Interventional Pain Management Associates

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Welcome!

We are pleased you have chosen Interventional Pain Management Associates for your care. We understand how traumatic and isolating chronic pain can be. Finding the right treatment plan is a step that brings you closer to relief. Our multidisciplinary team will help you feel better, improve your functionality and help you live a more satisfying life. We certainly want your appointments to be informative and productive.

In order to accommodate you, we ask that you complete the following required forms in their entirety:

- New patient Intake Form
- Medical History checklist

Please pay close attention to these required forms, as your appointment may need to be rescheduled if either of them is missing. Horizon NJ Health in particular have specified guidelines for their patients.

What to expect at your first visit:
Your first visit will consist of a thorough history and physical examination. You will be seen by a medical assistant first, then a physician. The initial evaluation may take up to an hour from start to finish, but this time is important for an assessment and treatment plan to be formulated. Due to the length of this examination, and various other factors such as insurance authorizations, **please do not expect medications or injections during your first visit.** Out of fairness to all our patients we ask that you try to arrive 15 minutes early for your visit, and please call at least 24 hours in advance if you must cancel. If you are more than 15 minutes late for your appointment it may need to be rescheduled. In addition, appointments canceled less than 24 hours in advance will be considered a no show, and after 3 no shows you will not be rescheduled.

Please bring the following to your first appointment:

- Completed intake form including medical history checklist
- Insurance cards and one form of photo ID
- **All relevant past medical records including MRI, CT scans, bone scans, and /or EMG reports.**
- Worker's compensation/auto insurance phone number, adjustor's name and a mailing address

- **Your insurance is your responsibility. Please bring your insurance card, your referral if applicable and a photo ID** to your office visit. Please contact your primary care physician for a referral if applicable. **If you do not bring a referral your office visit will be rescheduled. Please be advised that we do not have access to the electronic referral system so we require you to bring a paper referral to your visit or have your primary care physician fax one to us.**
- Physical/occupational/aquatic therapy discharge summaries*

*Special note to Horizon NJ Health patients: your insurance requires you to have had an MRI and completed physical therapy within the last year before they will authorize fluoroscopic injection therapy. You may want to discuss these requirements with your referring physician and have them completed before your visit in order to expedite your care.

Interventional Pain Management Associates is committed to success and safety. Thank you for taking the time to provide this information that is important for the level of care we can provide. Your answers will help us individualize your treatment and optimize your success and safety.

Sincerely,
Maher Ibrahim, MD

Your appointment is scheduled for: _____

MI/cf

Interventional Pain Management Associates

Maher Ibrahim, M.D.

Appointment Date: _____

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ SSN: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Email Address: _____

Marital status: _____ Religious Preference: _____ Gender: _____

Referring Physician: _____

Address: _____ Phone: _____

Referring Physician's Fax: _____ Email: _____

Primary Care Physician: _____

Address: _____ Phone: _____

Primary Care Physician's Fax: _____ Email: _____

Pharmacy phone number: _____

Insurance Carrier:

1. _____ ID#: _____

2. _____ ID#: _____

Claim Adjustor (if applicable): _____ Phone: _____

If you are not the insured, what relation are you to the insured? (Spouse/Child) _____

If you are not the insured, what is the insured's DOB? _____

Nearest Relative (relationship): _____ Phone: _____

Address: _____

Are You Employed: (Y or N) _____ Occupation: _____

If employed, how long? _____ If unemployed, How Long? _____

Is this due to pain? (Y or N): _____

Do you plan to go on disability? (Y or N): _____

Please list your medical problems, other than pain (such as heart disease, stroke, cancer, arthritis, diabetes, hypertension, as well as psychiatric illness, etc):

1. _____

2. _____

3. _____

4. _____

5. _____

Please list all your current medications with dosages:

1. _____

2. _____

3. _____

4. _____

5. _____

Please list all your medications with dosages for pain management in the past:

1. _____

2. _____

3. _____

4. _____

5. _____

Please list any allergies to medications: _____

Please list any intolerance to medications: _____

Please list any prior surgeries not related to pain, and dates performed:

1. _____

2. _____

3. _____

4. _____

5. _____

Please list any prior surgeries related to pain (such as laminectomy) and dates performed:

