Physical Medicine and Pain Center
34 Scotch Road, Ewing NJ 08628
Phone: 609-883-0614 Fax: 609-883-7879

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Dr. Rosenberg and his staff are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect and how and when we use to disclose that information. It also describes your rights as they relate to your protected health information which does not include Independent Medical Examination (IME's). This applies to all protected health information as defined by federal regulations.

HIPAA NOTICE TO PATIENT

If you are a patient seeking treatment for injuries from Physical Medicine and Pain Center, or a patient receiving medical treatment for injuries fro the Physical Medicine and Pain Center, you are entitled to the following rights under a Federal Public low Known as the Health Insurance Portability and Accountability Act of 1996, Pub. L No. 104-191 (HIPPA) and accompanying Federal regulations known as the Privacy Rule.

If, however, the purpose of your visit to the Physical Medicine and Pain Center is for an Independent Medical Evaluation (IME) at the request of your insurer because you have made a claim for benefits with an insurance company, you are not a patient seeking treatment from Physical Medicine and Pain Center but rather an insured undergoing a medical evaluation to be conducted by a physician performing evaluative services at the request of the insurer, and you are therefore not entitled to the protections of HIPPA as set forth below.

WHAT HIPAA MEANS TO YOU

HIPAA IS DESIGNED TO ENSURE THAT INFORMATION ABOUT YOUR MEDICAL RECORDS (Protected Health Information) shall not be disclosed by Physical Medicine and Pain Center to any party without your authorization unless we disclose it for the following governmentally approved purposes. We may lawfully disclose your medical records to: a business associate performing physician services, such as a laboratory performing tests, an MRI facility, a referring physician, etc., to assist us, and/or to assist other physicians with whom you are, or will be, treating, in determining a diagnosis and/or which medical services should be rendered on your behalf, provided that the business associate executes and agreement with us that business associate will also not disclose your Protected Health Information except as in accordance with HIPP; We may lawfully disclose your Protected Health Information to assist us in obtaining payment for services we render on your behalf from your insurer or other payor; We may also disclose your Protected Health Information in order to assist us in improving the services we render by assessing the care and outcome in your case and comparing the results with other like or similar cases.

Additionally, there are (potential) disclosures or your Protected Health Information to parties that (if requested) we are, or we may be, required by law, under certain circumstances, to make, to the following types of parties: To the Food and Drug Administration, the Secretary of the Department of Health and Human Services, and other applicable public health agency, your Workers Compensation insure, law enforcement agencies, correctional facilities, authorized family members and funeral directors.

While your (physical) file is the property of Physical Medicine and Pain Center, you have the right to inspect and obtain a copy of your file, provided you pay Physical Medicine and Pain Center a photocopy charge of $1.00 per page in accordance with Medicare standards; you have the right to request a restriction or restriction(s) on contain uses and disclosure of the information contained in your file; You have the right to obtain an accounting from Physical Medicine and Pain Center of its disclosures of your health information; You have the right to revoke your authorization to use to disclose health information except to the extent hat action has already been taken; You have the right to request communication of your health information by alternative means or at alternative locations; You have the right to obtain a paper copy of Physical Medicine and Pain Center's notice of information practices upon request.

We must notify you if we cannot agree to a requested restriction you make on certain uses and disclosure of your information, except to the extent you are already on notice that we would be prohibited by operation of Federal or State of County Law as set forth above in this notice from complying with your request.

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Patient Name: _____ Date of Birth: _____Age:_____
Referring Doctor: _____ Family Doctor: _____
Reason for Today's visit: _____
_____
How long have you had this problem? (Days, weeks, months, etc)_____
What makes it better or worse? (Include any prior medical treatments, medications, physical therapy injections, etc)_____
_____
_____
Are you allergic to any drugs? Yes or No If *yes, please list those drugs below*
1._____Reaction_____
2._____Reaction_____
3._____Reaction_____

List all current medication and dosages and over the counter medications:
1._____2._____
3._____ 4._____
5._____ 6._____

<u>Past Medical History</u> (Please check all that apply to you):

