NORTH AMERICAN
SPINE & PAIN

AJ Rastogi, MD Kieran Slevin, MD
Co-Medical Directors

NEW PATIENTS MAY NOT BE PRESCRIBED OPIOIDS DURING THEIR FIRST VISIT DEPENDING UPON THE OUTCOME OF YOUR INITIAL ASSESSMENT

Date: _____

Name: _____ _____ _____
Last First M.I.

DOB: _____ **Age:** _____ **SSN:** _____ **Sex:** Male ☐Female

Address: _____

City: _____ **State:** _____ **ZIP:** _____

Home Phone: _____ **Cell:** _____ **Work:** _____

Email Address: _____

Race: _____ **Ethnicity:** _____ **Preferred Language:** _____

Gender Identity: ☐Male ☐Female ☐Transgender Male ☐Transgender Female ☐Genderqueer ☐Decline ☐Other: _____

Sexual Orientation: ☐**Heterosexual** ☐**Homosexual** ☐**Bisexual** ☐**Undecided** ☐**Decline** ☐**Other:** _____

Marital Status: ☐Single ☐Married ☐Partnered ☐Separated ☐Divorced ☐Widow

Employment Status: ☐Full Time ☐Part-time ☐Unemployed ☐Retired ☐Disability

Tobacco Use: ☐Never ☐Former ☐Current ____ # packs per day **Alcohol Use:** ☐Yes ☐No

Emergency Contact Name: _____

Phone Number: _____ **Relationship:** _____

Insurance Information

Primary Insurance: _____ **ID#**_____

Secondary Insurance: _____ **ID#**_____

Pharmacy Information

Pharmacy: _____ Phone**:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Prescription Insurance: _____ **ID#:** _____ **RX BIN#**_____

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Physician Information

Primary Care Physician: _____ **Phone:** _____
Referring Physician: _____ **Phone:** _____

What is the main problem for which you are seeking treatment?

_____

How long have you had your current pain problem? _____ Years _____Months

Onset of Pain: How did your current pain problem start (**Check one**):
☐Work Injury ☐Injury (not at work) ☐Recurrence of previous injury ☐Cause unknown
☐Auto Accident ☐Illness (non-injury) ☐Other _____

Severity of Pain: In general, over the past month, the intensity of my pain has been:
☐No Pain (0) ☐Mild (1-2) ☐Mild-Moderate (3-4)
☐Moderate (5-6) ☐Moderate-severe (7-8) ☐Severe (9-10)

Timing of Pain:
☐Occasionally (less than 30% of the time) ☐Intermittently (30-60% of the time)
☐Near Constantly (60 to 95% of the time) ☐Constantly (96-100% of the time)

What worsens the pain? (Check all that apply)
☐Bending ☐Walking ☐Sitting ☐Exercise ☐Standing ☐Touch ☐Coughing/Sneezing
☐Bowel Movement ☐Driving ☐Lying Down ☐Other: _____

What helps relieve the pain? (Check all that apply)
☐Lying Down ☐Standing ☐Stretching ☐Anti-Inflammatories ☐Pain Medication ☐Relaxation
☐Sitting ☐Ice ☐Heat ☐Other: _____

Do you have limited ability walking? ☐Yes ☐No
Do you need assistance walking? ☐Cane ☐Walker ☐Wheelchair
How long can you sit? ☐0-30 minutes ☐30-60 minutes ☐1-2 hours ☐More than 2 hours
How long can you stand? ☐0-30 minutes ☐30-60 minutes ☐1-2 hours ☐More than 2 hours

Are you <u>not</u> able to perform any of the following daily activities? (Check all that apply)
☐Going to Work ☐ Household Chores ☐Yardwork or Shopping ☐Socializing with friends
☐Participating in Recreational Activities ☐Caring for yourself ☐Caring for family

