CARDINAL SPINE & PAIN MEDICINE, P.C.

PATIENT REGISTRATION

Name: _____ DOB:_____/_____/_____
Last First M.I.

Address: _____
Street City State Zip Code

Home: (_____)_____-_____ Work: (_____)_____-_____ Cell: (_____)_____-_____

Email Address: _____

Marital Status: M S W D Sex: M F Race: _____ S.S.#: _____-_____-_____

Primary MD: _____ Referred by: _____

Pharmacy: _____
Name Location

Patient's Employer: _____

Person Responsible for Bill (if other than patient): _____

Address (if different from above): _____

_____

Insurance Name: _____ _____
Primary Secondary

Policy Number: _____ _____

Primary Insured Name: _____ DOB: _____/_____/_____

Primary Insured Employer: _____

Relationship: _____ S.S.#: _____-_____-_____

I hereby authorize the release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to me: Cardinal Spine & Pain Medicine, P.C. I understand that I am responsible for any balance not covered by my insurance company.

_____ _____
Signature Date

Cardinal Spine & Pain Medicine, P.C.
Niraj Sharma, M.D.

Pain Questionnaire

The purpose of this questionnaire is to obtain a complete assessment of you and your pain problems. This is a long questionnaire because pain is a very complex problem that affects all aspects of your life. We are trying to evaluate how the pain has affected your life so that we can make the best recommendation possible to assist you in your recovery.
This record is confidential and no one can see it without your permission.

Patient's Name: _____ DOB: _____/_____/_____ Age: _____

Address: _____ Phone: (_____)_____-_____

Signature/Relationship of person completing this form: _____

Referring Physician's Name: _____ Phone: (_____)_____-_____

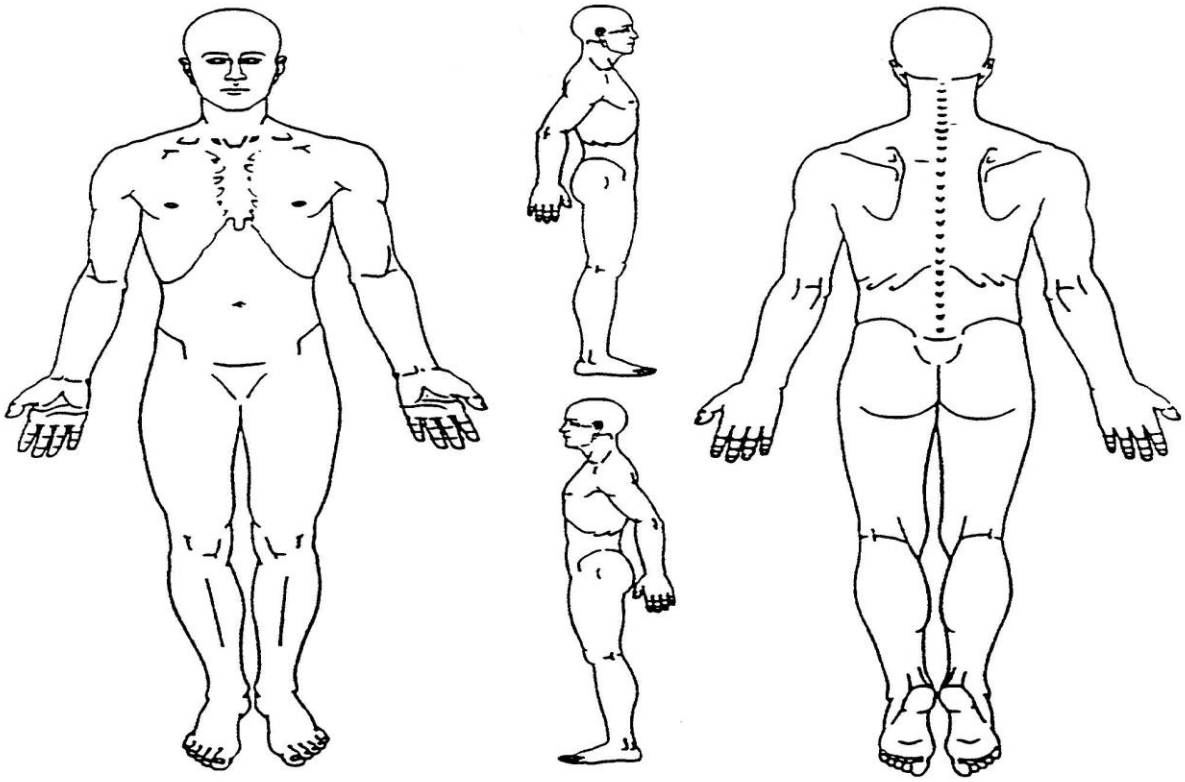
Address: _____

Are you currently receiving or in the process of receiving worker's compensation related to your problem? YES _____ NO _____

