PPC PRIMARY PAIN CONSULTANTS

Rae Aranas, MD Interventional Spine and Pain Specialist
www.primarypain.com

27 Monroe Street, Bridgewater, NJ 08807

Phone: (908) 864-7725 Fax: (888) 874-5226

Today's Date:_____

Name: _____ Date of Birth:_____

Address: _____ Male ☐ Female ☐

City: _____State_____ Zip Code_____ Social Security # _____-____-____

Home Phone:_____ Cell Phone:_____

Email: _____

Who is your primary care doctor? _____ Primary doctor phone: _____

How were you referred to our practice? _____

Employment Information: Full-time ☐ Part-time ☐ N/A ☐ Employer Name:_____

Race: □Native American □Asian □Black □White □Refuse to Answer □Other

Preferred Language: □English □Spanish □Other

Ethnicity: □Hispanic □Non-Hispanic □Refuse to Answer

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Address (if different from above)_____

Phone Number: _____

HEALTH INSURANCE INFORMATION

PRIMARY Insurance Company Name: _____

Name of Insured: _____ DOB of Insured: _____

Member ID #: _____ Group #: _____

Relationship to insured: Self ___ Spouse ___ Child ___ Other ___

SECONDARY Insurance Company Name: _____

Name of Insured: _____ DOB of Insured: _____

Member ID #: _____ Group #: _____

Relationship to insured: Self ___ Spouse ___ Child ___ Other ___

FOR AUTO ACCIDENT RELATED INJURY

Auto Insurance Company Name: _____

Claim #: _____ Date of Accident: _____

Policy #: _____

Adjusters Name: _____ Phone Number: _____

FOR WORKER'S COMP:

Employer Name: _____ Date of Injury: _____

PLEASE FILL OUT IF APPLICABLE:

Attorney Name: _____ Attorney Phone Number: _____

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Patient Name:_____

CURRENT HISTORY:

1. What is the main reason for your visit today? (Check all that apply)

☐Back Pain ☐Neck Pain ☐Leg Pain ☐Arm Pain ☐Other:_____

2. How did your pain begin?☐

☐On the job ☐ After a fall ☐ I don't know when it began ☐☐ After a certain activity_____ ☐Motor Vehicle Accident (Date of Accident: _____)

3. How long has this been a problem?☐

☐Less than 2 months ☐2-6 months ☐6-12 months ☐greater than 1 year

☐I've had it a long time (about _____ years)

Please briefly describe the circumstances around your injury or onset of problem:

_____

_____

_____

_____

How does each of the following affect your pain? Please check.

Sitting	☐Better	☐Worse	☐No Change
Standing	☐Better	☐Worse	☐No Change
Walking	☐Better	☐Worse	☐No Change
Lying Down	☐Better	☐Worse	☐No Change
Rising from Chair	☐Better	☐Worse	☐No Change
Heat	☐Better	☐Worse	☐No Change
Cold/Ice	☐Better	☐Worse	☐No Change
Massage	☐Better	☐Worse	☐No Change
Physical Activity	☐Better	☐Worse	☐No Change

