REGISTRATION INFORMATION NEW JERSEY PAIN MANAGEMENT

DATE_____ PHONE:_____ CELL:_____

PATIENT_____ DOB:_____
LAST FIRST MI

STREET ADDRESS:_____

CITY_____ST_____ZIP_____

SSN: _____SEX: ___M___F MARITAL STATUS__S__M__D/S___W

DATE OF ACCIDENT/INJURY_____ JOB____AUTO_____OTHER_____

REFERRING DOCTOR_____
NAME ADDRESS

EMAIL ADDRESS_____

EMERGENCY CONTACT:_____PHONE:_____

PATIENT EMPLOYER_____
BUSINESS ADDRESS_____OCCUPATION_____
BUSINESS PHONE_____

INSURANCE: PRIMARY COVERAGE_____

MEDICAL:_____ID#_____
ADDRESS_____PHONE_____
GROUP#:_____SUBSCRIBER_____

WORKER'S COMP CARRIER_____
ADDRESS_____
CLAIM #_____
CONTACT/ADJUSTOR_____PHONE#_____

MVA/AUTO INS. CARRIER_____
ADDRESS_____
CLAIM#_____PHONE#_____
ADJUSTOR_____

ATTORNEY_____PHONE#_____
ADDRESS_____

In consideration of services rendered or to be rendered to the above named patient, I hereby authorized payment directly to Dr. Sharon C. Worosilo, M.D. / The NJ Pain Management Institute of any and all insurance benefits to which I may otherwise be entitled for services rendered by the provider, but not to exceed the provider's regular charges for such services.

In the event the provider's charges are outstanding, I hereby authorized the provider to file such claim on my behalf, so that the provider may realized the payment of its charges. I understand that if the provider does not receive payment from the insurer, I am personally responsible for the payment of the provider's charges.

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, x-ray, physical findings, diagnosis, and prognosis. You are authorized to provide this information in accordance with the Personal Injury Benefits Law.

SIGNATURE_____ DATE_____
Relationship to Patient (if other than self)_____

PATIENT FORM

DATE:_____

NAME:_____

ANSWER ALL QUESTIONS, SIGN AND RETURN

I am _____(age) years old.
I heard about you from:_____
My family doctor is:
Name:_____
Address:_____
Phone: _____

Explain where your pain is (e.g., neck, back)._____
_____

My pain started (date you started having pain, e.g. since 1995, 2 months ago, April ,93)
_____

Check the ones that apply to your condition:

__1. My pain is related to arthritis
__2. Started after surgery
__3. Work related injury
__4. Injury related
___ 5. Auto Accident
___ 6. Cancer
___ 7. Other

I have had the following surgeries:__back/neck surgery _____ laminectomy ____discectomy ___fusion

Other Surgeries: _____

Select only ONE of the following:
____My pain is **LOCALIZED**. It does **NOT RADIATE**
____My pain is not localized. It **RADIATES**. (Explain where the pain starts and where it radiates to):
_____

My pain (choose only ONE):
__1. Has been getting worse
__2. Has been getting better
__3. Has stayed the same

My pain is:
___1. Mild
___2. Moderate
___3. Severe

I am in pain: (choose only ONE)
__1. All the time
__2. Most of the time(75%)
__3. Half of the time (50%)
__4. Some times (less than 25%)

My pain is: (choose ALL that apply)
___1. Sharp
__2. Throbbing
___3. Dull
__4. Shooting
___5. Burning
__6. Electric like
___7. Aching
__8. Numb like

My pain is worse: (choose only ONE)

___1. In the Morning
___2. At Night
___3. Not a particular time
___4. OTHER_____

In addition to the pain I experience: (choose ALL that apply)

___Numbness ___Tingling
___Weakness ___Increase sensitivity to touch
___Change in temperature ___Coldness

My pain feels worse with: (choose ALL that apply)

___1.Physical Activity ___2.Laying down ___3.Coughing ___4.Straining
___5.Standing ___6.Sitting ___7.Sneezing

My pain feels better with: (choose ALL that apply)

___1.Ice/Heat Application
___2.Standing
___3.Sitting
___4.Laying Down
___5.Activity

I have had: (circle ALL that apply)

X-rays MRI CT-Scan Bone Scan EMG conduction studies Myelogram

PRESCRIPTION medications_____
_____

ALLERGIES_____

Do you take any aspirin products? **YES** **NO**...If yes:_____

CIRCLE the treatments that apply and HOW MUCH they helped:

Motrin/Advil/Tylenol/Naprosyn	helped a lot	helped a little	did not help at all
Vicoden/Tylenol 3/ Percocet	helped a lot	helped a little	did not help at all
Neurontin/Lyrica	helped a lot	helped a little	did not help at all
Steroids	helped a lot	helped a little	did not help at all
Physical Therapy	helped a lot	helped a little	did not help at all
Chiropractic	helped a lot	helped a little	did not help at all
Accupuncture	helped a lot	helped a little	did not help at all
Psycotherapy	helped a lot	helped a little	did not help at all
Surgery	helped a lot	helped a little	did not help at all
Injectional Therapy	helped a lot	helped a little	did not help at all

