Onyx Medical Practitioner
Rehabilitation Offices of New York
Patient Registration Form

Date:_____

Patient Information:

Last Name:_____ First Name:_____ M Initial:_____
SS #_____ Date of Birth:_____
Address:_____
City/St/Zip:_____
Home Phone:_____ Cell:_____
Age:_____ Sex:_____ Weight:_____ Height:_____

Primary Doctor:_____ **Is this no fault/workers compensation : YES / NO**
How Did You Hear about our Clinic?_____
Email:_____

Emergency Contact:

Name:_____ Relationship:_____
Home Phone:_____ Cell Phone:_____

Insurance Information:

Primary Insurance:_____ Insured ID#_____
Group #_____
Address:_____
City/St/Zip_____ Phone_____
Policy Owner_____ **Insured Date of Birth**_____
Patient Relationship to Policy Owner_____

Policy Holder Information (if different then yourself)

Last Name:_____ First Name:_____ M Initial____
Address:_____
City/St/Zip_____ Date of Birth_____
SS#_____
Employer_____ Work Phone_____

Pain Management Comprehensive Intake Form-
History and Physical

Medical History: Have you ever had or been told you have (check all that apply):

Cardiovascular:

( ) Chest pain or angina

( ) Heart Disease

( ) MI, Heart attack, blocked artery

( ) Congestive heart failure

( ) High blood pressure

( ) Peripheral vascular disease

( ) Abnormal heart bleed

( ) Pacemaker

( ) Angioplasty or heart cath

( ) Rheumatic fever

( ) Damaged heart valve

Neurological:

( ) Epilepsy or seizures

( ) Fainting spells or dizziness

( ) Stroke _____

( ) Headaches/migraines

Respiratory:

( ) Asthma

( ) Shortness of breath

( ) Emphysema

( ) TB

( ) Smoking: now past

How many packs per day?

Gastrointestinal:

( ) Ulcers, heart burn, reflux

( ) Diverticulitis or colitis

( )Other:_____

Other:

( ) Chronic numbness/pain

( ) Depression or anxiety

( ) Other Nervous Problems

( ) Dentures

( ) Partial Plate

( ) Glasses

( ) Hearing aid

Metabolic:

( ) Diabetes

( ) Thyroid disease

( ) Adrenal gland problem

( ) Steroid use ___

Liver/kidney/blood:

( ) Kidney Disease

( ) Shunt, graft, fistula

( ) Dialysis

( ) Liver disease

( ) Gallbladder

( ) Hepatitis (type_____)

( ) Anemia

( ) East bruising or bleeding

( ) Anticoagulants (blood thinners)

( ) Back injury/ nerve damage

( ) Skin condition

( ) Arthritis/rheumatism

History of Cancer:_____

Social Family History: Marital Status S M D W Separated

Mother: living/deceased Cause:_____ Father: living/deceased Cause:_____

Usual Diet_____

Alcohol: _____drinks per day Other Drug use:_____

History and Physical

Current Employment Status: ( ) Employed Full Time ( ) Employed Part Time ( ) Retired ( ) Self Employed

( ) Unemployed due to pain ( ) Unemployed for other reasons ( ) Applied of disability

Occupation:_____

With Whom do you live? ( ) Self ( ) Spouse ( ) Children ( ) Parents ( ) Friend(s) ( ) Other_____

Allergies:_____

Reaction:_____

Have you or any blood relatives ever had a reaction to anesthesia? Yes No_____

Medications you take at home: (including pain medications)

Medicine: Dose: How Often: Last Dose:

_____

_____

_____

_____

Previous Surgeries: (Including the Dates)

_____

_____

_____

Any problems with surgery or anesthesia? Yes No

_____

ROS: please check the box if you currently have any of the following

( ) fever, weight loss, sweats ( ) Cough, Sputum production, wheeze ( ) shortness of breath

( ) Weakness or paralysis of arms/legs ( ) Headache(S) How Often?_____ ( ) Dizziness, vision changes

( ) Sweling or rash_____ ( ) Change in bowel habits____ Stool color____ ( ) chest pain/palpitations

( ) Easy bruising, bleeding, using blood thinner ( ) Change in bladder habits (frequency, pain)

( ) Pregnant or possibly pregnant?

History and Physical Page 3

Where is your Pain?_____
Does it go anywhere else? Yes _____ No_____ Where?_____
When did it start?_____
How long have you had this pain?_____
Did it start: ___Gradually ___Suddenly__ Not Sure
How often do you have this pain? ____ Continuously ___Comes and goes
How Often? ____minutes ___hours ____times a day ____days a week
It is: ____getting better ____getting worse ____staying the same

How did it start?

