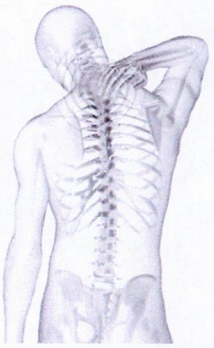


Champey Pain Group

TWO CONVENIENT LOCATIONS

1 Mount Prospect Ave.
Verona, NJ 07044
Phone: 973-433-7230
Fax: 973-433-7235

195 Route 46, Suite 202
Mine Hill, NJ 07803
Phone: 973-989-5185
Fax: 973-328-4097

Visit us at: www.champeypaingroup.com or Email: champeypaingroup@gmail.com

Dear Future Patient:

Thank you for choosing Champey Pain Group. We look forward to helping you with your pain management needs.

In order to save you time, please fill out all of the enclosed forms. Please bring these forms as well as your Driver's License and Insurance Card(s) to your appointment:

Should you need to change or cancel your appointment, please call 973-989-5185.

Thanks!

CHAMPEY PAIN GROUP

PATIENT DEMOGRAPHIC INFORMATION

Patient Last Name: _____ First Name: _____ MI _____

Date of Birth: _____/_____/_____ Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Other

Social Security #: _____ Employment Status: ☐ Employed ☐ Retired

Email address: _____ ☐ Other ☐ Student

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____

Employer: _____ Work Phone #: _____

INSURANCE INFORMATION:

Primary Insurance: _____ Secondary Insurance: _____

ID#: _____ ID #: _____

Group #: _____ Group #: _____

Guarantor (Policy Holder): _____ Guarantor (Policy Holder): _____

Guarantor's Date or Birth: _____ Guarantor's Date of Birth: _____

Guarantor's Employer: _____ Guarantor's Employer: _____

PRIMARY CARE DOCTOR INFORMATION:

Primary Care Physician: _____

Address: _____

Phone #: _____ Fax #: _____

IN CASE OF EMERGENCY WE SHOULD CONTACT:

Name: _____

Relationship: _____

Phone #'s: _____

CHAMPEY PAIN GROUP

PATIENT RECORD OF DISCLOSURES

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

In general, the HIPAA privacy rule gives individuals the right to request a restriction on use and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

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

❑ Home Telephone: _____

❑ Work Telephone: _____

❑ OK to leave message with detailed information

❑ Leave message with call back number only

❑ Other: _____

_____

❑ Written Communication

❑ OK to mail to my home address

_____

❑ OK to mail to my work address

_____

❑ Other: _____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of any requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below. If completed properly, it will constitute an adequate record. Note: Use and disclosures for Treatment, Payment, and/or Health Care Operations (TPO) may be permitted without prior consent in an emergency.

PERSONS TO WHOM INFORMATION MAY BE DISCLOSED:

Date	Disclosure to Who Address & Fax	1	Description of Disclosure	By Whom Disclosed	2

(1) T = Treatment P = Payment O = Healthcare Operations

(2) F = Fax P = Phone E = E-mail M = Mail C = Cell Phone O = Other

EXPIRATION DATE OF AUTHORIZATION:

This authorization is effective indefinitely unless revoked or terminated by the patient or the patient's personal representation. Expiration Date of Authorization: _____

RIGHT TO TERMINATE OR REVOKE AUTHORIZATION:

You may revoke or terminate this authorization by submitting a written revocation to Champey Pain Group.

POTENTIAL FOR RE-DISCLOSURE:

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it was sent. The privacy of this information may not be protected under the federal privacy regulations.

Overall, by signing this form you are giving Champey Pain Group permission to release or receive your medical records to or from any physician office, hospital, attorney, or any person's name from above you approved us to disclose information to.