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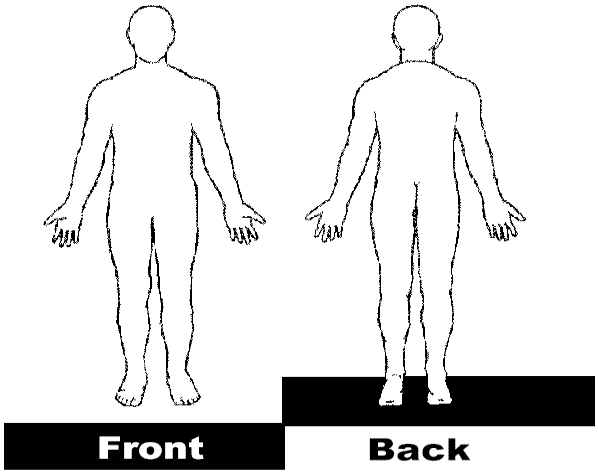
Please mark the location(s) of your pain on the diagrams below with an "x."



Check all that describe your pain:

☐Burning ☐Pressure-like ☐Shooting
☐Sharp ☐Stabbing ☐Throbbing
☐Cramping
☐Numbness ☐Pins and needles
☐ Dull/Aching
☐Falling ☐Muscle spasms
☐Dropping objects
☐Loss of bladder or bowel control
☐Weakness in upper extremities
☐Weakness in lower extremities
☐Other: _____

Other Symptoms: (Check all that apply)

☐Fever	☐Nausea	☐Chest pain	☐Memory loss
☐Recent weight gain/loss	☐Vomiting	☐Heart palpitations	☐Seizures
☐Double/blurry vision	☐Constipation	☐Shortness of breath	☐Depression
☐Dizziness	☐Diarrhea	☐Swelling	☐Anxiety
☐Difficulty urinating	☐Muscle weakness	☐Joint stiffness	☐Decreased range of motion

Previous Pain Treatment: (Check all that apply)

☐Surgery ☐Injections ☐Physical Therapy ☐Exercise ☐TENS unit ☐Heat ☐Ice ☐Brace
☐Medications ☐Chiropractic ☐Psychotherapy ☐Biotherapy ☐Pain Management

Past Surgical History: Type of surgery and approximate date: _____
_____

Past Medical History: (Check all that apply)

☐Thyroid Disease ☐Diabetes ☐Liver Disease ☐Heart Disease ☐Cancer ☐Stroke
☐Adrenal Disease ☐Kidney Disease ☐Multiple Sclerosis ☐HIV/AIDS ☐Arthritis
☐Anxiety ☐Depression ☐Bleeding Problems ☐Seizure or Epilepsy ☐Asthma ☐Emphysema
☐Other: _____

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Family Health History: _____
_____

Have you ever had psychiatric, psychological, or social work evaluation or treatment for any issue, including pain?
Yes, treated for: _____ No _____

Have you ever considered/planned/attempted suicide? Yes _____ No _____

Do you have difficulty sleeping? ☐Yes ☐No **Do you snore?** ☐Yes ☐No

Are you tired upon awakening? ☐Yes ☐No

Are you allergic to contrast dye used for X-Ray/MRI/CT? ☐**Yes** ☐**No**

Past Medications:
☐Percocet ☐Tramadol ☐Fentanyl ☐Vicodin ☐Suboxone ☐Methadone ☐Dilaudid ☐Oxycodone
☐MS Contin ☐Tylenol ☐Ibuprofen ☐Muscle Relaxer ☐Lyrica ☐Gabapentin ☐Ativan ☐Xanax
☐Medical Marijuana ☐Other: _____

Medication Allergies and the reaction/s:
_____
_____

Current Medications:
_____
_____
_____
_____

I certify that the information provided above is true and correct

Patient Signature: _____

Date: _____

Call Center:
1-(855) 862-7767

info@naspacmd.com
www.naspacmd.com

Main Office:
404 Creek Crossing Blvd.
Hainesport, NJ 08036

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CONTROLLED SUBSTANCE AGREEMENT

I, _____ DOB: _____, have read and understand the following agreement. I agree to abide by it if I am placed on time contingent or as needed controlled substances. I have been fully open with my pain management physician and have revealed any history of previous substance abuse and all currently prescribed medication by other physicians.

