

Pain Specialist, PA
Seashore Ambulatory Surgery Center
1907 New Road
Northfield, NJ 08225

Last Name: _____ First Name: _____ Age: _____
Street Address: _____ City: _____ Zip: _____
Date of Birth: _____ Sex M or F Social Security #: _____ Married Yes or No
Home Phone: _____ Cell phone: _____ Work: _____
Employer: _____ Can we call you at work? _____
E-mail Address: _____

Insurance Information (ALL information must be filled out.)

If you have NO INSURANCE, please check here: _____

PLEASE PRINT ALL INFORMATION CLEARLY!

A) Is this a (circle one): Workman's Compensation OR Motor Vehicle Accident?

If this does not apply, please advance to section B

Date of accident or Injury: ____/____/____

Insurance Company: _____ Claim #: _____

Insurance Company Address: _____

Adjuster: _____ Adjuster Phone #: _____

Attorney: _____ Attorney's Phone #: _____

Address of attorney: _____

B) Primary Medical Insurance: *(Note if we do not participate with your insurance and you don't have out of network benefits, payment will be your responsibility. If referrals are needed, it is your responsibility to get them). If this is a workman's comp or motor vehicle accident we still need your primary medical information.*

Name of Insurance: _____ ID #: _____

Name of Subscriber: _____ SSN#: _____

Date of Birth: _____ Relationship to subscriber: _____

C) Secondary Medical Insurance:

Name of Insurance: _____ ID#: _____

Name of Subscriber: _____ SSN #: _____

Date of Birth: _____ Relationship to subscriber: _____

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Date: _____

Last Name: _____ First Name: _____

Height: _____ Weight: _____ Handed: RIGHT or LEFT

Occupation: _____

Primary Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

What have you been referred here for? _____

When did your pain start? _____ Is it related to a Car Accident or Work Injury: _____

Have you had X-Rays, MRIs, CAT scan, EMG or any other tests pertaining to this pain: _____

What did you have: _____

Where were they done: _____

Address: _____

CHIEF COMPLAINT

Where is your pain located? _____

What treatment have you had for your pain? (circle all that apply)

Acupuncture Chiropractic Surgery Physical Therapy Tens

Biofeedback Psychologist Pain Clinic Nerve Blocks

Other (please explain) _____

Please list all physicians you have seen for your pain (if any)

Name	Address	Phone
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Last Name: _____ **First Name:** _____ **Date:** _____

Please list all medications you have taken for your pain:

_____ Did it work? _____
_____ Did it work? _____
_____ Did it work? _____

Describe your pain in detail: (Constant, Intermittent, Dull, Sharp, Burning, Shooting, ETC)

What makes it worse: _____

What makes it better: _____

On a scale of 0 to 10 (0 = no pain and 10 = worst) how would you rate your pain at it's
baseline: _____ and when it is at it's worse: _____

How well are you coping with your pain? Place a mark on the line below.

Well ----- Poorly

Please indicate your level of functional limitation. Place a mark on the line below.

Unlimited ----- Very limited

Does the pain cause you sleep disturbance? _____

Do you think you have depression? _____

Do you think you have anxiety? _____

ADDITIONAL MEDICAL HISTORY

Check all that apply:

High Blood _____ Difficulty Breathing _____ Emphysema _____ Diabetes _____ Angina _____

Heart Disease _____ Asthma _____ Hepatitis _____ HIV _____ Other _____

Are you currently taking Aspirin or any other blood thinners? _____

Have you ever had a DEXA Scan to test your bone density? _____ When: _____

List allergies to any medications: _____

Last Name: _____ First Name: _____

Please list all surgical procedures that you have had: _____

SOCIAL HISTORY

All information provided will be kept confidential.

Do you smoke? YES or NO How much a day? _____

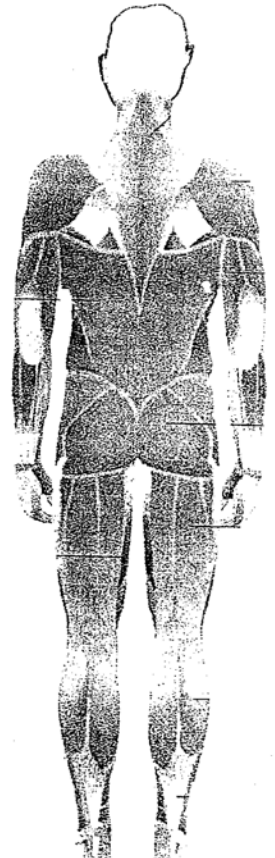
Do you drink alcohol YES or NO How much per day? _____

Do you use recreational drugs YES or NO How much per day? _____

Do you wish to stop any of the above? _____

Do you have any other personal health information we should be aware of? (urinary incontinence, impotence, premature ejaculation, lack of sexual interest, addiction to medication or substance abuse)

Place an "X" on the figure below where your pain starts and show with an arrow where it goes. If the pain covers a large area, shade the area.