( ) Accident (date: _____/_____/_____)
( )Other Injury (_____/_____/_____)
( ) Cancer:_____
( ) Work Injury (_____/_____/_____)
( ) Following an operation _____
( )No obvious cause

What makes your pain better?

( ) Sitting ( ) Standing ( ) Walking ( ) Heat
( ) Exercise ( ) Cold ( ) Stretching ( ) Brace
( ) Immobilization ( )Other _____

Please check all that describe your pain:

	None	Mild	Moderate	Severe
Throbbing	____	____	_____	_____
Shooting	____	____	_____	_____
Stabbing	____	____	_____	_____
Tingling	_____	____	_____	_____
Cramping	_____	_____	_____	_____
Burning	_____	_____	_____	_____
Aching	_____	_____	_____	_____
Numb	_____	_____	_____	_____
Heavy	_____	_____	_____	_____
Tender	_____	_____	_____	_____
Tiring	_____	_____	_____	_____
Exhausting	_____	_____	_____	_____
Sickening	_____	_____	_____	_____
Fearful	_____	_____	_____	_____
Punishing	_____	_____	_____	_____
Cruel	_____	_____	_____	_____

What Treatments have you tried for pain?

( ) Exercise	( ) Massage	( ) Chiropractor	( )Acupuncture	( ) Brace
( ) Physical Therapy	( ) Warm Pack	( ) Ice Pack	( ) Nerve Block	( ) Biofeedback
( ) TENS Unit	( ) Traction	( ) Psychologist	( ) Psychiatrist	( ) Surgery

History and Physical Page 4

Previous Medications Tried: (Check all that apply)

NSAIDS: ( )Aspirin ( )Ibuprofen ( )Advil ( )Motrin ( )Naprosyn _____

Relaxants: ( )Flexural ( )Valium ( )Xanax ( )Ativan ( )Librium_____

Sleep Medications: ( )Ambien ( )Restoril ( )Benadryl ( )Halcion_____

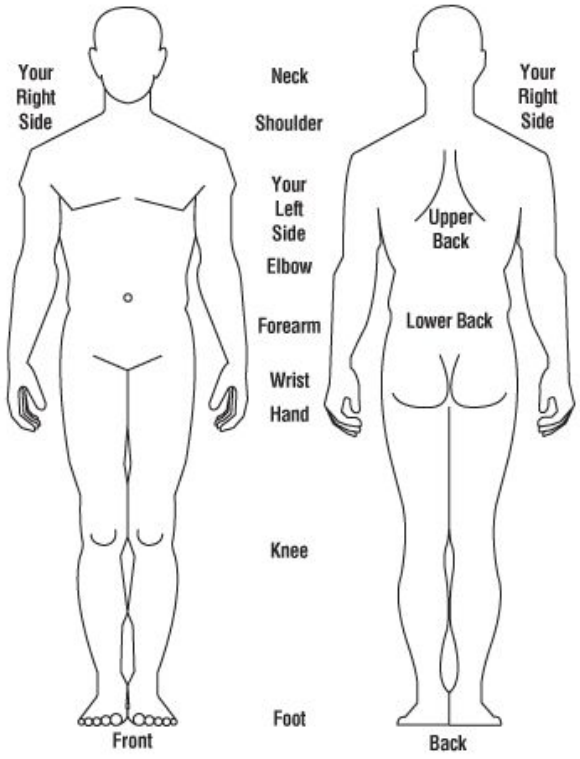
Narcotics: ( )Vicodin ( )Darvocet ( ) Tylenol 3 ( )Codeine ( )Percocet
( )MS Contin ( )Oxytocin ( ) Demerol ( )Morphine ( )Methadone ( )Dilaudid

Neuropathic Pain Medications: ( )Neurontin ( ) Klonopin ( )Tegretol ( )Dilantin
( )Ultram ( )Prazosin ( )Maxtil ( )Prazosin

Please put an 'X' on the line to describe your pain at its **LEAST:**
No Pain_____Worst possible pain
Please put an 'X' on the line to describe your pain at its **WORST:**
No Pain_____Worst possible pain
Please put an 'X' on the line to describe your pain **NOW:**
No Pain_____Worst possible pain
How much does your pain interfere with your sleep?
No Pain_____Worst possible pain

On average, it takes me ____minutes/hours to fall asleep.
I sleep ____hours a night. It takes me ___minutes/hours to get back sleep.