(Please initial every paragraph).

_____**1.** Medications will be taken as directed by my physician. I will have enough medication to last until my next visit. If I run out of medication PRIOR to my next appointment, NO ADDITIONAL MEDICATION CAN BE AUTHORIZED.

_____**2.** I understand that I need to have a monthly appointment with my physician for medication management. I further understand that refill issues will only be discussed by phone on Mondays - Friday in an urgent situation. Phone calls will not be returned on refill issues other days of the week. Refills are NEVER made over the weekends.

_____**3.** I understand that controlled substance prescriptions generally CANNOT be phoned or faxed to a pharmacy. All prescriptions **must** be filled in the state in which they were prescribed.

_____**4.** I understand that controlled substance prescriptions are MY responsibility. If anything happens to my prescriptions (lost, stolen, flushed down the toilet, etc.), I am personally responsible. Under such circumstances, prescriptions will not be rewritten or reordered.

_____**5.** I understand that I am to obtain ALL my prescriptions for controlled substances only from North American Spine & Pain while under their care. I will notify my pain physician if I receive a controlled substance from any other physician or source. If I violate this and obtain a controlled substance from any other source, or if I give or sell any controlled substance or prescriptions, then I have violated this agreement.

_____**6.** If it appears to the physician that there are no demonstrable benefits to my daily function or quality of life from the controlled substance, I will gradually taper my medications as prescribed by the physician. I will not hold North American Spine & Pain or any staff member of North American Spine & Pain liable for problems caused by misuse, abuse, or discontinuance of controlled substances.

_____**7.** I will inform my physician immediately if I develop serious side effects, or go to an emergency room due to pain, or if I become pregnant, because if I am of childbearing age, I could give birth to a child physically dependent upon a controlled substance. These issues will be reviewed with my pain management physicians.

_____**8.** I understand that if I develop another pain condition (toothache, abdominal pain, etc.) this does not allow me to self-increase my medications. I will see my local doctor, disclose all medication that I am taking and inform North American Spine & Pain of any additional medication that have been ordered prior to taking them.

_____**9.** Signs of addiction and psychological dependence will be interpreted as a need for weaning and detoxification.

_____**10.** I agree to submit to a urine and / or blood screen to document appropriate blood levels of prescribed analgesics and to detect the use of non-prescribed medication at any time.

I understand that I may be discharged from North American Spine & Pain for any positive result for illegal drugs, for a urine sample that has a temperature reading below 90 degrees, for refusing to give a urine sample when requested or for not showing up at designated off-site lab in the allotted amount of time I am given to arrive there.

_____**11.** There is risk of excessive sedation when controlled substances are combined with sedatives, hypnotics, or depressants such as alcohol. Therefore, I agree to avoid concurrent use of such non- prescribed substances.

_____**12.** I recognize that chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy, and behavioral modifications strategies to secure increased functioning and improved coping skills. I also recognize that my active participation is extremely important, I will actively participate in ALL aspects of the Pain Management Program and / or any recommendations that I am given for additional treatment.

_____**13.** I understand my pain management physician may need to discuss my care with family members or other physicians. I will allow such communication but only with my prior consent and if it maintains the confidence of my physician– patient relationship.

_____**14.** I understand that I may be randomly contacted and requested to engage in a pill counting procedure. I will be given 24 hours to present myself to the practice with all my prescribed controlled substances from the practice or I may be asked to do so prior to my next visit without prior notice. If I am unable to present myself to the practice within 24 hours as asked, I will present myself to the nearest pharmacy within 24 hours and follow the instructions provided to me by the medical staff contacting me.

_____**15.** I understand that my insurance company will be billed for any testing which North American Spine & Pain feels is necessary in conjunction with my care. If my insurance company does not pay for drug screens or other testing, I will be responsible to pay for these myself, directly to the lab I am assigned if it is appropriate under my payor obligations.