Pain Diagram

(Please use appropriate symbols to show locations of the related symptoms)

Pain: +++ Numbness: - - - Tingling: xxx



Patient's Name: _____ DOB: _____ Age: _____ Date: _____

Pain History (Circle the one that applies)	Pain Intensity (Circle the one that applies)
Throbbing, Shooting, Stabbing, Sharp, Cramping, Gnawing, Hot Burning, Aching, Numbness, Tingling, Dull, Pulling	**0 1 2 3 4 5 6 7 8 9 10** 0 = No Pain 5 = Moderate Pain 10 = Worst Pain Number your pain when it is worst: _____ Number your pain when it is least: _____ Number your pain on average: _____

Have you fallen in the past 12 months? (circle one) Yes No
When did the pain begin? _____
How did your pain begin? _____
Briefly describe the circumstance when your pain began: _____
_____
In general, when is your pain the worst?
Morning: _____ Afternoon: _____ Evening: _____ Night: _____ No pattern to the pain: _____
How often do you have the pain?
Constantly (100% of the time) _____ Nearly Constantly (60-90% of the time) _____
Intermittent (30-60% of the time) _____ Occasionally (less than 30% of the time) _____
Please circle when your pain is felt:
Worse: Walking Lifting Bending Lying Weather Changes Standing Other: _____
Better: Heat Ice Rest Lying Weather Changes Standing Medication: _____

Prior Treatments

Treatment	Helpful	Not Helpful
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Diagnostic Procedure Done

Diagnostic Test	Body Part Evaluated	Date
Plain X-Rays		
MRI		
CT Scan		
EMG		
Bone Scan		
Discogram		
Myclogram		

Patient's Name: _____ DOB: _____ Age: _____ Date: _____

Past Medical History

Date of Last Seasonal Flu Shot (MM/YY): _____

☐Heart Problems _____

☐Hypertension _____

☐Circulation Problems _____

☐Diabetes _____

☐Kidney/Bladder Problems _____

☐Liver Problems _____

☐Cancer _____

☐Blood Disorders _____

☐Lung Problems/Asthma _____

☐Intestinal Problems/Ulcers _____

☐Blackouts/Falls _____

☐Other _____

☐Any medical devices implanted in your body? _____
(i.e., pacemaker, portacath, pump, rods, prosthesis, etc.)

Past Surgical History

Name of Surgery	Date

Please list <u>all medications</u> and dosages you are currently taking. **PLEASE DO NOT OMIT** any blood thinners you may be taking; i.e., Coumadin, Lovenox, Heparin, Plavix, Aggranox, etc.

Medication	Dosage	Medication	Dosage

Please list all drug allergies _____

_____

Social History

Emergency Contact: _____ Relationship: _____ Phone: _____

Do you take care of other family members? _____

Previous/Current Occupation: _____

Are you currently working? YES _____ NO _____ If not, why? _____

Do you have any legal issues that are current or pending related to your current medical problem _____

If yes, please specify _____

Do you smoke? YES _____ NO _____ If yes, how many per day? _____

Recreational drug use? YES _____ NO _____

Alcohol use? YES _____ NO _____ If yes, how many per day/week? _____

Patient's Name: _____ DOB: _____ Age: _____ Date: _____

Family History

Do you have a family history of the following? Please circle the ones that apply.