1. _____

2. _____

3. _____

Family Medical History:

1. _____

2. _____

3. _____

4. _____

5. _____

With whom do you live? _____

Are there any substance abuse issues in your household? ☐ Yes ☐ No If yes, please explain: _____

_____

Are you able to care for yourself? ☐ Yes ☐ No If no, please give caregiver's name & phone number: _____

Are you currently involved in a lawsuit? ☐ Yes ☐ No If yes, please explain: _____

_____

Where is your pain? Be specific and list **in order of most severe to least severe**:

1. _____ Most severe

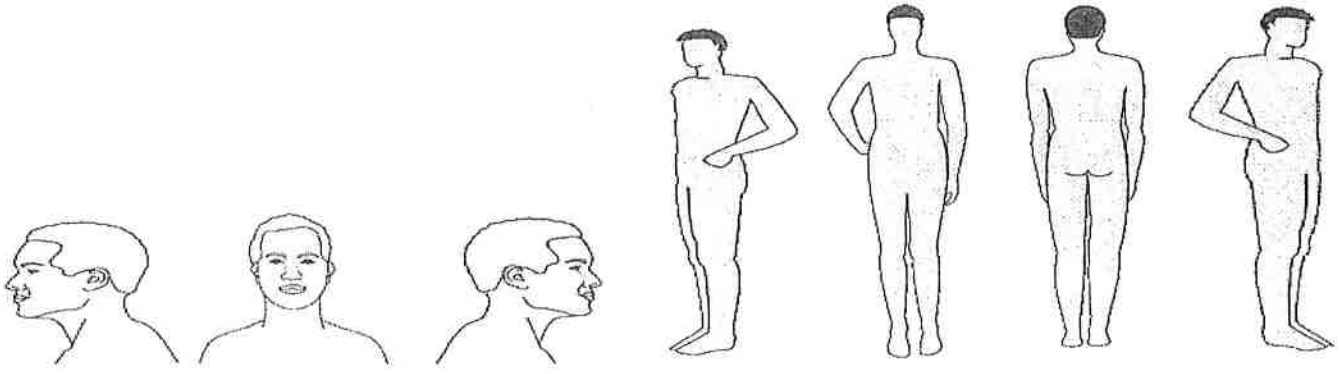
2. _____

3. _____

4. _____

5. _____ Least pain

Please mark where your pain is located:



Left R-Front-L Right Left R – Front-L L-Back – R Right

When did your pain start? _____

Was there a particular event that caused your pain? ☐ Yes ☐ No Please explain: _____

How often does your pain occur and for how long? _____

What makes your pain worse? _____

What makes your pain better? _____

	Date	Facility	Results
____X-rays	_____	_____	_____
____CAT Scan	_____	_____	_____
____MRI	_____	_____	_____
____EMT	_____	_____	_____
____Myelogram	_____	_____	_____
____Other	_____	_____	_____

Please list any other doctors you have consulted regarding this problem:

	Name	Specialty	Date	Phone
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Please check off any treatments you have undergone for this problem, and if they have helped or not helped your problem:

	Helped Yes	Helped No		Helped Yes	Helped No
_____ Surgery	☐	☐	____ Chiropractor	☐	☐
_____Medications	☐	☐	____ Ultrasound	☐	☐
_____	☐	☐	____ Acupuncture	☐	☐
_____	☐	☐	____ Biofeedback	☐	☐
_____	☐	☐			
_____Nerve block, steroid or trigger point injection	☐	☐	____Hypnosis	☐	☐
____ Bed rest	☐	☐	____Relation	☐	☐
____ TENS	☐	☐	____ Exercise	☐	☐
____Heat	☐	☐	____ Traction	☐	☐
____Other	☐	☐			

Pain can be very difficult to describe. It is helpful to compare the intensity of your pain at different intervals. Please rate the intensity of your pain on a scale of 0 to 10. **0 = no pain 10 = the worst pain you can imagine**

What is your pain now? 0 1 2 3 4 5 6 7 8 9 10

What is your level of pain when it is most severe? 0 1 2 3 4 5 6 7 8 9 10

What is your level of pain when it is least painful? 0 1 2 3 4 5 6 7 8 9 10

On subsequent visits, we will refer to the 0 to 10 pain scale and ask you to rate your pain.