EXPLAIN what kind and WHEN_____

Did you have any side effect or bad effect to any of the above treatments?_____
_____
_____

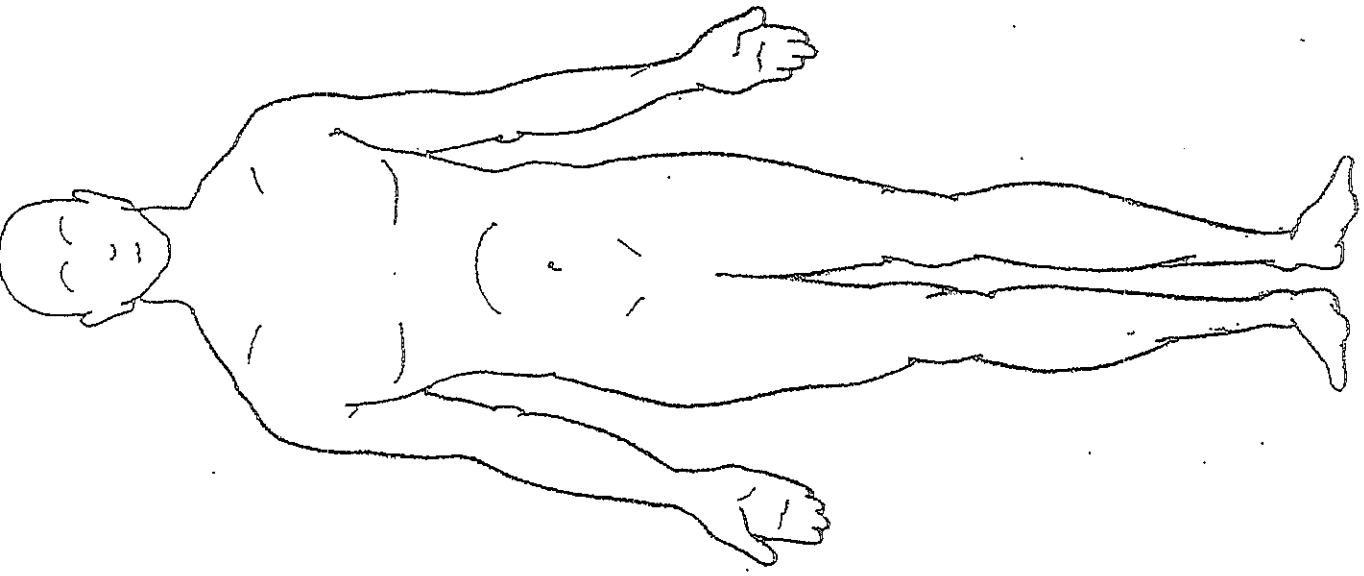
Do you have a history of ANY of the following: (check ALL that apply)

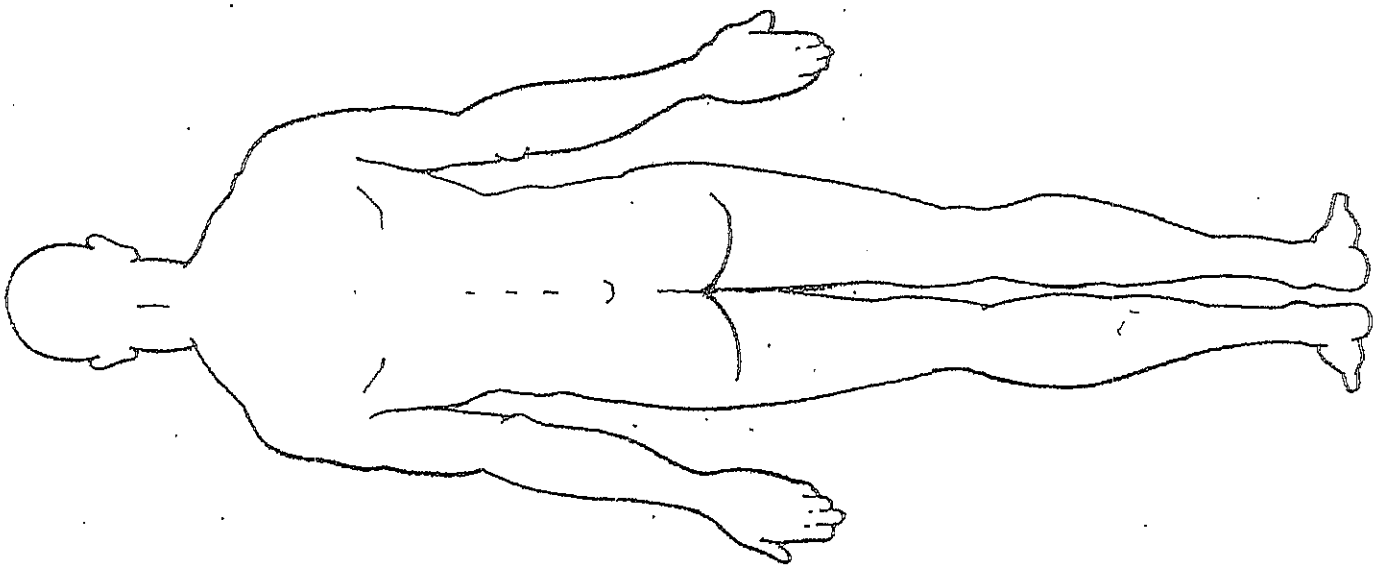
___Hypertension
___Angina (chest pain)
___Shortness of Breath
___Current Cough or Cold
___Pneumonia
___Asthma
___Bronchitis
___Emphysema
___Headache (how long) _____
___Stroke
___Seizures
___Jaundice
___Hepatitis
___Kidney Disease
___Reflux
___Diarrhea
___Diabetes
___Thyroid Condition
___Bleeding Disorders
___Anemia
___Arthritis
___HIV/Hepatitis