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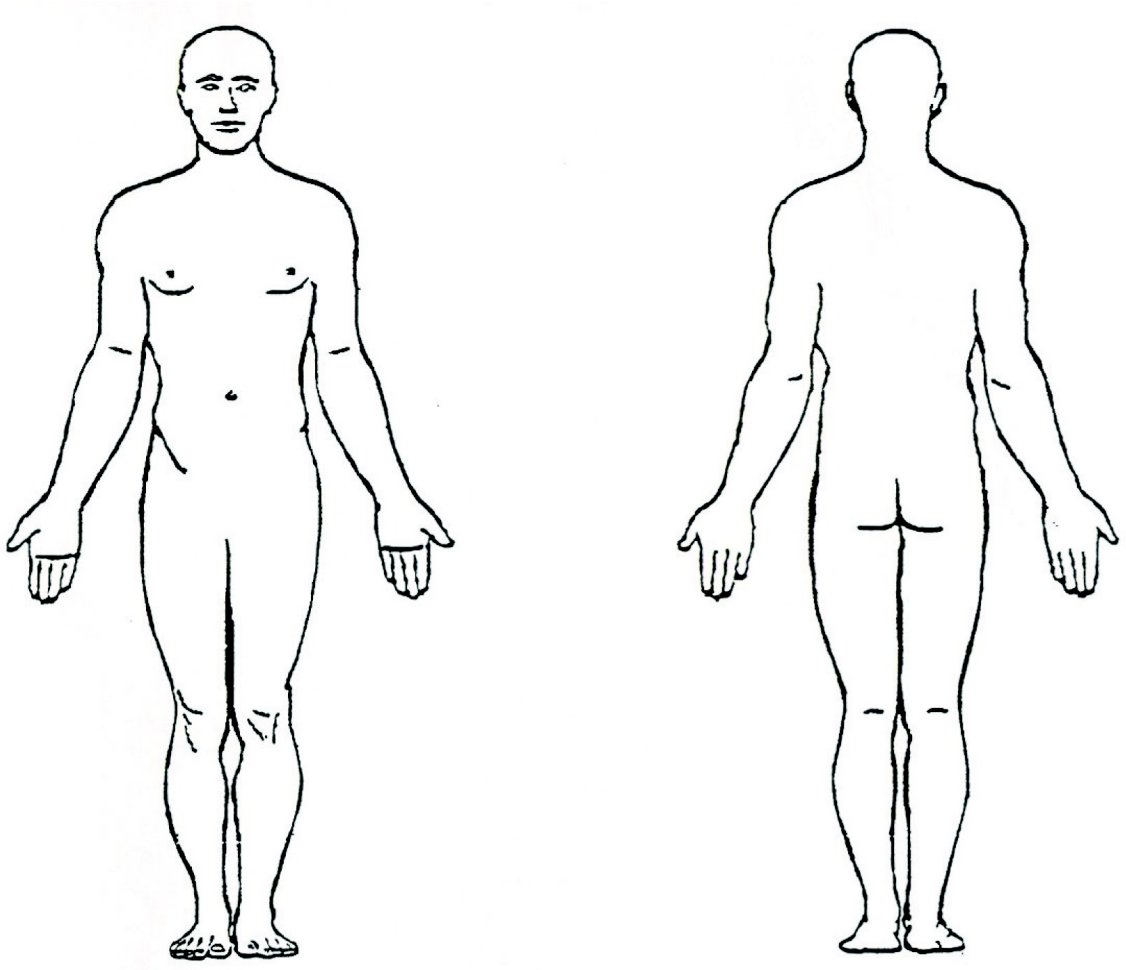
Patient Name:_____

Please mark these drawings according to where you are hurt or feel pain.
For example, if the right side of your neck hurts, mark the drawing on the right side of the neck.
Please indicate which sensations you feel by referring to the symbols below.

////STABBING ◆XXXX BURNING ◆++++ PINS & NEEDLES ◆OOOO NUMBNESS ◆^^^^ ACHING



Right Left Left Right

Do your affected areas have weakness? ☐Yes ☐No If yes, where?

Arm ☐Right ☐Left Hand ☐Right ☐Left Leg ☐Right ☐Left Foot ☐Right ☐Left

Other: _____

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Patient Name:_____

On a scale of 0-10 (10 being the worst) what is your AVERAGE pain level?:

Low Back Pain: _____

Right Leg Pain: _____

Left Leg Pain: _____

Right Buttock Pain: _____

Left Buttock Pain: _____

Middle Back Pain: _____

Neck Pain: _____

Right Arm Pain: _____

Left Arm Pain: _____

PAIN LEVEL	**No Pain**	0
	Mild	1-3
	Moderate	4-6
	Severe	7-9
	Excruciating	10

Height: _____

Weight: _____

Please circle your overall pain level TODAY from 0-10:
0 1 2 3 4 5 6 7 8 9 10

Please circle your LOWEST pain level in the past week from 0-10:
0 1 2 3 4 5 6 7 8 9 10

Please circle your HIGHEST pain level in the past week from 0-10:
0 1 2 3 4 5 6 7 8 9 10

Please circle how much your pain interfered with your activities this week from 0-10:
0 1 2 3 4 5 6 7 8 9 10

Is your pain worse at night? ☐Yes ☐No

Does your pain wake you up at from sleep? ☐Yes ☐No

Does coughing affect your pain? ☐Yes ☐No

Do your legs tire/hurt if you walk too far? ☐Yes ☐No

How far can you walk before symptoms begin? ☐Less than 1 block ☐1-3 blocks ☐more than 3 blocks

Bladder control: ☐No problem ☐Can't empty bladder ☐Loss of urine (accidents)

Bowel control: ☐No problem ☐Constipation ☐Loss of control (accidents)

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Patient Name:_____

Please list the physicians you have treated with and when:

Primary care:	_____	Phone:_____	Date:_____
Chiropractor:	_____	Phone:_____	Date:_____
Pain Management:	_____	Phone:_____	Date:_____
Spine Surgeon:	_____	Phone:_____	Date:_____
Orthopedic:	_____	Phone:_____	Date:_____
Physical Therapy:	_____	Phone:_____	Date:_____
Acupuncture:	_____	Phone:_____	Date:_____

Previous tests (check all that apply):

☐X-Ray ☐Discography ☐CAT Scan ☐CT/Myelogram ☐Bone Scan

☐MRI ☐Nerve Test (EMG/NCV) ☐Other_____

Please list all current medications: (Include over-the-counter and supplements)

Medication	Reason Taken	Dosage	Prescribing Doctor

Are you allergic to:

Medications: ☐Yes ☐No Latex: ☐Yes ☐No Contrast Dye: ☐Yes ☐No

If yes, please list allergies:

_____

_____

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Patient's Name:_____

PAST MEDICAL HISTORY

Conditions you have had in the past (check all that apply): □**NONE**

CARDIAC
- □ Heart Attack
- □ Coronary Artery Disease
- □ Heart Valve Disorder
- □ Arrhythmia
- □ High Blood Pressure
- □ Other_____

NEUROLOGICAL
- □ Multiple Sclerosis
- □ Seizures
- □ Headaches
- □ Migraines
- □ Other_____

PSYCHIATRIC
- □ Depression
- □ Anxiety
- □ Schizophrenia
- □ Bipolar Disorder
- □ Other_____

VASCULAR
- □ Stroke/ TIA
- □ Peripheral Vascular Disease
- □ Migraines
- □ Mitral Valve Prolapse
- □ Other_____

RENAL
- □ Kidney Disease
- □ Kidney Stones
- □ Urinary Incontinence
- □ Dialysis
- □ Other_____

RESPIRATORY
- □ Asthma
- □ COPD
- □ Other_____

GASTROINTESTINAL
- □ GI Bleeding
- □ Gastric Ulcer
- □ Acid Reflux
- □ Other_____

ENDOCRINE
- □ Hyperthyroidism
- □ Hypothyroidism
- □ Diabetes
- □ Other_____

CANCER (type)
_____
_____
_____

PAST SURGICAL HISTORY

Have you ever had a reaction to anesthesia?_____

Type of Surgery	Surgery Date

FAMILY HISTORY

Please list any significant family health history. (Heart attack, Lung Disease, Genetic Disease)

_____

_____

_____

_____

Patient's Name:_____

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SOCIAL HISTORY

Alcohol	Do you drink alcohol? _____	☐ Yes	☐ No	
	If yes, what kind? _____			
	How many drinks per week? _____			
Tobacco	Do you use tobacco?	☐ Yes	☐ No	
	☐ Cigarettes – packs/day ___ ☐ Chew - #/day___		☐ Pipe - #/day ___	☐ Cigars - #/day__
	☐ # of years_____		☐ **Or year quit**_____	
Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No	If so, what drug? _____
Have you ever used recreational or street drugs?		☐ Yes	☐ No	

Do you have any pending litigation? ☐ Lawsuit ☐Worker's Comp ☐ Disability Claim ☐S.S. Claim

REVIEW OF SYSTEMS

CONSTITUTIONAL
- ☐ Weight loss or gain
- ☐ Fever
- ☐ Fatigue
- ☐ Chills
- ☐ Night sweats

EYES
- ☐ Double vision
- ☐ Vision changes
- ☐ Cataracts
- ☐ Glaucoma

ENT/MOUTH
- ☐ Tooth pain
- ☐ Hearing loss
- ☐ Ringing ears
- ☐ Swallowing difficulties

NEURO
- ☐ Dizziness
- ☐ Lightheadedness
- ☐ Headache
- ☐ Balance problems

PSYCH
- ☐ Depression
- ☐ Mood swings
- ☐ Memory problems
- ☐ Anxiety

ENDO
- ☐ Excessive thirst
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Hot flashes

HEM/LYMPH
- ☐ Bruising
- ☐ Nosebleeds
- ☐ Lack of energy

GENITOURINARY
- ☐ Excessive urination
- ☐ Incontinence of urine
- ☐ Blood in urine
- ☐ Frequent bladder/kidney infections

MUSC/SKELETAL
- ☐ Difficulty walking
- ☐ Joint stiffness
- ☐ Muscle pains
- ☐ Pain during walking