Please mark an "**X**" on the line to represent the intensity of your pain.

0 1 2 3 4 5 6 7 8 9 10

No Pain **Worst Pain**

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ıer Ibrahim, M.D.

MEDICAL HISTORY (Check answer(s) that apply)

PATIENT NAME: _____

1. Constitutional Symptoms ☐ **No Problems**
- ☐ weight loss _____lbs., period of time _____
- ☐ weight gain_____lbs., period of time_____
- ☐ recurrent fever
- ☐ general weakness
- ☐ fatigue – persistent

2. Skin ☐ **No problems**
- ☐ dry skin
- ☐ recurrent rashes
- ☐ eczema
- ☐ itching
- ☐ changes in skin color
- ☐ changes in hair or nails

3. Henatologic/Lympathic ☐ **No problems**
- ☐ swollen glands
- ☐ low blood count (anemia)
- ☐ easy bruising
- ☐ easy bleeding
- ☐ slow to heal after cuts
- ☐ history of blood transfusion
- ☐ enlarged glands
- ☐ phlebitis
- ☐ HIV positive
- ☐ on blood thinners

4. Head/Face ☐ **No problems**
- ☐ headaches/migraines
- ☐ history of head injury – no residual problems
- ☐ history of head injury with residual problems of _____
- ☐ facial pain
- ☐ TMJ R L
- ☐ Tic douloureux R L _____

5. Eyes ☐ **No problems**
- ☐ nearsighted
- ☐ far sighted
- ☐ wear glasses
- ☐ wear contact lenses
- ☐ cataracts at present time R L
- ☐ conjunctivitis R L
- ☐ glaucoma R L
- ☐ double vision
- ☐ blurred vision

6. Ear / Nose / Mouth

Ears ☐ **No problems**
- ☐ hard of hearing R L
- ☐ hearing aids R L
- ☐ frequent earaches R L
- ☐ chronic ear discharge R L
- ☐ vertigo
- ☐ ringing in the ears R L

Nose/Sinuses ☐ **No problems**
- ☐ sinus discharge
- ☐ nasal discharge
- ☐ repeated nosebleeds
- ☐ deviated nasal septum
- ☐ chronic sinus problems
- ☐ chronic stuffy nose
- ☐ hay fever
- ☐ nasal polyps

Mouth/Throat ☐ **No problems**
- ☐ teeth ____loose _____none
- ☐ dentures ____full _____partial
- ☐ bleeding gums
- ☐ dry mouth
- ☐ sore throat
- ☐ hoarseness
- ☐ vocal cords polyps
- ☐ trouble swallowing

7. Chest / Breasts ☐ **No problems**
- ☐ breast masses
- ☐ breast surgery
- ☐ chest surgery
- ☐ other explain: _____

8. Respiratory ☐ **No problems**
- ☐ smoker _____pack(s) per day since _____
- ☐ recurrent cough
- ☐ chronic bronchitis
- ☐ sarcoidosis
- ☐ emphysema
- ☐ chronic obstructive pulmonary disease
- ☐ bronchial asthma
- ☐ tuberculosis
- ☐ wheezing

9. Cardiac / Peripheral – Vascular

Cardiac ☐ **No problems**
- ☐ heart trouble
- ☐ swelling of the feet
- ☐ high blood pressure
- ☐ chest pain
- ☐ heart attack
- ☐ bypass surgery
- ☐ angioplasty
- ☐ mitral valve prolapse
- ☐ heart murmur
- ☐ valvular surgery
- ☐ heart failure
- ☐ shortness of breath with walking

Peripheral – Vascular ☐ **No problems**
- ☐ poor circulation in arm R L
- ☐ blood clots in arm R L
- ☐ varicose veins R L
- ☐ poor circulation in legs R L
- ☐ blood clots in legs R L
- ☐ vascular surgery _____

10. Hepatic- Biliary/Gastrointestinal/Abdominal
- ☐ any liver disease
- ☐ history hepatitis ____Active ____Inactive
- ☐ history jaundice due to gallbladder disease
- ☐ gallbladder problems