1. Have you ever had a heart attack? **YES NO**
2. Have you ever had any cardiac stenting? **YES NO**
3. Have you ever had a blood clot? **YES NO**
4. Have you ever had a stroke? **YES NO**

Anatomical Documentation Chart

Please indicate on the anatomical model where your pain is.





Patient Signature_____

Physician Signature_____

THE NEW JERSEY PAIN MANAGEMENT INSTITUTE
SHARON C. WOROSILO, M.D.
49 VERONICA AVE., SUITE 102
SOMERSET, NJ 08873

PATIENT'S BILL OF RIGHTS ACT

YOU have the right to respectful care, and to be treated respectfully.

YOU have the right to be informed about your diagnosis, to know what your treatment options are, and know what the potential outcomes of each treatment may be.

YOU have the right to know the names of those treating you.

YOU have the right to refuse treatment, as permitted by law. You can refuse treatment and still receive alternative care.

YOU have the right to privacy. No medical practitioner should ever release information about your condition or treatment to anyone, unless you give express consent to release information.
New Jersey Pain Management Institute will not discuss or release medical information without written authorization signed by the patient is given. Information will not be discussed with spouses or family members. The Privacy Act applies to EVERYONE!!!!!!!!

YOU have a right to review your medical records, and if necessary, have the information explained to you. You have the right to have an addendum attached to your notes and will become a part of your legal medical file. Please be advised that while this is your medical information, the chart is the property of the physician or facility and must be maintained as required by law.

YOU have a right to know what alternative medical care may be available to you.

YOU have the right to know what your treatment may cost you.

YOU are responsible for providing all information about your past car, illnesses and medications to your physician when she is trying to find the best possible treatment for you.

YOU are responsible for being considerate of the needs of others in the office.

YOU are responsible for providing all insurance information when requested, and following the requirements for your individual insurance plan fo seeking treatment with the Doctor.

Signature_____
Patients Name

Date_____

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BILLING AGREEMENT

In order to keep your cost of healthcare services to an absolute minimum we have adopted the following policy:

Insurance billing is done as a courtesy for our patients. However, it is the patients responsibility, not this office, to negotiate with their insurance carrier.

Patient or authorized guardian, must supply all information necessary to file a claim with the insurance company or employer.

All insurance benefits must be assigned so that payment is send directly to this office.

The patient must pay all required co-payments, deductibles or fees in full for non-covered services at time of service.

Any remaining balance after the insurance has met their portion of the obligation and that they state is patient responsibility is payable in thirty days. Any payment plans must be arranged and accepted by the billing manager. We reserve the right to cancel payment plan should you fail to pay. A $10.00 a month billing charge will be added to your balance. All balances must be paid in full within six (6) months. After six (6) months, a 35% collection and legal fee will be assessed on any unpaid balance, which is collected through the service of agency or lawyer. We accept Visa and Mastercard.

I hereby authorize payment directly for the professional services rendered and I shall be personally responsible for any unpaid balance to the provider. I authorize the release of any information needed for the insurance company to properly assess payment of the services.

_____

Patient Name

_____

Policy Holder/Authorized Guardian

_____

Witnessed

_____

Date

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SIGNATURE ON FILE

_____A. I authorize use of this form on **all** my insurance submissions.

_____B. I authorize release of information to all my **Insurance Companies**.

_____C. I understand that **I am responsible** for my bill.

_____D. I authorized my doctor to act as my agent in helping me obtain payment from my insurance companies.

_____E. I authorize payment directly to my doctor.

_____F. I authorize my physician to obtain any medical information, (records, IME Reports, etc) directly from my insurance company.

_____G. I permit a copy of this authorization to be used in place of the original.

Name:_____ Date:_____

Signature: _____

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PATIENT'S WITH COMMERCIAL INSURANCE

Please be aware, those patients with COMMERCIAL INSURANCE COMPANIES **(Blue Cross/Blue Shield, Aetna, Cigna, ETC.),** who have services rendered with the following provider, The New Jersey Pain Management Institute, may receive payment directly from the insurance company. In the event you receive the payment, please contact the office immediately at **732-745-7246** for further instructions.

I _____ have been informed that payment for services rendered by the above provider may be sent directly to me. I agree to forward these payments as soon as I receive the check (s). Failure to do so will result in collection activity.

_____ _____

Patient Signature **Date**