I fully understand that if I do not abide by the above paragraphs, then I may (at my pain physician's discretion) no longer receive any type of controlled substance medication from North American Spine & Pain. I understand that if I have a problem or questions with any of the above paragraphs, I can make an appointment to discuss this with my physician and receive clarification.

Patient Name (Print): _____

Patient Signature: _____

Date: _____

Physician Signature: _____

Employee Signature: _____

I hereby certify that I, on the patient's request, have read this contract to the patient as stated above and a copy was given to the patient.

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Co-Medical Directors

COMMUNICATION CONSENT

I Authorize messages with medical/appointment information to be left on a voicemail at: (check all that apply)

Home: _____ Cell: _____ Work: _____

I authorize the following people to access my medical information (medical care/treatment, financial history, insurance information) and have my permission to schedule, confirm, cancel and/or reschedule an appointment for me. I understand that if I need to change this information, it is my responsibility to request this in writing.

1)Name_____Relationship_____Phone_____

2)Name_____Relationship_____Phone_____

RELEASE OF MEDICAL RECORDS

Should it become necessary, North American Spine and Pain has my permission to discuss my health information, including test results, with the individuals listed below. The people that are listed below are also authorized for the above statement regarding appointments and prescriptions. I understand that if I need to change this information, it is my responsibility to request this in writing. Please include any doctors and/or attorneys you may be working with regarding your current health condition/s.

1)Name_____Relationship_____Phone_____

2)Name_____Relationship_____Phone_____

Patient Name (Print): _____

Patient Signature: _____

Date: _____

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IRREVOCABLE ASSIGNMENT OF BENEFITS / LETTER OF PROTECTION / LIEN

I/ ME/ MY, *(Patient Name)* _____, the insured and/or beneficiary of the policy of *(Ins Co/Policy# / claim #)*_____ insurance providing medical benefits to me, do hereby authorize you, *(Insurance Co.)*_____to pay directly to **NORTH AMERICAN SPINE & PAIN** (hereinafter referred to as "NASPAC"), upon receipt of the itemized statement for services rendered the amount set forth therein. My insurance policy was in full force and effect at the time services were rendered. Payment, in whole or in part, shall be considered the same as if paid by my company directly to me, the insured. A photocopy of this assignment shall be valid as the original.

I authorize "NASPAC," to obtain legal counsel by and through any law firm of their choosing and to enter legal (PIP Arbitrations) or other action to collect such sums due it, should sums not be paid within the legally prescribed time or for the proper amount. I do hereby promise full and complete cooperation with "NASPAC's" legal counsel, including attending any type of Medical Exam (PIP IME), Deposition, Arbitration or Court Proceeding. I understand that should I fail to cooperate with the legal counsel, I may be held personally responsible to "NASPAC" for any expense not covered by this assignment / letter of protection (hereinafter referred to as an "LOP") and or expensed not recovered due to my failure to cooperate.

I authorize NASPAC and its associates to provide medical care and treatment to me by today's standards. Any action stemming from this Assignment of Benefits Form & Release shall be instituted, prosecuted, and maintained in Burlington County, New Jersey. A photocopy of this Assignment of Benefits Form & Release shall be considered as effective and valid as the original. If any part or provision of this Assignment of Benefits Form & Release should be held void or invalid, the remaining provisions shall remain in full force and effect.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

The undersigned hereby consents and authorizes the release of all medical records, reports, films, etc., directly to "NASPAC**"** and/or their designated legal counsel, directly from _____or all hospitals, diagnostic facilities or physicians that have rendered medical treatment, diagnostic testing, or any type of medical service to the undersigned as a patient.

AUTHORIZATION TO RELEASE INFORMATION

(PIP carrier) _____ Insurance Co. is hereby authorized to release to "NASPAC," and/or their designated legal counsel, all or any part of my medical record, billing information, insurance policy information, EOB's and any information contained in my PIP file.

