
Blood Pressure	No	Yes		
Asthma/COPD	No	Yes		
Stroke	No	Yes		
Heart Problems	No	Yes		
Kidney Problems	No	Yes	**Current Medications:**	
Seizure disorders	No	Yes		
Bleeding/Clotting	No	Yes		
Liver/Hepititis	No	Yes		
Sleep Apnea	No	Yes		
Cancer	No	Yes		
Thyroid	No	Yes		

ALLERGIES

Latex Yes / No

Dye Yes / No

Other Medication Allergies

_____

_____

_____

_____

_____

_____

_____

_____

- **Patient Social History:** **Occupation:**_____ **Full time Part time** (circle one)

Marital status: Single_____ Married _____ Separated_____ Divorced_____ Widowed_____

Use of alcohol: Never_____ Rarely_____ Moderate_____ Daily_____

Use of tobacco: Never_____ Previously, but quit_____ Current packs/day_____

Use of drugs Never_____ Type/Frequency_____

- **Family Medical History, if pertinent:**

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Children	_____	_____	_____

Do you have an immediate family member or close friend with history of illegal drug use or alcohol addiction? Yes / No

- **Please check off if any current problems in any of the following areas:**

____General Wellness	____Lungs/Breathing	____Neurological	____Chest pain	____Reproductive/Urinary
____Headaches	____Fatigue	____Skin	____Thyroid Endocrine	____Trouble Sleeping
____Nausea	____Ears, Nose, Throat	____Blood/Lymph	____Memory	____Ringing in Ears
____Stomach/Digestion	____Psychiatric	____Dizziness	____Muscles/Joints/Bones	Eyes

If any of above areas are checked, please explain: _____

Previous back/neck pain history? _____

Do you experience weakness or numbness? ( ) Yes ( ) No

Do you experience pain at night? ( ) Yes ( ) No

Does cough, sneeze or strain increase pain? ( ) Yes ( ) No

Do you experience loss of bowel or bladder control? ( ) Yes ( ) No

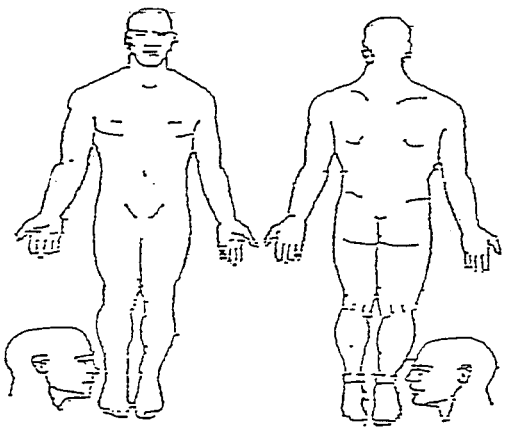
Recent weight loss, how much? _____

Previous treatment? Please CIRCLE any of the following you have had:

Physical Therapy Chiropractic Treatments

Anti-Inflammatory Medications Nerve Blocks/Injections

MRI CT SCAN X-RAYS EMG



Indicate the location of your pain

Patient Signature: _____

Spine and Pain Centers

Patient Name:_____ **DOB**____/____/____

PAYMENT AUTHORIZATION FORM

For and in consideration of services rendered, I agree to make payment to Spine and Pain Centers when billed for any and all charges not covered by valid insurance benefits. I authorize payment directly to Spine and Pain Centers for health insurance benefits payable to me under terms of my policy but not to exceed the balance due for services performed during this period of treatment. Spine and Pain Centers may seek, release and verify all or part of my medical and/or financial records to any person, corporation or government agency which is or maybe liable under a statute, regulation or contract to Spine and Pain Centers, myself, a family member or my employer for all or part of the Spine and Pain Centers charge.

If any of the following changes: patient's address, patient's phone number, patient's insurance information or any other information necessary for Spine and Pain Centers process your medical bill, the patient must inform Spine and Pain Centers promptly.

In the event the provider's charges are outstanding, I hereby authorize the provider to file such claim and/or action on my behalf so that the provider may receive payment of their charges. I understand that, if the provider does not receive payment from the insurer, I remain personally responsible for payment of the provider's charges.

Medicare – Authorization to release information and payment request:
I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to this or a related Medicare claim. I request that direct payment of authorized benefits be made on my behalf. I assign benefits payable for physician's services to the physician or organization furnishing the services or authorize such payment or organization to submit a claim to Medicare for payment.

Please check the appropriate box: (MEDICARE CERTIFICATION)

I am entitled to benefits under Medicare Hospital Insurance, Part A.

YES _____ NO _____

I am entitled to benefits under Medicare Hospital Insurance, Part B.