PAIN SPECIALISTS, P.A.
Dr. Morris Antebi
TREATMENT AGREEMENT

This is an agreement between:

and Pain Specialists, P.A./Dr. Morris Antebi regarding the diagnosis of:

chronic pain

for which the following medication(s) have been prescribed (narcotics): _____

all prescribed scheduled or controlled substances

I understand that there are alternative treatments, which have been explained to me.

The goal of my therapy is to reduce my pain to a level that is tolerable and will allow me to improve my ability to perform daily activities. I understand that daily use of a narcotic increases certain risks, which include, but are not limited to:

- Addiction
- Allergic reactions, overdose, and/or fatal complications
- Breathing problems
- drowsiness, dizziness, and/or confusion
- Impaired judgment and inability to operate machines or drive motor vehicles
- Nausea, vomiting and/or constipation
- Development of tolerance

I agree to the following guidelines:

1. I will take this medication only as prescribed and I will not change the amount or frequency without authorization from my physician. Unauthorized changes may result in my running out of medication early, and early refills will not be allowed. (See #2)
2. I understand that due to the high potential for abuse of these medications, the following rules apply: I will **NOT** be allowed to obtain early refills or receive replacement for lost or stolen medication. Refills will only be provided during regular office hours.
3. I will obtain **ALL** of my prescriptions through: *Dr. Antebi and/or Associates* _____
and will fill **ALL** my prescriptions at (pharmacy name) _____
In an acute emergency, another prescriber may prescribe medications for me, if this occurs, I will notify my primary care physician or nurse practitioner as soon as possible.
4. I will submit to random urine or blood tests if requested by my physician or nurse practitioner to access my compliance.
5. I agree to see : _____ *Dr. Antebi and/or Associates* _____
And will keep regularly scheduled appointments as long as I am taking this narcotic medication.
6. If I do not follow these guidelines, I understand that my treatment may be terminated.

I have discussed these risks, benefits, and alternatives to narcotic treatment with my provider. I have had an opportunity to ask questions and receive answers to those questions to my satisfaction.

Patient Signature: _____ **Date:** _____

Physician/A.P.N. Signature: _____ **Date:** _____



PAIN SPECIALISTS, P.A.

MORRIS E. ANTEBI, M.D.

Medical Director
(609) 645-8884

**PLEASE BE AWARE WE ROUTINELY DRUG TEST ALL PATIENTS.
THERE WILL BE A CHARGE AT THE TIME OF TESTING OF \$30.00
PER TEST USED. FOR PATIENTS WHO HAVE INSURANCE, WE WILL
BILL YOUR INSURANCE COMPANY, HOWEVER IF THEY DO NOT
COVER THE CHARGE, IT WILL BE YOUR RESPONSIBILITY.
SERVICES WILL NOT BE RENDERED (INCLUDING PRISCRPTIONS)
IF YOU REFUSE TO TAKE THE TEST.**

**Please sign below to acknowledge that you have read the above and
understand this charge is your responsibility.**

Print Name: _____

Signature: _____

Date: _____

**PAIN SPECIALISTS, P.A.
SEASHORE AMBULATORY SURGERY CENTER**

MORRIS E. ANTEBI, M.D.
Medical Director
1907 New Road
Northfield, NJ 08225
609-645-8884 fax 609-6419782
www.painspecialistpa.com

HIPPA – Policies of our office to protect your privacy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY AND SIGN BELOW. IF YOU HAVE ANY QUESTIONS, PLEASE DO NOT HESITATE TO ASK.

Your protected health information (PHI) will only be used with your consent to provide you treatment, to obtain payment from your health insurer, for case management and care coordination and health care operations. For any disclosure of PHI outside of this consent we will require written authorization from you. We may use or disclose your PHI if law or regulations requires the use or disclosure, such as but not limited to, legal proceeding, workman's compensation laws, and a threat to the health and safety of others.

