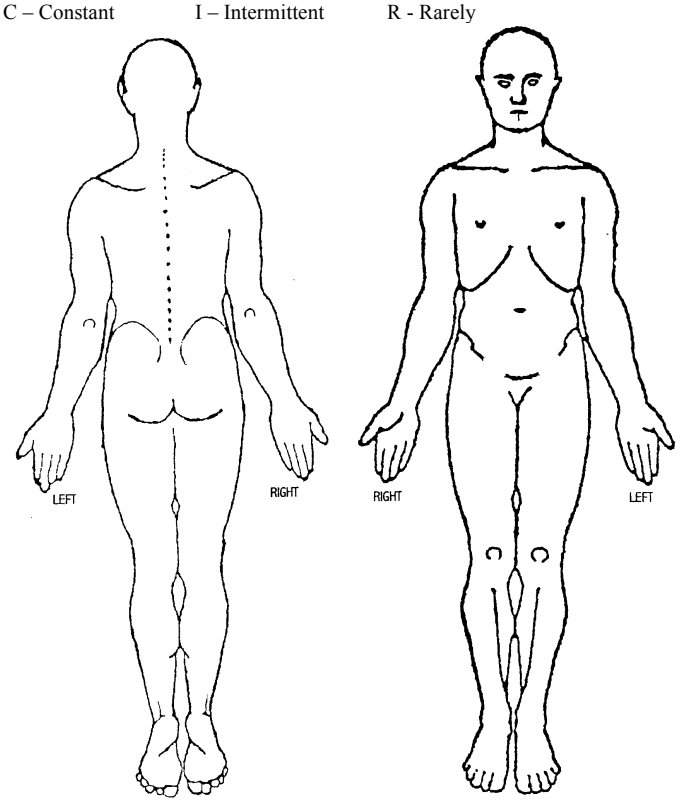
Not Part of Medical Record

Name: _____ Age: _____DOB:_____ Today's Date:_____ Date of Injury:_____
Gender: M / F

Please draw your pain using up to 5 colors.

Yellow – Aches/Soreness Red - Stabbing Blue – Burning
Green - Pins & Needle Black – Numbness
C – Constant I – Intermittent R - Rarely



Circle the number indicating your pain on a scale from 0 to 10.

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Imaginable Pain)

CG CR LM Am Ch Sv Nj Pr Ei

Rep film

L	ddd	bulge	hnp	hiz	fjh	fn	ss	ht	ep	sch	sp
121											
12											
23											
34											
45											
51											

Rep film

C	ddd	bulge	d/ost	hnp	rdg	uvh	fn	ss	fjh	sp
23										
34										
45										
56										
67										
71										

EMG:
RUE
LUE
RLE
LLE

Not Part of Medical Record

Date when your symptoms started: _____

Describe your pain:

How do these activities affect your pain?

	better	worse	no change
Sitting			
Standing			
Walking			
Bending			
Lifting			
Coughing			
Straining on toilet			
Changing Positions			
Getting up from seat			

What other things make your pain worse?

What other things make your pain better?

Your pain is… □Constant □Comes and Goes
Does pain wake you up at night? Y / N

Indicate the treatments you have received and results.

	better	worse	same	ongoing
□ Physical Therapy				
□ Chiropractic				
□ Accupuncture				
□ Muscle injections				
□ Epidural Injections				
□ Massage				

Are you able to perform these usual activities?