GASTROINTESTINAL
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Acid reflux
- ☐ Incontinence of bowels
- ☐ Blood in stools

RESPIRATORY
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Persistent cough
- ☐ Asthma

CARDIOVASCULAR
- ☐ Palpitations
- ☐ Chest pain
- ☐ Swelling hands/ feet
- ☐ Irregular heart beat

SKIN
- ☐ Skin rashes
- ☐ Bruising
- ☐ Changes in skin lesions
- ☐ Wounds
- ☐ Ulcers

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Patient's Name:_____

Agreement and Assignment of Benefits

I have read and understand the financial policy of **Primary Pain Consultants**, and I agree to abide by its terms. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment to Primary Pain Consultants. I understand that I am financially responsible for all services I receive from Primary Pain Consultants. This financial policy is binding upon you and your estate, executors and/or administrators, if applicable.

Patient/Parent/Guardian or Legal Representative Signature Date

Patient/Parent/Guardian or Legal Representative (printed name)

Notice of Privacy Practices

I acknowledge that I have read and understand **Primary Pain Consultants'** Notice of Privacy Practices, which is available for public inspection at our facility. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

Patient/Parent/Guardian or Legal Representative Signature Date

Patient/Parent/Guardian or Legal Representative (printed name)

Primary Pain Consultants Assignment of Benefits Form

I,_____(Print Name) hereby authorize benefits to be assigned to **Primary Pain Consultants ("Provider")** for healthcare services provided to me by Provider. I hereby certify that the insurance information that I have provided Provider is true and accurate as of the date of service and that I am responsible for keeping it updated at all times. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that my medical bill is paid in full. I also understand that all fees and services are due and payable on the date services are rendered and agree to pay all such charges incurred I full immediately upon presentation of the appropriate statement unless other arrangements have been made in advance.

I hereby authorize Provider to submit claims on my behalf to the insurance company listed on the copy of the current insurance card I have provided Provider. I assign exclusive and irrevocable right to any cause of action that exists in my favor against any insurance company or other person or entity in an amount of recovery not to exceed the extent of my bill for services provided by Provider, including exclusive and irrevocable right to receive payment for such services, make demand in my name for payments and prosecute and receive penalties, interest, court costs and other legally compensable amounts owed by an insurance company or other person or entity. I further authorize Provider to request and receive, on my behalf, from any insurance company or health care plan, any and all information and documents pertaining to my policy/plan, including a copy of the same and any information or supporting documentation concerning the handling, calculation, processing or payment of claims as such documents are required by law or regulation to be presented to me. In addition, I agree to cooperate and provide information as needed and appear as needed to assist in the prosecution of such claims for benefits upon request by Provider.

I hereby irrevocably designate, authorize and appoint Provider as my true and lawful attorney-in-fact. This power of attorney is hereby provided for the limited purpose of receiving all payments due under my policy/medical care plan on account of medical services and care rendered or to be rendered by Provider. This power of attorney shall automatically terminate, without formal action being taken, as soon as Provider has received payment in full and remedies under applicable regulatory guidelines for all medical care services provided to me. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein.

I hereby instruct and direct my insurance company to pay Provider directly for medical services and care provided by Provider, and to provide to Provider any and all relevant information and documentation in connection with such payments and claims for payment. I understand that I have the right and authority to direct where payment for services rendered is sent. If my current policy prohibits direct payment to the provider of service, I instruct that the insurer make out the check to me and mail payment directly to Provider at **27 Monroe Street, Bridgewater, NJ, 08807** for the professional or medical expense benefits otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered by Provider. Upon receipt of said check, I authorize Provider to endorse such checks for deposit only, and to deposit and apply all the proceeds toward payment on my account.

I agree and understand that any funds I receive from my insurance company in connection with medical services and care rendered by Provider will be immediately signed over and sent directly to Provider. This is a direct assignment of my rights and benefits under my medical policy/plan. This payment will not exceed my indebtedness to Provider, and I agree to pay, in a timely manner, any balance of professional service charges over and above the payments made to Provider pursuant to this assignment of benefits.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize Provider to be my personal representative, which allows Provider to: (l) submit any and all appeals if and when my insurance company denies me benefits to which I am entitled, (2) submit any and all requests for benefit information from my insurance company, and (3) initiate formal complaints to any state or federal agency that has jurisdiction over my benefits. I fully understand and agree that I am responsible for full payment of the medical debt if my insurance company has refused to pay 100% of Provider's billed charges within ninety (90) days of any and all appeals or request for information. Should the account be referred to an attorney or outside agency for col lection, I agree to pay reasonable attorney's fees and collection expenses. All delinquent accounts bear interest at the legal rate. I also agree that any fines levied against my insurance company will be paid to Provider for acting as my personal representative.