YES _____ NO _____

_____ _____

Date Signature

Spine and Pain Centers

Authorization of Designated Representative to Appeal a Determination

Date: _____

Patient Name: _____

Insured ID #:_____

I hereby authorize Spine and Pain Centers, as my designated representative, to appeal to my insurance

company,_____, on my behalf, in the determination of
(Please print the name of insurance company)

services rendered by _____, and as part of the appeal, I hereby
(doctor you are seeing today)

authorize _____ to disclose and furnish to my
(Please print the name of insurance company)

designated representative, Spine and Pain Centers, the following information:

All medical and financial information contained in my insurance file. I understand this information is privileged and confidential.

Patient Name:_____

Patient Signature:_____ Date:_____

_____

Signature of Spine and Pain Centers Representative

Spine & Pain Centers

Public law/rule of the State of New Jersey/Board of Medical Examiners mandates that a physician, podiatrist and all other licensees of the Board of Medical Examiners inform patients of any significant financial interest held in a health care service.

Accordingly, take notice that Drs. Sharma and Daknis have a financial interest in the following health care facilities to which patients are referred: Shrewsbury Surgical Center, Toms River Surgical Center, Physician's Surgical Center, Metropolitan Surgical Institute and SurgiCare Surgical Associates of Freehold.

In addition, take notice that these facilities contract individually with most insurance companies but might not participate with your health insurance company therefore you might be utilizing your out-of-network benefits. If you have questions regarding this coverage please contact the surgical facility directly.

You may, of course, seek treatment at a health care service provider of your own choice. A listing of alternative health care service providers can be found in the classified section of your telephone directory under the appropriate heading.

X_____

Patient Signature

_____

Patient Name

Spine and Pain Centers

Patient Name:_____ DOB_____/_____/_____

Please initial where applicable and sign at the bottom that you understand your responsibilities:

It is your responsibility to make sure that your accident insurance company has authorized your office visit. If your insurance company does not pay for the visit, you will be held accountable for the entire charge.

_____

It is **your responsibility** to adhere to all of the regulations and requirements of **your health plan,** in or out of network. If your health plan requires you to obtain a written referral and/or authorization number from your Primary Care Doctor for your office visit, **you must supply us with the referral/auth number**. If you do not, **you will be responsible for the entire charge of the office visit**. This is a rule of the Health Plan that you selected. We will help you when able but ultimately **this is your responsibility**.

_____

Patient's Signature _____

Date _____

Spine and Pain Centers
Patient Portal
Authorization Form

Please issue a username and temporary password for access to the patient portal at Spine and Pain Centers to

Patient Name:_____

DOB:_____

Social Security:_____

E-Mail Address:_____

Patient's Signature:_____

Your username and temporary password will be emailed to you at the address listed above.

SPINE AND PAIN CENTERS
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____
Please print your name here

_____ _____/_____/_____
Signature Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

The patient refused to sign.
Due to an emergency situation it was not possible to obtain an acknowledgement.
We weren't able to communicate with the patient.
Other_____

_____ _____/_____/_____
Employee Signature Date

I wish to be contacted in the following manner (check all that apply)

Home Phone #_____

OK to leave message with detail information
Leave message with call-back number only

Written Communication

OK to email to my email address

Cell/Other Telphone#_____

OK to leave message with detail information
Leave message with call-back number only

Persons authorized to receive information

_____relationship_____

_____relationship_____

_____ _____ _____/_____/_____
Printed Name **Patient Signature** **Date**

SPINE AND PAIN CENTERS
CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

Patient' s Name:_____

Patient's Date of Birth:_____ Patient's SSN:_____

Notice to Patient:
By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of **treatment**, various activities associated with **payment** and **health care operations**. Our **Notice of Privacy Practices** provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our **Notice of Privacy Practices**, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to **revoke** your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you.

You are entitled to a copy of this **Consent Form** after you have signed it.

(To Be Completed by Patient or Patient's Representative)

I, _____, have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

_____ _____
Patient's Signature or Signature of Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient

Our Privacy Officer can be contacted as follows:

Angela Kosh

1430 Hooper Ave, Suite 202
Toms River, NJ 08753

Phone: 732-345-1180 Fax: 732-530-4476 E-Mail: asalone@spineandpain.com

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on September 23, 2013 and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer. Information on contacting us can be found at the end of this notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share our protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other healthcare professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you my also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer.

Right to request Restriction of PHI: If you pay full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013. The Omnibus Rule restricts provider's refusal of an individuals request to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.
Required by Law: We may use or disclose your health information when we are required to do so by law (Court or administrative orders, subpoena, discovery request or other lawful process).
We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.
National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to our health or safety or that of others.
Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, and disease /infection exposure and to prevent and control disease, injury and/or disability.
Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.
Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.
Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting pain in exchange for the PHI). "Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or fee otherwise expressly permitted by law. Corporate transactions (i.e. sale, transfer, merger, consolidation) are also excluded from the definition of "sale."
Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.
Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). We will provide access to health information in a form/format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records.
Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.
Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a complaint form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

Spine and Pain Centers
Angela Kosh, Privacy Officer
732-345-1180 ext. 207
asalone@spineandpain.com
655 Shrewsbury Ave
Shrewsbury, NJ 07702