	Yes	No	Need help
Dressing	□	□	□
Bathing	□	□	□
Toileting	□	□	□
Grooming	□	□	□
Walking inside	□	□	□
Walking outside	□	□	□
Climbing stairs	□	□	□
Driving	□	□	□
Carrying bags	□	□	□
Cooking	□	□	□

List current medications:
_____
_____
_____
_____
_____

Any Blood thinners: Y / N
Xarelto Pradaxa Eliquis
Coumadin Plavix Aspirin
_____
_____
_____

List chronic Illness:
□ Heart disease □ High blood pressure
□ Diabetes □ Irregular heartbeat
□ Asthma □ Ulcer □ Glaucoma
□ Stroke □ Thyroid
□ Seizures □ Heart attack
List all other medical problems:_____
_____
Recent illness: _____
Recent infections: _____
Recent procedures: _____

How much alcohol do you drink?_____
Prior history of substance abuse and treatment? Y/N
Currently working? Y / N
Occupation:_____

Lately, have you experienced…

□ fever	□ fatigue
□ night sweats	□ muscle pain
□ weight loss	□ joint pain
□ weight gain	□ joint swelling
□ dizziness	□ rashes
□ seizures	□ insomnia
□ headaches	□ visual loss
□ palpitations	□ blurry vision
□ chest pain	□ blackouts
□ shortness of breath	□ poor concentration
□ coughing	□ depression
□ heartburn	□ anxiety
□ rectal bleeding	□ anal numbness
□ bleeding gums	□ abdominal pain
□ burning with urination	□ pelvic pain
□ incontinence of urine	□ irregular menses
□ incontinence of stool	

List allergies to medications:
_____
_____
_____
_____

Iodine? Y / N
Seafood? Y / N
Dye? Y / N
Latex? Y / N
Lidocaine? Y / N

List prior surgery:_____
Pacemaker?_____
Defibrillator?_____
_____
_____

List your main doctors and phone # if you know:
Referring:_____
Primary Care:_____
Chiropractor: _____
Orthopedist:_____
Other: _____

IF YOU WERE IN A MOTOR VEHICLE ACCIDENT, PLEASE FILL OUT THIS SECTION

Date of accident: _____

Type of vehicle: Make: _____ Model: _____ Year: _____

Were you the driver? ☐ Yes / ☐ No Wearing a seatbelt? ☐ Yes / ☐ No

Airbags deployed? ☐ Yes / ☐ No Loss of Consciousness? ☐ Yes / ☐ No

Was vehicle drivable? ☐ Yes / ☐ No Was vehicle totaled? ☐ Yes / ☐ No

Police report taken? ☐ Yes / ☐ No Amount of Damage: $_____

Which part of vehicle was struck? ☐ Rear ended ☐ Front Impact ☐ Driver side impact ☐ Passenger side impact

Describe the accident_____

_____

Taken by Ambulance? ☐Yes or ☐ No Which hospital? _____

What was done in the hospital? _____

Xrays taken? ☐Yes or ☐ No What body parts? _____

Were you admitted to the hospital? ☐Yes or ☐ No

What was hurting within the first 48hours? _____

_____

_____

_____

What is still hurting now?

_____

_____

_____

_____

IF YOU WERE INVOLVED IN A WORK RELATED INJURY, PLEASE FILL OUT THIS SECTION

Date of Injury: _____

Describe the injury:

_____

_____

_____

_____

What was hurting within the first 48hours? _____

_____

_____

_____

What is still hurting now? _____

_____

_____

_____

Describe your treatment so far:

1st Doctor seen: Dr. _____ When? _____ Still going? ☐ Yes / ☐ No
Treatment provided: _____

2nd Doctor seen: Dr. _____ When? _____ Still going? ☐ Yes / ☐ No
Treatment provided: _____

3rd Doctor seen: Dr. _____ When? _____ Still going? ☐ Yes / ☐ No
Treatment provided: _____

4th Doctor seen: Dr. _____ When? _____ Still going? ☐ Yes / ☐ No
Treatment provided: _____

Have you had Physical Therapy? ☐Yes or ☐ No How long? _____ Still going? Y / N Helpful? Y / N
Have you had Chiropractic? ☐Yes or ☐ No How long? _____ Still going? Y / N Helpful? Y / N

Did you have an MRI? ☐ Yes / ☐ No Which body part? _____
Did you have any injections? ☐ Yes / ☐ No What kind? _____
Other treatment: _____

Occupation:

Were you working before the accident? ☐ Yes / ☐ No Occupation: _____

How much time did you take off from work following the accident? _____

Were you able to return to work? ☐ Yes / ☐ No When? _____

Any doctors restrictions? _____

Are you on short term disability? ☐ Yes / ☐ No Are you on long term disability? ☐ Yes / ☐ No

Employer: _____
How long have you been at this job? _____
List prior employment and how long you were there

_____ _____
_____ _____

Describe your current job and any physical demands:
Hours/day: _____ Days/week: _____ Length of commute: _____
Any lifting? ☐ Yes ☐ No How many pounds? _____ How frequently? _____
Reaching? ☐ Yes ☐ No Pulling? ☐ Yes ☐ No Pushing? ☐ Yes ☐ No Overhead? ☐ Yes ☐ No
Kneeling? ☐ Yes / ☐ No Bending? ☐ Yes ☐ No Crouching? ☐ Yes ☐ No Driving? ☐ Yes ☐ No
Describe any other physical demands:

_____
_____
_____

Prior History of Injuries:

Describe any prior accidents or injuries. Give dates, body part injured, treatment and whether or not it resolved.

_____
_____
_____
_____
_____
_____

Demographics and Insurance – Social and Family History

Last name: _____ First: _____ M.I. _____
Address: _____ City: _____ State: _____ Zip code: _____
Social security #:_____ Email: _____
Home Phone#: _____ Cell#: _____ work #:_____
Sex: ☐M ☐F Marital status: ☐single ☐married ☐widowed ☐divorced ☐separated
Race: _____ Ethnicity: _____ Pref Language: _____
People you live with including children and ages:_____

Emergency Contact: _____ relationship: _____ phone#:_____
If patient is a minor – parent's social security# _____

Employer information
Name: _____
Address: _____ City: _____ State: _____ Zip code: _____
Phone#: _____ Occupation: _____

Medical Health insurance information
Primary carrier: _____ Policy Holder: _____ ID number:_____
Insured's employer: _____ SS#:_____ DOB: _____

Secondary carrier: _____ Policy Holder: _____ ID number:_____
Insured's employer: _____ SS#:_____ DOB: _____

If applicable, complete the following: ☐Workman's compensation ☐ Auto related injuries
Insurance co: _____ Date of accident: _____
Claim#: _____ Adjuster's name: _____
Name of insured (policy holder): _____
Attorney's name (if applicable): _____ Phone #: _____ ext: _____
Employer at time of injury: _____ Phone#: _____
Address: _____ City: _____ State: _____ Zip code: _____

Pharmacy
Name: _____Address: _____City: _____ Phone#_____

Smoking Status:
Tobacco Usage: Never _____ Current Smoker_____ Former _____
Type: Cigarettes _____ Cigars_____ Chewing ____ Other _____
Years Used: _____ Frequency: Daily_____ Packs per Day_____ Occasionally _____

Family History:
Do you have a family history of any of the following?

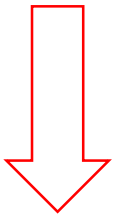
	Mother	Father	Sister	Brother
Arthritis	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Cardiac Disease	_____	_____	_____	_____
Hypertension	_____	_____	_____	_____

Height: _____ Weight: _____Recent Blood pressure (If known): _____

OPIOID RISK TOOL

If you are requesting or being considered for Controlled Substance Prescriptions including Opiates, you must fill out this form. You have the right not to fill out this form, however, Opiates will not be prescribed by this office.

Simply check the boxes that apply



		Check each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse:	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse:	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 – 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease:				
	Attention Deficit Disorder Obsessive Compulsive Bipolar Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
	TOTAL	———	———	

Total Score Risk Category

Low	0–3
Moderate	4–7
High	>7

Opiate Pain Medication Agreement

If you are not requesting opiate medication, then you will not need to sign this agreement. If, on the other hand, you seek relief of pain through prescription opiate medication, then you will be required to understand and sign this agreement. Your physician will still need to evaluate whether or not opiate medication is an appropriate treatment option for you and your condition.