_____ _____ _____

Name of Patient or Patient Representative (Please Print) Date of Birth Date

_____ _____

Signature of Patient or Patient Representative Relationship to Patient

CHAMPEY PAIN GROUP

ASSIGNMENT OF BENEFITS

Patient Name: _____ DOB: _____

For treatment provided and other good and valuable consideration, I _____ _____ (Hereinafter Patient) hereby assign all rights and benefits that PATIENT has under any group health, HMO Plan, individual health, PIP, disability or any other health or medical insurance policy or reimbursement plan that may pay benefits for services and treatment that PATIENT has received or will receive.

This assignment includes, but is not limited to, all rights to collect benefits directly from PATIENT'S insurance company for services and treatment that PATIENT has received and all the rights to proceed against PATIENT'S insurance company in any action including legal suit if for any reason PATIENT'S insurance company fails to make payments of benefits to which PATIENT is due. This assignment also includes the right to recover attorney's fees and cost for such action brought by the provider as PATIENT'S assignee.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

_____ _____

Signature of Insured Date

CHAMPEY PAIN GROUP

INFORMED CONSENT AND PAIN MANAGEMENT AGREEMENT

NAME OF PATIENT: _____ DATE: _____

PAIN MANAGEMENT POLICY: I understand and agree to the following: That this pain management policy relates to my use of any and all medication(s) (i.e., opoids, also called "narcotics", "painkillers", and other prescription medications, etc.) for chronic pain prescribed by my physician. I understand that there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substance(s). **Therefore, medication(s) will only be provided as long as I follow the rules in this Agreement.**

My physician may at any time choose to discontinue the medication(s). Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medication(s) and/or my discharge from care and treatment. Discharge may be immediate for any illegal behavior.

- My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the **medication(s) may be discontinued**.
- I will **disclose** to my physician all medication(s) that I take at any time, prescribed by any other physician.
- I will use the medication(s) **exactly as directed by my physician**.
- I agree not to share, sell, or otherwise permit others, including my family and friends, to have access to these medications.
- I **will not allow or assist in the misuse/diversion of my medication; nor will I give or sell them** to anyone else.
- All medication(s) must be obtained at **one pharmacy, where possible**. Should the need arise to change pharmacies, my physician must be informed at the next scheduled visit. I will use only one pharmacy and I will provide my pharmacist a copy of this agreement. I authorize my physicians to release my medical records to my pharmacist as needed.
- I understand that my medication(s) will be refilled on a regular basis. I understand that my prescription(s) and my medication(s) are exactly like money. **If either are lost or stolen, they WILL NOT BE REPLACED.**
- Refill(s) **will not be ordered before the scheduled refill date**. However, early refill(s) may be allowed when I am traveling and I make arrangements in advance of the planned departure date. Otherwise, I will not expect to receive additional medication(s) prior to the time of my next scheduled refill, even if my prescription(s) run out.
- I will receive medication(s) **only from ONE physician** unless it is for an emergency or the medication(s) that is being prescribed by another physician is approved by my physician.
- Informed that I have been receiving medication(s) prescribed by other doctors that has not been approved by my physician may lead to a discontinuation of medication(s) and treatment.
- If it appears to my physician that there are no demonstrable benefits to my daily function or quality of life from the medication(s), then **my physician may try alternative medication(s) or may taper me off all medication(s)**. I will not hold my physician liable for problems caused by the discontinuance of medication(s).

- **I agree to submit to urine and/or blood screens** to detect the use of non-prescribed and prescribed medication(s) at any time and without prior warning. If I test positive for illegal substance(s), such as marijuana, speed, cocaine, etc., treatment for chronic pain may be terminated. Also, a consult with, or referral to, an expert may be necessary: such as submitting to a psychiatric or psychological evaluation by a qualified practitioner such as an addictionologist or a physician who specializes in detoxification and rehabilitation and/or cognitive behavior therapy/psychotherapy.
- I recognize that my chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, alternative medical care, etc. I also recognize that **my active participation** in the management of my pain is extremely important. I agree to **actively participate in all aspects of the pain management program** recommended by my physician to achieve increased function and improved quality of life.
- I agree that I **shall inform any doctor** who may treat me for any other medical problem(s) that I am enrolled in a pain management program, since the use of other medication(s) may cause harm.
- I hereby give my **permission** to discuss all diagnostic and treatment details with my other physician(s) and pharmacist(s) regarding my use of medications prescribed by my other physician(s).
- I must take medication(s) as instructed by my physician. **Any unauthorized increase** in the dose of medication(s) may be viewed as a cause for discontinuation of the treatment.
- I must **keep all follow-up appointments** as recommended by my physician or my treatment may be discontinued.