☐High blood pressure	☐Coronary artery disease	☐Vascular disease	☐Diabetes
☐Heart disease/attack	☐Congestive heart failure	☐Thyroid disease	☐Emphysema
☐Lyme disease	☐Bleeding disorder	☐Seizures	☐Gastric reflux
☐Multiple Sclerosis	☐Enlarged prostate	☐Hepatitis	☐Liver disease
☐Osteoarthritis	☐Rheumatoid arthritis	☐Stomach ulcers	☐Kidney disease
☐Asthma	☐COPD	☐Cancer	☐Scoliosis

Please list any medical conditions you may have not mentioned above:_____
_____

<u>Past Surgical History</u> (Please check all that applies to you and list the date of surgery)

☐Knee arthroscopy (rt/ft)	☐Shoulder arthroscopy (rt/ft)
☐Spine surgery (neck/back)	☐Joint replacement
☐Hernia repair	☐Laparotomy
☐Eye	☐Thyroid
☐Peripheral bypass	☐Cardiac catheterization
☐Coronary arteries bypass graft	☐Hysterectomy

Please list any other surgery you may have had in the past not listed above: _____
_____

<u>Family History</u>: (Please check all that apply to your family)

☐Bleeding disorder	☐Coronary artery disease	☐Hepatitis	☐Cancer
☐Heart Disease/Attacks	☐Seizures	☐Lung Disease	☐Rheumatoid arthritis
☐Kidney disease	☐Malignant hyperthermia	☐Scoliosis	☐Asthma

Please list any other disease that a member of your family may have that is not listed above: _____
_____

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Social History: **Single / Married / Widowed/ Divorced / Separated**

☐ **Do you smoke? (How much/how long)** **Yes** **No**

☐ **Do you drink Alcohol? (How many per wk)** **Yes** **No**
Social occasions only **Yes** **No**

☐ **Have you ever used IV drugs?** **Yes** **No**

Occupation: _____

Sports: **Golf** **Tennis** **Football** **Soccer** **Baseball** **Basketball**

List any other sports you do: _____

Please check any of the following symptoms that you've experienced recently:

Constitutional	**☐Fever**	**☐ Night sweats**	**☐Weight loss**
Eyes	**☐Red eyes**	**☐ Blurring vision**	**☐Vision loss**
Ears/Nose/Mouth	**☐Nose bleeds**	**☐ Soar throat**	**☐Hearing loss**
Cardiovascular	**☐Chest pain**	**☐ Palpitations**	**☐Leg swelling**
Respiratory	**☐Shortness of breath**	**☐ Chronic cough**	**☐Wheezing**
Gastrointestinal	**☐Nausea**	**☐ Vomiting**	**☐Diarrhea**
Genitourinary	**☐Burning/urination**	**☐ Blood in urine**	**☐Urinary incontinence**
Skin	**☐ Rash**	**☐ Hives**	**☐Skin infection**
Neurological	**☐Headache**	**☐ Tremor**	**☐Seizures**
Psychiatric	**☐Depression**	**☐ Panic attacks**	**☐Suicidal ideation**
Endocrine	**☐Excessive thirst**	**☐ Cold intolerance**	**☐Excessive sweating**
Hematological/Lymph	**☐Easy bruising**	**☐ Swollen glands**	**☐Easy bleeding**
Allergy/Immune	**☐Runny nose**	**☐ Sinus congestion**	**☐Itchy eyes**

Please describe in detail the symptoms and treatment you have related to the problems checked above:

_____
_____
_____

Patient Signature:
_____**Date**_____

Reviewed by Physician:
_____**Date**_____

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ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE AND DESIGNATION OF DISCLOSURE

1. **Acknowledgement of Practice's Notice of HIPAA Privacy**:
   I have received a copy of the Notice of HIPAA for Physical Medicine and Pain Center.