A photocopy of this Assignment shall be considered as effective and valid as the original.

_____

Signature of Patient/Guarantor Date

_____

Signature of Policy Holder Date

_____

Signature of Witness Date

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CANCELLATION / NO SHOW / LATE ARRIVAL POLICY

We understand that unanticipated events occasionally happen in everyone's life. In our desire to be effective and fair to all patients, the following policies are honored:

No Shows & 24-Hour Cancellations:

When you make an appointment, we reserve a significant amount of time specifically for you. Unfortunately, when a patient doesn't show for their scheduled appointment, another patient loses an opportunity to be seen. Therefore, if you need to cancel or reschedule, please kindly notify us as soon as possible, preferably at least 24 hours in advance.

New Patients or patients who are scheduled for procedures must call 24 hours in advance to make any changes to their appointment. If at least 24-hour notice is not given prior to the scheduled appointment time, you will be subject to a fee. Without the proper amount of time of notification, you will be responsible for a fee in accordance with the schedule outlined below. No show and cancellation charges are not covered by insurance and are due payable prior to any appointments.

Fee Schedule

No Shows and cancellations of regular office visits less than 24 hours in advance	**$35**
No Shows and cancellations of procedures and new patient appointments less than 24 hours in advance	**$50**

LATE ARRIVALS:

Appointments are scheduled for the exact amount of time that your provider feels is necessary, which is why it is essential that you arrive on time. We require that you call our office to let us know that you will not be able to arrive on time *in advance of your scheduled time*. Depending on how late you arrive, your session may be shortened or canceled in order to accommodate other patients whose appointments follow yours. Out of respect and consideration to your provider and other patients, please plan accordingly and arrive on time. Thank you.

_____ _____

Patient/ Guardian name Date

_____

Patient/ Guardian signature

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CONTROLLED SUBSTANCE AGREEMENT

This agreement is a tool to protect both you and the physician by establishing guidelines, within the laws, for proper and controlled substance use. The words "we" and "our" refer to the facility and the words “I’, "you", and "me", or "my" refer to you, the patient.

1. All controlled substances must come from the physician whose signature appears below or, during his/her absence, by the covering physician, unless specific authorization is obtained for an exception. I understand that I must tell the physician whose signature appears below or, the covering physician, all drugs that I am taking, have purchased, or have obtained over the counter medications. Failure to do so may result in drug interactions or overdoses that could result in harm to me, including death. I will not seek prescriptions for controlled substances from any other physicians, healthcare provider or dentist.

2. Medication use must be specifically followed according to the doctor's recommendation and Controlled Substance Agreement. **NO REFILLS** will be given before proper expiration date and will only be given according to our guidelines. Our guidelines are as followed:

   - ALL controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies; our office must be informed.
   - Patients must provide 3 business days for the office to refill prescriptions.
   - Prescriptions cannot be mailed.
   - The Pharmacy you have selected is_____Phone:_____

3. You may not share, sell, or otherwise permit others, including spouse or family members, to have access to any controlled substances that you have been prescribed. Unannounced urine or serum toxicology specimens may be requested from you, and your cooperation is required. Presence of unauthorized substances in urine or serum toxicology screens may result in your discharge from this facility,
4. I will not consume excessive amounts of alcohol in conjunction with controlled substances. I will not use, purchase or otherwise obtain illegal drugs, including marijuana, cocaine, etc. I understand that driving while under the influence of any substance, including a prescribed controlled substance, or any combination substances (e.g. alcohol and prescription drugs), which impairs my driving ability, may result in DUI charges.
5. Medications or written prescriptions may not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, etc. IF your medication has been stolen it will not be replaced unless explicit proof is provided with direct evidence from authorities. A report narrating what you told authorities is not enough. Early refills will not be given. Renewals are based upon keeping scheduled appointments.
6. In the event you are arrested or incarcerated related to legal or illegal drugs, refills on controlled substances will not be given.
7. I UNDERSTAND that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribed by this physician and other physicians at the facility, and that law enforcement officials maybe be contacted. I affirm that I have full right and power to sign and be bound by this agreement, and that I have read it and understand and accept all of its terms. A copy of this document has been given to me.

Patient’s Name:_____ Date:_____

Patient’s Signature:_____ Witness Signature:_____