_____

Patient Signature

CHAMPEY PAIN GROUP
MEDICAL HISTORY

To help us understand your problem, please complete ALL QUESTIONS and ALL of the attached forms:

Name: _____ Age: _____ Date: _____

Who referred you to us? _____ Height: _____ Weight: _____

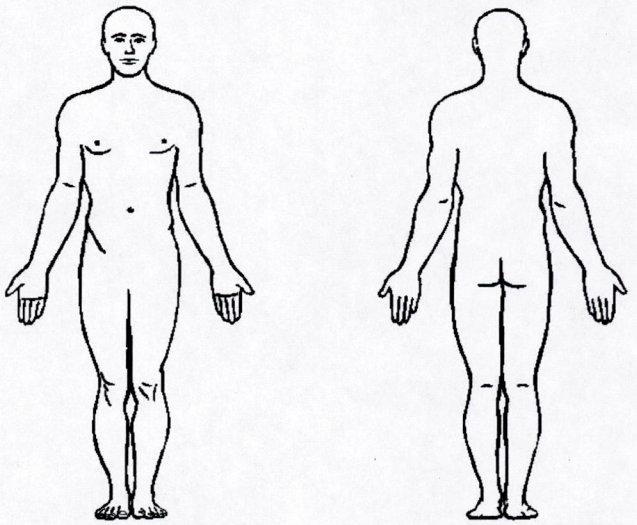
Which part of your body hurts the most? _____

How long have you had this pain? _____

On a scale from 0 to 10, "0" being no pain and "10" being the worst pain imaginable, circle the number that described you level of pain:

No Pain - 0 1 2 3 4 5 6 7 8 9 10 - Worst pain imaginable

Shade in or circle areas below where you have pain and check ALL the words that best describe your pain:



( ) Aching	( ) Stinging	( ) Cramping
( ) Numbness	( ) Radiating	( ) Excruciating
( ) Hotness	( ) Coldness	( ) Soreness
( ) Burning	( ) Shooting	( ) Stabbing
( ) Tightness	( ) Heaviness	( ) Dullness
( ) Sharpness	( ) Constant	( ) Brief
( ) Tingling		

Pain caused from: Accident ( ) Yes ( ) No Illness ( ) Yes ( ) No Unknown Cause ( ) Yes ( ) No

If accident or illness, please explain and give date: _____

_____

_____

_____

_____

Social History:

Marital Status: ( ) Married ( ) Divorced ( ) Single

Do you currently work: ( ) Yes ( ) No What is/was your occupation? _____

Smoker ? ( ) Yes ( ) No If you quit, when? _____ How many cigarettes did you/do you smoke per day? _____ Number of years? _____

Alcohol use ? ( ) Yes ( ) No If yes, how much? _____ how often? _____

History of street drug use? ( ) Yes ( ) No If yes, what type? _____

Do you have a history of alcoholism? ( ) Yes ( ) No

Family history of drug or alcohol abuse? ( ) Yes ( ) No

Is there any possibility that you are pregnant? ( ) Yes ( ) No

Have you been tested for HIV Virus? ( ) Yes ( ) No

Have you ever been treated for depression or any other mental health issue? ( ) Yes ( ) No If yes, please explain:

_____

Treating Physician's Name: _____ Phone Number: _____

Last Visit: _____ Frequency of Visits: _____

Origin of Depression: _____

Cardiovascular	Respiratory	Genitourinary	Muscle/Joint Disease
( ) Palpitations	( ) Shortness of Breath	( ) Change in Bowel Control	( ) Redness in Joints
( ) Leg Swelling	( ) Chronic Cough	( ) Change in Bladder Control	( ) Arthritis/Joint Disease
( ) Chest Pain/Angina	( ) Wheezing	( ) Blood in Urine	( ) Frequent Muscle Spasm
	( ) Sputum Production		( ) Back or Neck Problems
			( ) Swelling of Joints

Neurological	Endocrine	Gastrointestinal	Hematologic
( ) Epilepsy or Seizures	( ) Frequent Urination	( ) Nausea	( ) Easy Bleeding
( ) Weakness	( ) Change in Appetite	( ) Diarrhea	( ) Poor Blood Clotting
( ) Dizziness	( ) Heat or Cold Tolerance	( ) Rectal Bleeding	( ) Bleeding Disorder
( ) Fainting	( ) Sweating	( ) Heartburn	
( ) Numbness		( ) Constipation	
( ) Headache			

Psychiatric	Constitutional
( ) Depression	( ) Recent Weight Loss
( ) Anxiety	( ) Recent Weight Gain
( ) Stress	( ) Fever/Chills
( ) Previous Psychiatric Care	( ) Visual Chance
	( ) Hearing Change

Please list past or current medical problems:

( ) Heart Disease	( ) Lung Disease	( ) Diabetes	( ) Stroke	( ) Herpes (Shingles)
( ) Hypertension	( ) Kidney Problems	( ) Liver Disease	( ) Seizures	( ) HIV/AIDS
( ) Migraines	( ) Thyroid Disease	( ) Anxiety/Depression	( ) Gerd/Ulcer	( ) Heptatitis
( ) Open Wound	( ) Infection	( ) Other		

Have you ever had cancer? ( ) Yes ( ) No If yes, which type(s)? _____

Are you currently receiving treatment? ( ) Yes ( ) No If yes, type(s) of treatment? _____

_____

Please list all medications you are currently taking:

1.	4.	7.	10.
2.	5.	8.	11.
3.	6.	9.	12

Do you have any allergies to medication or food? ( ) Yes ( ) No

Please list your allergies and the reaction below:

Medication	Reaction	Medication	Reaction
1.		4.	
2.		5.	
3.		6.	

Have you ever taken or been given:	YES	NO	ADVERSE REACTION?
Anticoagulants, Blood thinners, Coumadin, Plavix, Pletal	( )	( )	_____
Cortisone or Steroids	( )	( )	_____

Please list any surgeries:

Surgery/Date	Surgery/Date
1.	5.
2.	6.
3.	7.
4.	8.

Family History: Describe current health, age, cause of death, illness, diabetes, cancer, hypertension, etc.

Relationship	Age	Yes	No	Medical History or Cause of Death
Father				
Mother				
Sibling				
Sibling				

Please indicate the factors or activities that increase or decrease your pain:

Factors	Increase	Decrease	No Effect	Factors	Increase	Decrease	No Effect
Weather Change				Pressure			
Heat				Sexual Activity			
Cold				Bowel Movement			
Physical Activity				Bright Light/ Noise			
Posture				Sneeze, Cough			
Walking				Lying Down			
Sitting				Other			

Please check any of the following treatments you have had for this pain problem:

Treatment	Approx. Date/Details	Yes	No
( ) Pain Clinic			
( ) Nerve Blocks, Epidurals			
( ) Tens Unit			
( ) Physical Therapy			
( ) Acupuncture			
( ) Chiropractor			
( ) Psychiatrist/Psychologist			
( ) Massage Therapy			
( ) Other			

Please indicate which diagnostic procedure (test) you have had for this pain problem:

Procedure/Test	Body Part	Approx. Date	Facility Performed
( ) MRI Scan			
( ) CY Myelogram			
( ) X-Ray			
( ) EMG/NCV			
( ) Discogram			
( ) Bone Scan			

Please list other physicians you have seen for your pain:

Name	Recommendation	Specialty	Appt. Date