Thank you for making an appointment to see a physician at Spine & Pain Centers. This appointment does not guarantee that we will agree to accept you as a patient. Our doctor will evaluate your condition at the initial visit and determine if further treatment is necessary.

Narcotics will not be prescribed until you have been cleared by our team of specialists.

To aid our doctor in determining the best course of treatment, please bring the following information to your first appointment.

INSURANCE ID CARD and Referral if necessary

WORKER'S COMPENSATION OR AUTOMOBILE PERSONAL INJURY INSURANCE CLAIM INFORMATION if applicable, including

- INSURANCE COMPANY ADDRESS
- CLAIM NUMBER
- DATE OF ACCIDENT
- ADJUSTER/CASE MANAGER'S NAME AND PHONE NUMBER
- YOUR ATTORNEY'S NAME, ADDRESS AND PHONE NUMBER

MRI, CT SCAN OR X-RAY FILMS AND REPORTS even if the films are 2 to 3 years old

LIST OF ALL MEDICATIONS that you are currently taking

COMPLETED PATIENT FORMS (attached)

REFFERING DOCTOR'S AND PRIMARY CARE DOCTOR'S name and address

If you have any questions about your appointment, please call 732-345-1180.

Spine and Pain Wall Office Directions

1967 State Route 34, Suite 102 Wall, NJ 07719

732-345-1180

From the North:

Take Garden State Parkway South Exit 98, then south on Route 34. Make right at first traffic light (immediately before the LUK Oil gas station) onto Allenwood Road. Make the second left into Allenwood Corporate Park, Building C, Suite 102.

Take Route 18 South to Route 138 West. Make left onto Allenwood Road (you must actually take right jug handle to make this left). Continue straight on Allenwood Road and cross Route 34. Make left into Allenwood Corporate Park, Building C, Suite 102.

From the South:

Take Garden State Parkway North to exit 98, then follow signs to Route 138 East. At first traffic light make right onto Allenwood Road. Continue straight on Allenwood Road and cross Route 34. Make second left into Allenwood Corporate Park, Building C, Suite 102.

Take Route 70 North to Route 34 North. Go around the Wall traffic circle and after next traffic light at Allenwood Road take immediate right jug handle(immediately before the Getty gas station). Cross over Route 34 (LUK Oil gas station will be on your left). Make second left in Allenwood Corporate Park, Building C, Suite 102.

From the East:

Take Route 34 North. Go around the Wall traffic circle and after next traffic light at Allenwood Road take immediate right jug handle (immediately before the Getty gas station). Cross over Route 34 (LUK Oil gas station will be on your left). Make second left into Allenwood Corporate Park, Building C, Suite 102.

From the West:

Take I-195 East to Route 138 East. At first traffic light make right onto Allenwood Road. Continue straight on Allenwood Road and cross Route 34. Make second left into Allenwood Corporate Park, Building C, Suite 102

Or

Take Route 34 South, cross under the Garden State Parkway and take a right at the first traffic light (immediately before the LUK Oil gas station) onto Allenwood Road. Make second left in Allenwood Corporate Park, Building C, Suite 102

PATIENT INFORMATION

Date:_____

Last Name:_____First Name:_____M:_____

Sex: ☐Male ☐Female Date of Birth:_____ Social Security:_____

Marital Status: _____ Preferred Language: ☐English / Other_____

Race: ☐White ☐African American ☐Other_____

Address:_____Town:_____ State/Zip:_____

Home Phone _____Cell Phone_____Work Phone_____

E-Mail Address_____Preferred Contact: Home / Cell / Work / E Mail (circle one)

Emergency Contact Name:_____ Phone:_____

Referring Doctor:_____**Primary Care Doctor**:_____

Employer/School:_____Occupation:_____

Pharmacy Name, Address, Phone:_____

Primary Insurance Information

Type: ☐Health Insurance ☐Workers Comp ☐Auto/PIP Accident ☐None/Self-Pay

Subscriber's Name:_____**Date of Birth**:_____
Address:_____SS#_____
Insurance Company:_____**Date of Accident**:_____
Address:_____Phone#_____
Group/Claim #_____Policy/ID#_____
Case Manager:_____Phone #_____

Secondary Insurance Information

Subscriber's Name:_____**Date of Birth**:_____
Address:_____SS#_____
Insurance Company:_____**Date of Accident**:_____
Address:_____Phone#_____
Group/Claim #_____Policy/ID#_____
Case Manager:_____Phone #_____

SPINE & PAIN CENTERS OF NEW JERSEY & NEW YORK

INTIAL PATIENT INTAKE

PATIENT NAME:_____**DOB:**_____**DATE:** _____

Weight:_____ **Height:**_____

Chief Complaint:_____

Is Your Pain From an Auto or Worker Comp Accident? ☐**YES** ☐**NO**

Initial Pain Level (0-10 10 being worst) _____ How often is your pain present? ☐Occasional ☐Frequent ☐Constant

What makes symptoms worse?