Gastrointestinal ☐ **No problems**
- ☐ loss of appetite
- ☐ abdominal pain
- ☐ problems with gas
- ☐ heartburn
- ☐ recurrent nausea
- ☐ recurrent diarrhea
- ☐ recurrent constipation
- ☐ ulcer
- ☐ hiatal hernia
- ☐ regurgitation
- ☐ reflux
- ☐ indigestion
- ☐ history of vomiting blood
- ☐ blood in stools

MEDICAL HISTORY (Check answer(s) that apply)

PATIENT NAME:_____

☐ loss of control of bowels
☐ bleeding ulcers
☐ diverticular disease
☐ Chron's disease

11. Urinary ☐ **No problems**
☐ frequent urination
☐ difficulty with urination
☐ burning on urination
☐ inability to control urination
☐ loss of control

☐ blood in urine
☐ kidney stones

12. Genitalia / Reproductive
Male ☐ **No problems**
☐ discharge
☐ painful testicles
☐ lumps in testicles
☐ hydrocele
☐ sexually transmitted disease(s)
☐ sexual dysfunction

Female ☐ **No problems**
☐ menstruation ☐ Regular ☐ Irregular
☐ first day of last menstrual period ___/___/___
☐ premenstrual syndrome, since _____
☐ recurrent vaginal discharge
☐ number of pregnancies _____ miscarriages _____
abortions_____
☐ Cesarean section(s), number _____
☐ on hormones
☐ history cancer of uterus – ovaries
☐ sexual dysfunction
☐ sexually transmitted disease(s)

13. Endocrine ☐ **No problems**
☐ excessive thirst or urination
☐ heat intolerance
☐ cold intolerance
☐ change in hat or glove size
☐ thyroid trouble ☐ Underactive ☐ Overactive
☐ sugar diabetes-since _____
Insulin dependent yes / no
☐ disease of pituitary gland
☐ disease of adrenal gland
☐ Cushing's disease

14. Muscoloskeletal ☐ **No problems**
☐ muscle cramps
☐ stiff joints
☐ swelling of joints
☐ generalized arthritis
☐ rheumatoid arthritis
☐ fibromyalgia syndrome
☐ osteoporosis
☐ neck pain
☐ upper back pain
☐ low back pain
☐ heel spurs
☐ gout
☐ difficulty with walking
☐ cold upper extremities R L
☐ cold lower extremities R L
☐ pain in feet

☐ neck pain
☐ upper back pain
☐ low back pain
☐ heel spurs
☐ gout
☐ difficulty with walking
☐ cold upper extremities R L
☐ cold lower extremities R L
☐ pain in feet

15. Neurological / Psychiatric
Neurological ☐ **No problems**
☐ frequent or recurrent headaches
☐ fainting
☐ migraines
☐ blackouts
☐ stroke
☐ dizzy spells
☐ gait difficulties
☐ seizures
☐ epilepsy
☐ tremors
☐ neuropathy
☐ weakness
☐ paralysis

Psychiatric
☐ problems with concentration
☐ confusion
☐ problems with thinking or thought process
☐ problems with memory
☐ depression
☐ anxious
☐ shaky
☐ agitated

16. Allergies / Immunolgic
Allergies ☐ **No problems**
☐ drug allergies _____
_____
☐ food allergies _____
_____
☐ environmental allergies _____

Immunolgic ☐ **No problems**
☐ Immunologic disorders
☐ AIDS
☐ lupus

Interventional Pain Management Associates

Name:_____ Date:_____

All professional services are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. Please be advised that we will submit to your primary and secondary insurance. Any remaining balance after receipt of explanation of benefits from your primary/or secondary insurance carrier will be billed to you.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Name of Subscriber:_____

Relationship: ___ Self ___ Spouse ___ Parent ___ Other

Primary Insurance Policy:_____

Secondary Insurance Policy:_____

I request that payment of authorized Medicare/other insurance company benefits be made either to me on my behalf or to IPM, Interventional Pain Management Associates for any services furnished to me by that third party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers and information needed for this or related Medicare claim/other Insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the healthcare provider of any other party who may be responsible for paying my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information).