   _____ _____ _____ _____
   Name of Patient | Date of Birth | Signature of Patient/Parent/Guarding | Date

2. **Designation of Certain Relatives, Close Friends and Other Caregivers**:
   I agree that the practice may disclose certain of my health information to a family member, close personal friend or other caregiver, since such person is involved with my health care to payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care. I wish to be contacted in the follow manner (check all that apply):

   Telephone, Cell Phone, Written or Fax Communication

   Home Telephone Number_____
   Cell Phone Number _____
   Work Telephone Number_____

   ☐ OK to leave message with detailed information ☐ Leave message with call back numbers only

   Written Communication

   ☐ Ok to mail to my home address ☐ Ok to mail to my work/office address

   Fax Communication

   ☐ OK to fax to this number: _____

I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of the practices making the limited discourse described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

Print Name _____Last four digits of his/hers SS number required_____
Print Name _____Last four digits of his/hers SS number required_____
Print Name _____Last four digits of his/hers SS number required_____
Print Name _____Last four digits of his/hers SS number required_____

The following person(s) are not authorized to receive my Patient Health Information:
Print Name _____Print Name_____

_____ _____
Signature of Patient/Parent/Guardian | Date

The Privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and request fro, Patient Health Information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the patient/parent/guardian. Healthcare entities must keep a record of Patient Health Information disclosures. Information provided below will constitute an adequate record. Uses and disclosures for Treatment, Payment, and Health Care Operations may be permitted without prior consent.

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Patient Name: _____Date of Birth: _____Age: _____M_____F_____

Mailing Address: _____

Social Security# _____Home Phone #_____Cell #_____

Employer: _____Address:_____

Employer's Phone# _____Supervisor or Case manager: _____
Primary Care Physician: _____Address_____ Phone_____

REASON FOR VISIT – WAS THIS INJURY RELATED TO:

□ WORK RELATED □ AUTO RELATED □ HOME RELATED

INSURANCE INFORMATION

Insurance
Company Name: _____ Type: □ **Workers Compensation** □ Medical
□ Auto □ Home Owner's □ other

Company's Address_____

ID#_____**Group #**_____**Claim #**_____

Subscriber Name:_____**Subscriber DOB**_____**Relation to Subscriber**_____

Coverage effective Date:_____**Date of Injury:**_____

GUARANTOR INFORMATION (FOR MINORS, SPOUSE OR GUARDIAN)

Responsible Party:_____Responsible party SS_____DOB_____

Address_____Telephone#_____

Employer:_____Relationship to Patient_____

In Case of Emergency Notify: Name:_____Telephone#_____

How were you referred to our office?

□ Physician_____□Family/Friend_____
□Insurance Co._____ □Employer_____□Other_____

I hereby acknowledge that I am responsible for obtaining required pre-approval/referral managed care authorization prior to services being rendered to me. I hereby acknowledge that I am financially responsible for any unpaid balance and pending account past 30 days. I give and assign you, Physical Medicine and Pain Center, the right to ask, demand and collect and receive payment for my medical bills from such insurer or from such other sources as may be obligated for payment. I understand that the assignment of these rights by me does not obligate my physician(s) and Physical Medicine and Pain Center to take any action to collect or receive payment from an insurer or other source and I understand that any outstanding balance that my insurance does not cover is my absolute responsibility. This responsibility can only be changed if a prior arrangement was made in writhing by Physical Medicine and Pain Center.

It is hereby understood that if I falsify and information on this sheet, the balance will then become my full responsibility deemed payable upon demand. It is hereby understood that I am responsible for all deductibles, co-payments, co-insurance and/or services not covered by my insurance plan at the time such services are rendered. It is hereby understood and agreed that I will be responsible for an administrative charge of 2% per month that may be imposed on my bill for any unpaid balance beginning thirty (30) days after receipt of services. It is further understood and agreed that in the event Physical Medicine and Pain Center is forced to take legal action to collect any unpaid balance, that I will be responsible for paying Physical Medicine and Pain Centers for reasonable attorney fees, costs and interest associated with any and all legal actions as a result of the unpaid balance.

Signed: _____Date_____

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PATIENT INFORMED CONSENT AND MEDICATION ACCEPTANCE

I understand that you are prescribing a controlled substance for me for treatment of a medical problem. I will inform you of ANY drugs prescribed for me by another health provider.

Various controlled substances can relieve pain, anxiety, depression, sleep disorders, eating disorders, muscle spasm and certain attention/concentration disorders. These medications may improve certain physical and/or mental discomfort.

When taken without an examination and without a justified medical need, these medications may cause a sense of euphoria, or well-being that may lead to a physical or psychological "liking" for the drug. This may cause a dependence on the drug, meaning that abrupt withdrawal or cessation of that substance can result in conditions ranging from slight discomfort to serious side effects.