☐Walking ☐Standing ☐Sitting ☐Lying Down

What makes symptoms better?

☐Walking ☐Standing. ☐Sitting ☐Lying Down

Medical History

Patient Medical History:		
Diabetes	☐No	☐Yes
Blood Pressure	☐No	☐Yes
Asthma/COPD	☐No	☐Yes
Stroke	☐No	☐Yes
Heart Problems	☐No	☐Yes
Kidney Problems	☐No	☐Yes
Seizure disorders	☐No	☐Yes
Bleeding/Clotting	☐No	☐Yes
Liver/Hepatitis	☐No	☐Yes
Sleep Apnea	☐No	☐Yes
Cancer	☐No	☐Yes
Thyroid	☐No	☐Yes

Previous Hospitalizations/Surgeries When?

_____

_____

_____

_____

Current Medications:

_____

_____

_____

_____

_____

_____

ALLERGIES

Dye ☐Yes ☐No

Other Medication Allergies

_____

_____

_____

_____

_____

_____

_____

Patient Social History:

Occupation:_____ ☐**Full time** ☐**Part time**

Marital status: ☐Single ☐Married ☐Separated/Divorce ☐Widowed

Use of alcohol: ☐Never ☐Rarely ☐Moderate ☐Daily

Use of tobacco: ☐Never ☐Previously but quit ☐Current packs/day____

Use of drugs ☐Never ☐Type/Frequency_____

Family Medical History, if pertinent:

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Children	_____	_____	_____

Do you have an immediate family member or close friend with history of illegal drug use or alcohol addiction? ☐Yes ☐No

Please check off if any current problems in any of the following areas:

☐General Wellness ☐Lungs/Breathing ☐Neurological ☐Chest pain ☐Reproductive/Urinary
☐Headache ☐Fatigue ☐Skin ☐Thyroid ☐Endocrine ☐Trouble Sleeping
☐Nausea ☐Ears, Nose, Throat ☐Blood/Lymph ☐Memory ☐Ringing in Ears
☐Stomach/Digestion ☐Psychiatric ☐Dizziness ☐Muscles/Joints/Bone ☐Eyes ☐Weight Loss

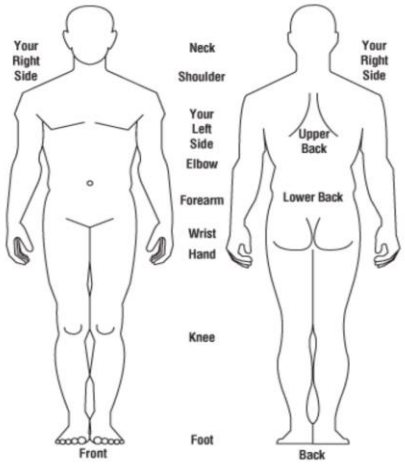
If any of above areas are checked, please explain: _____

Previous treatment? Please Check any of the following you have had:

☐Physical Therapy ☐Chiropractic Treatments ☐Anti-Inflammatory Medications
☐Nerve Blocks/Injections ☐Home based exercise/Self-care/Ice /Heat

☐MRI ☐CT SCAN ☐X-RAYS ☐EMG

Mark the location of your pain



Patient Signature: _____

PAYMENT AUTHORIZATION FORM

Patient Name:_____ **DOB**_____/_____/_____

For and in consideration of services rendered, I agree to make payment to Spine and Pain Centers when billed for any and all charges not covered by valid insurance benefits. I authorize payment directly to Spine and Pain Centers for health insurance benefits payable to me under terms of my policy but not to exceed the balance due for services performed during this period of treatment. Spine and Pain Centers may seek, release and verify all or part of my medical and/or financial records to any person, corporation or government agency which is or maybe liable under a statute, regulation or contract to Spine and Pain Centers, myself, a family member or my employer for all or part of the Spine and Pain Centers charge.

If any of the following changes: patient's address, patient's phone number, patient's insurance information or any other information necessary for Spine and Pain Centers process your medical bill, the patient must inform Spine and Pain Centers promptly.

In the event the provider's charges are outstanding, I hereby authorize the provider to file such claim and/or action on my behalf so that the provider may receive payment of their charges. I understand that, if the provider does not receive payment from the insurer, I remain personally responsible for payment of the provider's charges.