Your PHI will not be shared with a family member, close friend or any other person without written consent by you. The only exception is for minor children (age 17 and under); the parent or legal guardian will have the right to the information.

You have the right to inspect and obtain a copy of your PHI. You may request an amendment of your PHI for as long as the PHI is maintained in the records. You have the right to request in writing, that we not use any part of your PHI for treatment, payment or health care operations. However, if we believe that the restriction is not in the best interest of either party or we cannot reasonably accommodate the request; we are not required to agree to your request. You have the right to receive confidential communication by alternative means and at alternative locations. For example, you can request your bills be sent to another address.

We cannot control or be held responsible for any third party misuse of your PHI. If you feel that your rights have been violated, please contact the office manager. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

For further information, please do not hesitate to contact our practice manager.

I authorize Pain Specialists/Seashore Ambulatory Surgery Center to release any medical or incidental information to the following individuals:

Name

Relationship to the patient

By signing below, you state you have read and understand the above information and consent to the use of your PHI as outlined,

Print _____ Signature _____ Date _____

Pain Specialists / Seashore Ambulatory Surgery Center
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Assignment of Benefits Form

I _____ (Print Name) hereby authorize benefits to be assigned to Pain Specialists / Seashore Ambulatory Surgery Center, for healthcare services provided to me by Pain Specialists / Seashore Ambulatory Surgery Center. I hereby certify that the insurance information that I have provided Pain Specialists / Seashore Ambulatory Surgery Center is true and accurate as of the date of service and that I am responsible for keeping it updated. 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 my insurance company may not pay 100% of the amount of the medical claim and I may be responsible for any and all amounts not payable by my insurance company including any portion paid and not applied to in network benefits for any out of network services.

I hereby authorize Pain Specialists / Seashore Ambulatory Surgery Center to submit claims, on my behalf, to the insurance company listed on the copy of the current insurance card I have provided Pain Specialists / Seashore Ambulatory Surgery Center, in good faith. I fully agree and understand that the submission of a claim does not absolve me of my responsibility to ensure the claim is paid in full.

*** I hereby irrevocably, designate, authorize and appoint Pain Specialists / Seashore Ambulatory Surgery Center 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. This power of attorney shall automatically terminate, without formal action being taken, as soon as Pain Specialists / Seashore Ambulatory Surgery Center has received payment in full and remedies under applicable regulatory guidelines for all medical care services provided to patient. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein. I hereby authorize my insurer to assign and transfer any and all applicable ERISA plan benefits and rights to Pain Specialists / Seashore Ambulatory Surgery Center and any business associates working with them to make sure all rights and benefits are administered accurately, including the right to receive any applicable plan documents/remedies, disclosures, pursue appeals, administrative reviews and litigation on my behalf. This authorization includes any and all other rights permissible under state and federal laws including the right for administrative review by the appropriate governing body.

I hereby instruct and direct my Insurance Company to pay Pain Specialists / Seashore Ambulatory Surgery Center directly. I understand under applicable ERISA, state and/or federal regulatory guidelines 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 under my rights per state and federal ERISA regulations hereby instruct and direct my Insurance Company to provide SPD documentation stating such non-assign ability clause to myself and Pain Specialists / Seashore Ambulatory Surgery Center. Upon proof of non-assign ability documentation I instruct that the insurer make out the check to me and mail it directly to the Provider and address listed on the submitted claim for the professional or medical expense benefits, and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered.

I agree and understand that any funds I receive by my insurance company due for services rendered by Pain Specialists / Seashore Ambulatory Surgery Center will be immediately signed over and sent directly to Pain Specialists / Seashore Ambulatory Surgery Center.

This is a direct assignment of my rights and benefits under this plan/policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. Upon receipt of said check, I authorize Pain Specialists / Seashore Ambulatory Surgery Center to receive any such checks, endorse them for deposit only, and to deposit and apply all the proceeds toward payment on my account.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize Pain Specialists / Seashore Ambulatory Surgery Center to be my personal representative, which allows Pain Specialists / Seashore Ambulatory Surgery Center to: (1) submit any and all appeals 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 my benefits based on 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 collection, the undersigned shall 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 Pain Specialists / Seashore Ambulatory Surgery Center for acting as my personal representative.

I authorize Pain Specialists / Seashore Ambulatory Surgery Center and its associates to provide medical care reasonable by todays standards. 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