_____

Signature of Patient or Responsible Party Date

_____(Please initial) I have been offered a copy and an explanation of the Notice of Privacy Practices (HIPPA)

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ASSIGNMENT OF BENEFITS & POWER OF ATTORNEY

Patient's Name: _____

Date of Accident: _____

I, the above named patient assign to Interventional Pain Management Associates/Maher Ibrahim, MD my rights and interest in the personal injury protection endorsement of the automobile liability insurance policy or other insurance policy listed. This assignment is given with respect to all treatment, care and diagnostic treatment given by the assignees to or its employees. I authorize this provider to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation.

I hereby assign benefits and authorize payment directly to the above medical provider and/or its staff of any insurance benefits made as payment to me (or a minor for whom I am guardian) as reimbursement for services provided to me (or a minor for whom I am the guardian) for their services. I agree to immediately forward to this office any insurance payments which are made to me.

I irrevocably authorize the above medical provider to retain an attorney of his/her choice on my behalf for collection of unpaid or underpaid medical expense benefits. I direct that all reimbursable medical payments go directly to the above medical provider.

I consent the above medical provider to act on my behalf in regard to my general health insurance coverage pursuant to the "benefits denial appeals process" set forth in the NJ Administrative Code. In the event the insurance carrier responsible for making medical payments in this matter does not accept this assignment, or this assignment is challenged or deemed invalid, I execute this limited/special power of attorney and appoint and authorize provider's collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case in my name including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in provider's name as a medical provider rendering services to me and designate provider's attorney as my attorney in fact. I further grant limited power of attorney to my medical provider named above to receive and collect directly from the insurance carrier money due to this provider for services rendered to me as a result of the above accident, and hereby instruct the insurance carrier to pay this provider directly for all services rendered to me.

I authorize the above medical provider and his/her attorney to obtain medical information regarding my physical condition from any other health care provider or attorney, including but not limited to hospitals, diagnostic centers etc., and I specifically authorize such health care provider(s) to release all such information to the above named provider about me, including medical reports, X-ray reports, narrative reports and any other report or information regarding my physical condition.

Dated: _____ _____

Patient Signature

Dear Patient:

You have been scheduled to have your upcoming procedure at Hamilton Surgical Services(the "Facility")

The following disclosure is made at or prior to the time that the referral is made:

In accordance with Federal Regulations (42 C.F.R. 416.50(a)(ii) and the Public Law and applicable rules of the State of New Jersey, Board of Medical Examiners (C.26:2H-12; N.J.A.C. 13:35-6.17) a physician , podiatrist, and all other licensees of the Board of Medical Examiners must inform patients of any significant financial interest in a healthcare service.

The Facility is owned (IN PART) by the physician of Interventional Pain Management Associates. Accordingly, please take notice that the physicians who will be performing your procedure has a financial interest in the healthcare service for which you are being referred.

You may, of course, seek treatment at a healthcare service provider of your own choice. A listing of alternative healthcare service providers can be found in the classified section of your telephone directory under the appropriate category.

You have the right to enter into an advance directive. An advance directive means a written statement of your instructions and directions for healthcare in the event of your future decision making incapacity. An advance directive may include a proxy directive or an instruction directive, or both. (N.J.A.C. 8.43A-1.3).

You have the right to make informed decisions regarding your care including the right to make decisions concerning the right to accept, refuse, or choose from alternatives of medical and/or surgical treatment.

By signing this disclosure you or your legal representative, acknowledge that: (1) you are receiving this notice prior to the date of the procedure; (2) you have been informed of the financial interests of the practitioners in this office;(3) you voluntarily desire to have your procedure performed at the Facility; (4) you have been informed that part or all of your procedure will be considered "out-of-network, if applicable; (5) you have the right to enter into an advance directive: and (6) you have the right to make informed decisions regarding your care.

Understood and agreed:

Patient Signature: _____ Witness: _____

Printed Name: _____ Printed Name: _____

Date: _____

H2.6C NOTICE OF PRIVACY PRACTICES

Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information

We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations

Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures

We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

Research: We may use or disclose information for approved medical research.

Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena or court order.

Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-elated injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights

You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health information.

We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.

Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.

Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any t ime. For more information about our privacy practices, contact the person listed below.

Complaints

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person

If you have any questions, requests, or complaints, please contact:

Privacy Officer
1235 Whitehorse-Mercerville Road, Suite 310
Hamilton, NJ 08619
Tel: (609) 581-6610

Effective Date: April 14, 2003