Pain Arthritis Cancer Psychological problems Bleeding disorder Other_____

Patient's review of systems (Circle the ones that apply to you)

Constitutional: Weight _____ Height _____ Fever/Chills Night Sweats Wt. Loss Wt. Gain
HEENT: Hearing Loss Hearing Aide R/L Sinus Problem Loose Teeth Dentures Partial/Full Glaucoma/Cataracts Glasses/Contacts
Endocrine: Diabetes Insulin Dependent/Oral Diabetic Medication Thyroid Problems Addison's Disease Excessive Thirst or Urination
Respiratory: Blood in Sputum Shortness of breath Chronic Cough Snoring Home Oxygen Home Breathing Treatment Airway Obstruction History of TB Sleep Apnea Nasal Septal Deviation
Cardiovascular: Angina Chest Pain Palpitations Heart Attack Chronic Heart Failure Shunts/Stents Heart Murmur (if yes, do you take antibiotics for dental work?) Rheumatic Fever Pacemaker
Gastrointestinal: Change in Appetite Hepatitis Liver Disease Ulcer Heartburn Diarrhea Gastrointestinal Bleeding (blood in stool, dark/tarry stool, vomiting blood) Nausea/Vomiting Constipation Bowel Incontinence
Gynecological: Last Period _____ Menopausal Hysterectomy
Genitourinary: Kidney Problems Burning While Urinating Blood in Urine Frequency Bladder or Kidney Infections Ostomy Dialysis Catheter Difficulty Urinating Urinating Incontinence
Neurological: Dizziness Headache Seizures Stroke Weakness of Extremities Fainting Numbness Paralysis Multiples Sclerosis Other: _____
Hematological: Easy Bruising Low Platelets On Aspirin/Non Steroid Anti-Inflammatory History of Cancer History of Radiation Therapy History of Chemotherapy
Musculoskeletal: Back Pain Neck Pain Joint Pain Arthritis Cast Osteoporosis Amputation Joint Replacement Artificial Limb Rheumatoid Arthritis
Skin: Sores Rashes Bruises Cuts Burns Incision Itching
Psychological: During the past month have you been….Tense Anxious Depressed Upset Discouraged Irritable

Patient consent form

Use of this form is optional and not required under the HIPAA privacy rule.

CARDINAL SPINE & PAIN MEDICINE, P.C.

1323 Route 9, Suite 206
Wappingers Falls, NY 12590

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Cardinal Spine & Pain Medicine, P.C.** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **Cardinal Spine & Pain Medicine, P.C.** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Cardinal Spine & Pain Medicine, P.C.** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Cardinal Spine & Pain Medicine, P.C. 1323 Route 9, Suite 206 Wappingers Falls, NY 12590**

With this consent, **Cardinal Spine & Pain Medicine, P.C.** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Cardinal Spine & Pain Medicine, P.C.** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, **Cardinal Spine & Pain Medicine, P.C.** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Cardinal Spine & Pain Medicine, P.C.** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Cardinal Spine & Pain Medicine, P.C.** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Cardinal Spine & Pain Medicine, P.C.** may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable

CARDINAL
SPINE & PAIN MEDICINE

1323 Route 9, Suite 206
Wappingers Falls NY 12590
(P) 845-297-2225 (F) 845-297-2224

We would like to thank you for choosing Cardinal Spine and Pain Medicine as your medical provider. We have written this document to keep you informed of our current office policies.

Office Hours: Our office is open Monday – Thursday, 9:00 a.m. – 4:30 p.m. Office is closed on Friday.
Appointments: We recognize that everyone's time is valuable, and make every effort to maintain the scheduled appointment times. Occasionally urgent situations disrupt the schedule. We ask for your understanding and patience during these delays. We will make every effort to keep your waiting time to a minimum while ensuring at each patient's needs are addressed.
Referral: If your insurance requires, you must get a valid referral from your primary care provider before your appointment. If you are a returning patient, please ask when you book your appointment whether your previous referral will still be valid. Failure to provide a referral from your primary care may result in non/reduced coverage by your insurer. You are responsible for non-covered or reduced expenses due to no/invalid referrals.
Cancellations: If you are unable to keep your appointment, please call. Late arrival may necessitate rescheduling your appointment. If you fail to keep an appointment and do not call within 24 hours to cancel, a $40.00 fee will be assessed to your account. A $100.00 charge will be applied to injections appointments that are not cancelled with a 48 hours advance notice. Please note, excessive missed, short notice cancellations and no shows of scheduled appointments may result in termination of a patient at the discretion of the practice.
Test Results: If you have diagnostic testing (lab, x-ray, MRI, CT scan, etc) please schedule a follow-up appointment within 7-14 days to go over the results with your physician. You will be subject to your copay/co- insurance. Results will not be provided over the phone.
Prescriptions and Refills:
• The best time to get a prescription refill is at your appointment.
• If you need to call for refills, don't wait until you have run out. Most refills require the doctor's approval. If the doctor is out for the afternoon, it may be the next day (or Monday) before it can be authorized.
• Don't go to the pharmacy to wait for your prescription to be called in. Call them first to see if it is ready.
• Some prescriptions cannot be called in. The prescription must be printed for you to pick up.
• Don't call after hours for prescription refills. There is no access to your chart and we may not be able to help you.
Narcotics: We do not treat chronic pain with narcotics. We do not call in narcotics after hours.
Dismissal: If you are "dismissed" from the practice it means you can no longer schedule appointments, get medication refills or consider us to be your doctor. You have to find a doctor in another practice.
Common Reasons for Dismissal
• Failure to keep appointments, frequent no-shows.
• Noncompliance, which means you won't follow physician instructions about an important health issue.
• Abusive to staff/belligerent behavior.
• Failure to pay your bill.
Dismissal Process
We will send a letter to your last known address, via certified mail, notifying you that you are being dismissed. If you have a medical emergency within 30 days of the date on that letter, we will see you. After that, you must find another doctor. We will forward a copy of your medical record to your new doctor after you let us know who it is and sign a release form.