- I agree that Dr. Scott Woska will be the only physician prescribing controlled substances/medication for me and that I will obtain all of my prescriptions for controlled substances at one pharmacy. I will not seek controlled substances from another physician.
- I will not take controlled substances in larger amounts or more frequently than is prescribed.
- I will not give or sell my medication to anyone else, including family members; nor will I accept any controlled substances from anyone else. I agree to be responsible for the secure storage of my medication at all times. I understand that lost or stolen medication will not be replaced.
- I will not use over-the-counter codeine containing medications.
- I will attend all reasonable appointments, treatments and consultations as requested by my physician.
- I understand that the long-term use of controlled substances to treat chronic pain may result in physical dependence on this medication, and that sudden decreases or discontinuation of the medication will lead to the symptoms of controlled substances withdrawal. I understand that controlled substances withdrawal is uncomfortable but not life threatening.
- I understand that there is a small risk that I may become addicted to the controlled substances I am being prescribed.
- I understand that my physician may, at any time, require that I have additional blood or urine monitoring and/or see a specialist in addiction medicine should a concern about addiction arise during my treatment. I will comply with all requests for laboratory tests including random urine monitoring ordered by my physician.
- I understand that the use of any mood altering substance, such as tranquilizers, sleeping pills, alcohol or illicit drugs (such as cannabis, cocaine, heroin or hallucinogens), can cause adverse effects or interfere with opioid therapy. Therefore I agree to refrain from the use of all of these substances without prior agreement from my physician and I agree that this information may be shared.
- I consent to open communication between my doctor and any other health care professionals involved in my pain management, such as pharmacists, other doctors, emergency departments, etc.
- I understand that if I break this agreement, my physician reserves the right to stop prescribing controlled substances and I may be discharged from this practice.
- I will comply with requests by my physician to go to the office for a pill count between scheduled visits.
- I understand narcotic medication will not be prescribed over the phone by my doctor; and I understand I cannot receive weekend refills.
- If I violate this contract I authorize communication to my other treating doctors and case manager.

_____	_____	_____
Print Name	Signature	Date

ASSIGNMENT OF BENEFITS AND RIGHTS FORM
LIMITED POWER OF ATTORNEY FORM
NOTIFICATION OF COMMENCEMENT OF MEDICAL TREATMENT FORM
(Twenty One Day Notice)

FROM: _____
(NAME OF PATIENT)

TO: _____
(NAME OF INSURANCE COMPANY)

RE: _____ _____
(CLAIM NUMBER) **(DATE OF ACCIDENT)**

PATIENT AUTHORIZATIONS:

ASSIGNMENT OF BENEFITS: I am the above named Patient (or Guardian if minor) and I authorize and direct the above named Insurance Company, or any other company, to pay directly any of the above named doctors, as well as Shore Orthopaedic Group, LLC, medical expense benefits otherwise payable to me for services provided to me (or a minor for whom I am the guardian) for their services. I understand that any of the above named doctors, as well as Shore Orthopaedic Group, LLC, may each bill for services rendered independently including Scott Woska, M.D. I authorize any of the above named doctors, as well as Shore Orthopaedic Group, LLC, to submit their bill to the above named Insurance Company, or any other company, with which I (or my spouse) have an insurance policy against which I may proceed for medical expense benefits.

ASSIGNMENT OF RIGHTS: In the event any of the above named doctors, as well as Shore Orthopaedic Group, LLC, elects to bring a lawsuit or arbitration against the above named Insurance Company, or any other company, I assign my rights, title and interest under the medical expense section and/or PIP section of the applicable insurance policy under which I am entitled to proceed for medical expense benefits. This Assignment of Rights shall allow any of the above named doctors, as well as Shore Orthopaedic Group, LLC, to retain an attorney of their choice to file litigation or arbitration for any unpaid medical expenses, and/or denied proposed medical treatment, against the above named Insurance Company, or any other company, against which I may proceed for medical expense benefits.