FINANCIAL RESPONSIBILITY

I hereby agree and acknowledge that if I may receive benefit checks directly from the insurance carrier for services rendered by "NASPAC," I hereby agree to immediately forward said check(s) to "NASPAC" upon receipt of same. It is understood and agreed that should I receive benefit checks and fail to forward any benefit checks to "NASPAC," "NASPAC" does maintain the right to request checks from me and initiate all collection efforts against me. If such action is taken by "NASPAC," I agree to be responsible for all benefit checks received by me, plus all reasonable collection costs incurred including, but not limited to reasonable attorney's fees, interest at a rate of 18% per annum, expert fees, and court costs. Failure to forward said payments to " NASPAC " in a timely fashion may cause a cessation or interruption of treatment. The payment of "NASPAC's" bills shall not be contingent upon MY success in obtaining a settlement, verdict or upon payment from any policy of insurance.

PATIENT'S CONTINUING OBLIGATION TO PROVIDE THIS ASSIGNMENT OF BENEFITS/LETTER OF PROTECTION/LIEN TO PATIENT'S ATTORNEY

I hereby acknowledge my continuing responsibility to provide this irrevocable assignment of benefits agreement to my present and all subsequent attorneys who are handling any claims that any way relate to the medical services provided by NASPAC. I

also acknowledge my agreement to obtains from my attorneys my attorney's acknowledgement of this agreement and my attorney's signature as required by the terms of the following Letter of Protection requirements of this Agreement.

LETTER OF PROTECTION (LOP) / ATTORNEY DIRECTIVE / IRREVOCABLE ASSIGNMENT

I hereby irrevocably authorize my Attorney(s)_____to pay directly to "NASPAC" sums as may be due and owing for services rendered by "NASPAC" and to withhold such sums from any bodily injury policies, disability, medical payment benefit, no fault benefits, health and accident benefits, workers compensation benefits, or any other insurance benefits obtained to reimburse the undersigned, or from any settlement, verdict or judgment which may be paid to me or my attorney as a result of the injury or illness for which I have received services from "NASPAC". I authorize my Attorney to release a copy of my Settlement Disbursement documents to "NASPAC" showing all payments received and distributions made upon the settlement/verdict on my case.

Patient Initials _____

I irrevocably assign to "NASPAC" all rights and benefits under any insurance contracts for the payment of services rendered by "NASPAC." I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by "NASPAC," be released to "NASPAC" and/or their legal counsel. I irrevocably authorize "NASPAC" to file insurance claims on my behalf for service rendered to me. I irrevocably direct that all such payments be made directly to "NASPAC."

I give "NASPAC" and/or their legal counsel my power of attorney and authorized them specifically to endorse/sign my name on any and all checks for payment of "NASPAC's" bills. I further acknowledge that I have a right to and have reviewed this legal document with my attorney and that I have received a copy of this agreement. I authorize my attorney to sign this Letter of Protection.

Patient's Signature: _____ Date: _____

The undersigned, being the attorney of record for the above patient, does hereby agree to observe all terms of the above and agrees to withhold such sums from any settlement, verdict or judgment as may be necessary to fully protect "NASPAC's" right to be compensated for services rendered and related to the above captioned claim / case. The undersigned further acknowledges the patient's agreement that the patient cannot revoke this Assignment of Benefits.

Attorney's Signature: _____ Date: _____

Note: Attorney, kindly sign, and date one copy and return as soon as possible to the address listed above as an acknowledgement of this document and your agreement to protect " NASPAC AOC 's" right to be reimbursed. Thank You.

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PATIENT FINANCIAL POLICY

North American Spine and Pain participates with a variety of insurance companies. As a courtesy, we will verify your primary insurance and file a claim for services rendered.