Medicare – Authorization to release information and payment request:
I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to this or a related Medicare claim. I request that direct payment of authorized benefits be made on my behalf. I assign benefits payable for physician's services to the physician or organization furnishing the services or authorize such payment or organization to submit a claim to Medicare for payment.

Please check the appropriate box: (MEDICARE CERTIFICATION)

I am entitled to benefits under Medicare Hospital Insurance, Part A.

☐YES ☐NO

I am entitled to benefits under Medicare Hospital Insurance, Part B.

☐YES ☐NO

_____ _____

Date Signature

SPINE AND PAIN CENTERS
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on September 23, 2013 and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer. Information on contacting us can be found at the end of this notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share our protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other healthcare professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you my also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013, immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased, you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer.

Right to request Restriction of PHI: If you pay full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013. The Omnibus Rule restricts provider's refusal of an individuals request to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Emergencies: We may use or disclose your health information to notify or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible, we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated, we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to

make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law (Court or administrative orders, subpoena, discovery request or other lawful process). We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to our health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, and disease /infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include diagnosis, nature of services and treatment. If you have elected to opt out, we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting pain in exchange for the PHI). "Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or fee otherwise expressly permitted by law. Corporate transactions (i.e. sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). We will provide access to health information in a form/format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a complaint form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

Spine and Pain Centers
Angela Kosh, Privacy Officer
732-345-1180 ext. 207
asalone@spineandpain.com
1967 Rt 34 Suite 102
Wall, NJ 07739

CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

Patient' s Name: _____

Patient's Date of Birth: _____ Patient's SSN: _____

Notice to Patient

By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of **treatment**, various activities associated with **payment** and **health care operations**. Our **Notice of Privacy Practices** provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our **Notice of Privacy Practices**, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to **revoke** your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this consent, we may decline to treat you.

You are entitled to a copy of this **Consent Form** after you have signed it.

(To Be Completed by Patient or Patient's Representative)

I, _____, have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

_____ _____
Patient's Signature or Signature of Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient

Our Privacy Officer can be contacted as follows:

Angela Kosh
1967 Route 34,
Wall, NJ 07719

Phone: 732-345-1180
Fax: 732-530-4476
E-Mail: angela@spineandpain.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____
Please print your name here

_____ _____/_____/_____
Signature Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

☐ The patient refused to sign.
☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
☐ We weren't able to communicate with the patient.
☐ Other_____

_____ _____/_____/_____
Employee Signature Date

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

☐ Home Phone # _____
☐ Cell/Other Telephone # _____
☐ OK to email to my email address _____
☐ Written Communication
☐ OK to leave message with detail information
☐ Leave message with call-back number only

☐ Persons authorized to receive information

_____relationship_____

_____relationship_____

_____ _____ _____/_____/_____
Printed Name Patient Signature Date

AUTHORIZATION TO OBTAIN MEDICAL RECORDS

1967 NJ-34, Suite 102, Wall Township, NJ 07719
Phone: 732-345-1180 | Fax: 732-530-4476

Patient's Name:_____ Date of Birth:_____

I request and authorize Spine and Pain Centers to obtain my protected health information from:

Name:_____

Address:_____

Fax:_____

The information to be released is to include: (indicate dates of treatment and portion of each to be released).

_____Reports of Operation
_____Consultation Reports
_____Radiologic Interpretation
_____Lab Test Results

Yes___ No____ I authorize the release of any records regarding drug, alcohol, mental health treatment to the person(s) listed above. If you do not make a selection, these records will be released as part of your records.

Unless otherwise revoked by myself, this authorization is to be considered valid only for 30 days from the date below. If information has been released under the terms of this authorization which I later revoke, I understand that Spine and Pain Centers will not be responsible for release prior to receipt of revocation.

Date: _____ Patient Signature: _____

PATIENT PORTAL AUTHORIZATION FORM

Please issue a username and temporary password for access to the patient portal at Spine and Pain Centers to:

Patient Name:_____

DOB:_____

E-Mail Address:_____

Patient's Signature:_____

Your username and temporary password will be emailed to you at the address listed above.

Public law/rule of the State of New Jersey/Board of Medical Examiners mandates that a physician, podiatrist and all other licensees of the Board of Medical Examiners inform patients of any significant financial interest held in a health care service.

Accordingly, take notice that Dr. Sharma has a financial interest in the following health care facilities to which patients are referred: Shrewsbury Surgical Center, Toms River Surgical Center, Physician's Surgical Center, Metropolitan Surgical Institute, Neptune Ambulatory Surgical Center and SurgiCare Surgical Associates of Freehold.

You may, of course, 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.

X_____
Patient Signature

_____
Patient Name