RELEASE FOR MEDICAL RECORDS: It is understood that certain privacy rights attach to my medical records as created by federal and/or state legislative bodies and/or federal and/or state regulatory bodies. In order to prove the medical necessity, reasonableness and/or causal relationship of the treatment rendered to me, I authorize release of the medical records to the assignee and/or its agents as necessary for any Demand for Arbitration (PIP). A photocopy of this document shall serve as an original.

LIMITED POWER OF ATTORNEY: In the event this Assignment of Benefits and Rights Form is held invalid by the above named Insurance Company, or any other company, I hereby authorize any of the above named doctors, as well as Shore Orthopaedic Group, LLC, to execute any document on my behalf required by the above named Insurance Company, or any other company, to effectuate the intent of this Assignment of Benefits and Rights Form.

RELEASE FOR IME REPORT: I authorize the Release of any IME Report and/or any Paper Review, prepared by any examining doctor, and/or any reviewing Medical Director, shall be released to my Treating Health Care Provider described above.

ACCEPTABILITY OF REPRODUCED COPY: Any reproduction (i.e. Photocopy, Facsimile, Scan, etc.) of this Assignment of Benefits and Rights Form shall be deemed as valid as the original.

I have read the above provisions. I understand the above provisions and agree to be bound by the above provisions.

Signature of Patient:_____ Date:_____

Signature of guardian if minor:_____ Date:_____

SHORE ORTHOPAEDIC GROUP - OUR FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require you read and sign prior to any treatment.

All patients must complete our information form in its entirety before seeing the doctor.

IF WE ARE NOT PARTICIPATING WITH YOUR INSURANCE PLAN, FULL PAYMENT IS DUE AT TIME OF SERVICE.

WE ACCEPT CASH, CHECKS, OR ATM/CREDIT CARDS.

REGARDING YOUR INSURANCE

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. You are responsible to know your insurance policy. In the event that we do accept assignment of benefits, we require that you provide a credit card with authorization to bill that account for the balance. If your insurance company has not paid your account in full within 60 days, the balance will automatically be transferred to your responsibility. Please be aware that some and perhaps all of the services that are provided may be uncovered services, and not considered reasonable and necessary under the Medicare program and/or other medical insurance if doctor is non-participating with the insurance company. I authorize the insurance company to forward payment directly to the physician. Should payment be sent directly to me, it is my responsibility to forward payment directly to physician. This office does not accept any and all medicaid insurances. By signing this waiver you are aware that you are responsible.

I AUTHORIZE MY INSURANCE CARRIER TO FORWARD PAYMENT TO MY PHYSICIAN'S OFFICE.

A CURRENT REFERRAL IS REQUIRED FOR OUR MANAGED CARE PATIENTS AT TIME OF SERVICE.

Insurance plans, where we are a participating provider, co-payments are due prior to treatment. You will be billed for any deductible and co-insurance amounts. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

Patients involved in worker's compensation or motor vehicle injuries must provide this office with an open claim number, name and address of insurance company, adjuster's name and phone number, in addition to your health insurance information. In the event that your claim is denied, you will be held responsible for all charges incurred. In accordance to New Jersey state laws, patients involved in motor vehicle accidents are responsible for their deductible and co-insurance amounts which may vary depending on your policy. Please refer to the above paragraph concerning your health insurance coverage for any outstanding balances.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

ADULT PATIENTS

Adult patients are responsible for full payment according to their plan at the time of service.

MINOR PATIENTS

A minor must be accompanied by a parent or guardian. The adult accompanying the minor is responsible for full payment. Unfortunately we cannot get involved in divorce and custody matters.

MISSED APPOINTMENTS

Unless canceled at least 24 hours in advance, we reserve the right to charge at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our financial policy. Please let us know if you have questions or concerns.