- I hereby assume financial responsibility for all copays, coinsurances, deductibles, and all other services not covered by my insurance company. I understand payment is due at the time of service and can be paid by cash or debit/credit card.
- Should my insurance deny a claim or not pay for services rendered, I am financially responsible since the relationship is between myself, the subscriber, and my insurance carrier. I agree to pay any balance owed within 30 days or I will call the office I received services from and make payment arrangements.
- It is my responsibility to obtain any insurance referrals from my primary care physician prior to my visit. If I have not done so, my visit will be cancelled/rescheduled.
- I agree that if I receive a payment from my insurance, that payment must be signed and forwarded to North American Spine and Pain, immediately and I will be responsible for all outstanding balances.
- I agree to provide at least 24 hours' notice should I need to cancel or reschedule an appointment. If I do not give proper notice, I may be charged a fee, which will vary based on the state the appointment was scheduled. This fee must be paid prior to future visits. No show fees are not covered by insurance companies.
- If I miss three (3) appointments (consecutive or accumulated), I may be discharged from North American Spine and Pain.
- I agree to always provide the most current insurance and demographic (name, address, phone number, primary care physician, other treating physicians) information.

Other Fees:

Medical records/Medical forms:
Fee assignment is based on the state services are rendered. Additional information can be provided upon request.

Medical Marijuana Program:
This service is currently not covered by insurance companies. Payment for any services related to the Medical Marijuana Program is the patient's responsibility.

By signing the below, I authorize North American Spine and Pain to release medical and other information necessary to insurance companies and third-party payers to process claims for services rendered. I hereby authorize payment for all medical insurance benefits, which are payable under the terms of my insurance policy, to be paid directly to North American Spine and Pain. In the event I receive such payment, I agree to deliver payment to North American Spine and Pain within 10 days of its receipt.

DISCLOSURE OF FINANCIAL INTEREST

State requirements and the Centers for Medicare & Medicaid Services require that we disclose to patients a physician's financial interest in an ambulatory surgical center or other health center to which the physician refers his or her patients. The following physicians have a 100% financial interest in North American Spine and Pain locations throughout New Jersey, Delaware, and Pennsylvania:

Dr. Abhijeet Rastogi, MD
Dr. Kieran Slevin, MD

Please sign below to acknowledge that you have been informed of the ownership interest in the above entities:

Patient Name (Print): _____

Patient Signature: _____

Date: _____

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ADVANCED DIRECTIVE

Most States mandate that all health care facilities ask each of their patients whether they have an advance directive (which is sometimes also referred to as a "living will"). At North American Spine and Pain, we have made this question part of the admission process. In addition, we request that if you have an advance directive, **bring a copy of it to North American Spine and Pain prior to or at your next scheduled appointment.**

An advance directive is used by an individual to indicate a voluntary, informed choice of accepting, rejecting, or choosing among alternative courses of medical treatment and allows the individual to give written instructions to those caring for him or her, indicating the type of health care he or she would wish to receive or to reject in the event he or she becomes unable to express these decisions.

There are two different types of advanced directives:
A Proxy Directive – This is a document in whereby a competent adult designates a trusted relative or friend to make health care decisions on his or her behalf when he or she is unable to make these decisions.
An Instruction Directive – In this document, a competent adult provides written instructions concerning the type of medical treatment he or she wants or does not want performed for him or her under what circumstances.

Please initial the appropriate response:

_____ **YES,** I have an advance directive and will provide a copy on or before my appointment.

_____ **NO,** I do not have an advanced directive and **do not** wish to obtain one.

_____ **NO,** I do not have an advance directive, but would like instructions of how to obtain one.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICES

I hereby acknowledge that North American Spine and Pain, upon request, will provide me with a copy of HIPAA Notice of Privacy Practices, and I acknowledge that they may use and disclose my health information for HIPAA authorized purposes, such as the purpose of treating me, obtaining payment for services rendered to me, and performing routine healthcare operations and services.

I also acknowledge that I have been provided with the opportunity to determine alternate means of communication by voicemail and electronic notices. I have also been provided the opportunity to determine what information I would like precluded from disclosure as my right and whom North American Spine and Pain can disclose my information to as my choice, which will include information up to and including protected health information (PHI).

I hereby also acknowledge that I was offered and accepted written information concerning Advanced Directives.

I acknowledge that I agree to bring or provide for an escort to take me home on the day of a procedure.

A copy of information regarding my rights as a patient (Patient Rights) can be provided to me, upon my request.

Patient Name (Print): _____

Patient Signature: _____

Date: _____