Financial Policies

No Insurance: Payment will be due in full at the time of service. We accept cash and credit cards (Visa & Mastercard) only.

Insurance: You will be asked to provide your insurance card(s) at every visit. This is to ensure that the information we have is correct, and that your plan is current and one in which we participate. Out of date cards with incorrect information or the wrong insurance cards can cause unnecessary delays in the payment of your claim. Frequently, small changes (for example, a group number change or plan change) may not be considered significant by patients, but insurers will not process claims that are not 100% accurate.

All office co-pays are to be paid at the time of service. The co-pay cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. If the co-pay is not paid at the time of service, you may not be seen. We accept cash or credit cards, but cannot take checks.

You may receive a statement from our office for any balance due. For your convenience we accept cash, checks, credit cards (Visa and MasterCard), and money orders. Payments are also accepted by phone.

We will submit insurance claims for our patients. However, the agreement of the insurance carrier to pay for medical care is a contract between you and the carrier. You should direct any questions and/or complaints regarding coverage to your insurance carrier, your employer (if in a group plan), or to your agent.

Insurances vary in their coverage, and it is the patient's responsibility to understand his/her medical benefits. There may be limitations and exclusions to coverage. The patient portion is set by the insurance company. **Patients are responsible for any co-insurances, deductibles, and any other non-covered billable services**.

Auto Accident/Liability Injury/Worker's Compensation: If your injury is a result of an auto accident, another party's negligence or due to an accident in your work place, please inform the receptionist. You are required to provide the information for your carrier, including name of case worker, phone number, date of accident and the body parts covered. If we provide medical services and they are not covered by your carrier, you will be responsible for payment to us for services rendered.

Return Checks: There will be a $40 charge assessed for any check returned by your bank for any reason.

Disability, Insurance Forms, Attending Physician Statements, FMLA: There will be a charge of $25.00 for the completion of medical forms and you may be required to schedule an appointment. Payment is due at the time that you pick-up these forms. Please allow 7-14 days for the completion of these forms. If you would like the forms mailed to you or another party, payment will be due prior to mailing. FMLA forms require that you come in for an appointment. Please be advised acceptance and completion of forms will be at the discretion of Cardinal Spine and Pain Medicine, PC.

Medical Records: We will provide you with a copy of your medical records upon request and for a fee. You will need to sign a letter of release prior to having them copied. Please allow 7-14 days for this request to be processed.

Billing: If you receive a bill from us, it is because we believe the balance is your responsibility. Please contact your insurance company first if you think there is a problem. If you have any questions about your bill, please call our billing department immediately. If you cannot pay your entire balance, please call to make payment arrangements.

Collections: Balances are due within 30 days of when the bill is issued. Bills will be issued after the insurance carrier pays its portion of the bill. If the balance remains unpaid after 90 days your account will be subject to collections due to violation of our financial policy and agreement of your financial obligation for services rendered.

****WE WILL NO LONGER BE CARRYING OVER BALANCES****

Acknowledgement

I acknowledge that I have received and read a copy of the **Cardinal Spine and Pain Medicine Office and Financial Policies.**

_____

Patient/Guardian Signature and Date