I HAVE READ THE FINANCIAL POLICY AND UNDERSTAND AND AGREE TO THESE TERMS.

_____	_____	_____
Print Name	Signature	Date

Legal Assignment of Benefits & Designation of Authorized Representative

I represent that I have valid and in-force insurance and/or employee health care benefits coverage, and hereby assign and convey directly to Shore Orthopaedic Group, LLC and Dr. Cary Glastein (the "provider(s)"), as my Statutory Derivative Beneficiary (SDB), commonly known as a Designated Authorized Representative, and a Claimant under the "patient Protection and Affordable Care Act" (PPACA), existing ERISA and other applicable federal and state laws, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from the provider(s), regardless of the provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to the provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from the provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the provider(s), to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including but not limited to, (1) obtaining information about the claim to the same extent as the assigner; (2) submitting evidence; (3) making statements about factors or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by the provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including if necessary, to bring suit by the provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Permission to Leave Messages

I give permission to Shore Orthopaedic Group to leave messages on my phone.
I give permission to Shore Orthopaedic Group to speak to my spouse.
I authorize the following person(s) to speak on my behalf: _____

_____ _____ _____

Print Name Signature Date

SHORE ORTHOPAEDIC GROUP L.L.C.
www.shoreortho.com
35 Gilbert Street South • Tinton Falls, New Jersey 07701 • (732) 530-1515 • Fax (732) 747-5433
1255 Route 70 • Lakewood, New Jersey 08701 • (732) 942-2300 • Fax (732) 942-8772
Interventional Pain Medicine • 1255 Route 70 • Lakewood, 08701 • New Jersey (732) 942-2020 • Fax (732) 942-2021

RECORDS RELEASE

I authorize the release of my medical records to:

Scott C. Woska, MD
1255 Route 70, Suite 15S
Lakewood, NJ 08701
732-942-2020
Fax: 732-942-8772

_____ _____ _____
Print Name Signature Date

SS#: _____ Date of Birth: _____

Disclosure of Financial Interest in Lakewood Surgery Center

Dear Patient:

In accordance with Federal Regulations and the Public Law of the State of New Jersey, it is mandated that a physician, podiatrist, chiropractor, and all other licensees of the Board of Medical Examiners must inform his/her patients of any significant financial interest he/she may have in a health care service.

Therefore, please note that the physician who will be performing your procedure/surgery has a financial interest in the **Lakewood Surgery Center, LLC** for which you are being referred.

Of course, you may seek treatment at a health care service provider of your own choice. A listing of alternative health care service providers can be found in the classified section of your telephone directory under the appropriate heading.

You have the right to make informed decisions regarding your care. This includes the right to accept, refuse, or choose alternatives in your medical and/or surgical treatment.

You have the right to enter into an advance directive, which can include a Living Will and Durable Power of Attorney. Please note that the **Lakewood Surgery Center, LLC** is an outpatient facility where only elective surgery/procedures are performed. If a life-threatening situation should occur, all emergency measures will be taken and may include transportation to a higher level of care.

You have a right to receive a copy of the Patient's Rights and Responsibilities.

In addition, depending upon your health insurance coverage, any services or facility fees associated with a referral to **Lakewood Surgery Center, LLC** will be considered to be "out-of-network" and will be reimbursed at an "out-of-network" rate by your insurance carrier or other third party payer.

By signing this disclosure, you or your legal representative acknowledge that: (1) you are receiving this notice prior to the date of the procedure/surgery; (2) you have been informed of the financial interests of the practitioners in this office; (3) you voluntarily desire to have your procedure/surgery performed at the **Lakewood Surgery Center, LLC**; (4) you have the right to make an informed decision regarding your care; (5) you have the right to enter into an advanced directive; (6) you have received a copy of the Patient's Rights and Responsibilities; and (7) you have been informed that your procedure/surgery will be considered "out-of-network".

Understood and agreed:

_____	_____	_____
Print Name	Signature	Date