The use of these drugs alone or in combination with other prescriptions or substances such as alcohol, antihistamines, nicotine and other over the counter (non-prescription) products as well including nutritional and dietary supplements can cause significant heightened or reduced effects. These may also affect my ability to operate a vehicle or dangerous equipment. After a trial period, these side effects may not be present nor cause any unusual events.

I understand that these drugs are to be taken only by me and according to my individualized instructions on the label. My supply of these medications will be kept in a safe palace and away from children; I will carry only enough doses with me for the time I will be away from home. Lost, forgotten or stolen drugs will not be replaced or reordered. I will protect my medications as I would other personal valuables such as jewelry, checkbook or credit cards.

My prescription for any of these classes of drugs is meant to enhance my comfort and well-being and will be discontinued when it is medically prudent. I also agree to random drug testing at the discretion of the physician. I have read and discussed this information with you and fully understand its meaning.

_____ _____

Patient Signature Physician Signature

_____ _____

Phone Number and Date Witness

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INFORMED CONSENT

I understand that the use of opioid analgesics can be safe and effective treatment for my chronic pain. I also understand that there exists a risk of developing an addiction disorder; however, I also understand that is extremely rare in patients who have no prior addiction history.

I WILL NOT increase my dosage unless I discuss this with my physician first, and he or she advises me to do so.

I WILL NOT give, lend, share, sell or transfer my medication to anyone else. Likewise, I will not receive, borrow or purchase additional opioid analgesics from anyone who is not a healthcare provider.

If any of my medication is lost or stolen, I will report this to the local police department and obtain a stolen/missing item report.

I WILL NOT alter my prescription in any way.

I have no history of substance (drug or alcohol) abuse. If I previously or concurrently use drugs or alcohol, I have brought it to my physician's attention.

I WILL agree to random urine/serum (blood) drug testing if and when requested.

IF I VIOLATE THIS AGREEMENT, MY DRUG THERAPY WILL BE TERMINATED AND I WILL BE RELEASED FROM MEDICAL CARE WITH:

Physical Medicine and Pain Center

Patient Name_____Date_____

Patient Signature: _____

Witness: _____

Pharmacy Name and Town_____

Physician Obtaining Consent: _____

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General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:
Patient Name:_____
Address:_____
_____
Phone:_____SSN_____Date of Birth_____

I authorize Physical Medicine and Pain Center to disclose/release the following information:

□ All Records
□ Laboratory/pathology records
□ X-ray/radiology records
□ Billing records
□Abstract/Summary
□Pharmacy/prescription records
□ Describe specifically_____
_____

****NOTE**** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

Please send the records listed above to:

Name:_____
Address_____
_____
Phone:_____
Fax:_____

Name:_____
Address:_____
_____
Phone:_____
Fax:_____

The information may be used / disclosed for each of the following purposes:

□ At my request (only patient can check this box)
□ For my health care
□ For Payment / insurance
□ Employment purposes
□ Other_____
_____

This authorization may not be valid for grater than one year from date of signature.
I understand that after the discloser my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment receive payment, or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use of disclosure of this protected health information.

_____ _____
Signature of patient or Patients personal representative Date

Representative's authority to sign for patient_____

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Assignment of Benefits Form

Patient Name:_____Date_____

I assign to Physical Medicine and Pain Center all my rights and benefits under any insurance contracts for payment for services rendered to me by Physical Medicine and Pain Center.

I authorize all information regarding my benefits under any insurance policy relating to any claims by Physical Medicine and Pain Center to be released to Physical Medicine and Pain Center.

I authorize Physical Medicine and Pain Center to file insurance claims on my behalf for services rendered to me. I irrevocably direct that all such payments go directly to Physical Medicine and Pain Center, 34 Scotch Road, Ewing NJ 08628.

I authorize Physical Medicine and Pain Center to act on my behalf and report any suspected violation of proper claims practices to the proper regulatory authorities.

Patient Signature:_____

Date:_____

Witness:_____

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Medicare Assignment of Benefits

Patient Name_____Medicare ID_____

"I request that payment of authorized Medicare benefits be made to Physical Medicine and Pain Center for any services furnished me by the physician or supplier. 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 for related services. I understand that I have the right to request charges and eligibility to determine my financial obligation prior to any commitment of services.

Patient's Signature_____

Date_____