On the diagram, please shade in the areas where you have pain:



Notice of Privacy Practices
Onyx Medical Practionier PC

Eff: 12/01/2014 Privacy Officer: Sekuleo Gathers, MD

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. It also discusses the uses and disclosure we will make of your protected health information. We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of the notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a written copy of our most current privacy policy notice from the Practice's Privacy Officer.

This office has always recognized the importance of privacy; this new federal law formalizes practices that have been followed routinely.

By the law, consent is not required to discuss your medical treatment with your other doctors or healthcare providers. This also allows for a prescription to be called into your pharmacy. Additionally, none is needed in the course of carrying out healthcare operations, such as quality assessment, or in communication with your insurance carrier for payment related issues, or for incidental uses, such as announcing a name in a waiting room or the use of sign-in sheets.

However, this office has always gone one step further in protecting you and does not believe in releasing specific information about you to any business or governmental entity without your written consent. Specific authorization is required to disclose protected information in non-routine circumstance, such as your employer or for use in marketing a product to you.

Medical information about you may be released for research and public health uses, as long as you are not individually identified.

We may contact you to provide appointment reminders for treatment or medical care, and also to recommend possible treatment alternatives or other health-related benefits and services that may be if interest to you.

You have the right to review when and to whom your information was released.

You may suggest additional restrictions with regard to certain uses and disclosures, if you wish.

Should you believe that your privacy rights have been compromised, you may report the violation, without penalty to you to, this office or the Secretary of Health.

This law requires that you acknowledge receipt of this notice; this has been included on the signature release on the bottom of this form.

You have the right to inspect and copy your health information; you must submit your request in writing to the Practice's Privacy Officer. If you request a copy of your health information we may charge you a fee for the costs of copying and mailing your records, as well as other costs associated with your request.

In order to inspect and copy your health information, you must submit your request in writing to the Practice's Privacy Officer. If you request a copy of your health information, we may charge you a fee for the costs of copying or mailing your records, as well as other costs associated with your request.

I acknowledge that I have read and understand the above Notice of Privacy Practices.

Signature:_____ Date:_____

Print Name:_____

Relationship to the Patient:_____

Onyx Medical Practitioner PC

I, _____, the undersigned, understand that should my insurance company make reimbursement of benefits to me, I agree to send or deliver payment promptly upon receipt to Onyx Medical Practitioner PC/ Sekuleo Gathers, MD for services rendered to be by Onyx Medical Practitioner PC.
Date:_____ Signature:_____

Assignments And Instructions For Direct Payment To Doctor

I hereby instruct and direct the _____ Insurance Company to pay by check made out a mailed directly to Onyx Medical Practitioner PC/ Sekuleo Gathers, MD.

OR

If my current policy prohibits direct payments to doctor, then I hereby also instruct and direct you to make out the check to me for professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay in a current manner, any balance of said professional fees for non-covered services and/or fees over and above insurance payment or as required by my insurance policy.

A photocopy if this Assignment shall be considered as effective and valid as the original. I also authorize the release of any medical or other information necessary to process claims for the doctor and authorize payment of medical benefits to the physician Onyx Medical Practitioner PC/ Sekuleo Gathers, MD.

Date:_____ Signature:_____

Informed Consent To Receive Treatment

I hereby give consent to treatment and certify that I understand the above authorization and the risks of possible complications. I have been adequately informed, and any questions I have asked have been satisfactorily answered. It has also been satisfactorily explained to me, the treatments which are being offered, and the anticipated risks, benefits, and experience of receiving such treatments. I represent that I am seeking pain management to further my own health and for no other reason. I am aware that I may withdrawal this consent nd stop treatment at any time.

Date:_____ Signature:_____

Trigger Point Injection Therapy

We are privileged that you have chosen us to help relieve your pain, as everyday 25 million Americans take some pain medication. Trigger Point Therapy (TPT) works to relieve chronic, muscular pain without oral medication. Trigger Points (myofascial pain) are small "knots," or areas of spasm, within a muscle. Trigger Point Therapy loosens the knots allowing blood flow to the areas and, as a result these areas begin to heal. Our staff has been specifically trained in the Trigger Point Injection Therapy.

Some Things You Should Know:

1. We are here to answer any questions about the treatment you may have.
2. Due to the large number of Insurance Companies and plans available we offer these general guidelines for you. Please note, some of these are based upon the rules of the individual health plan and are out of our control.

These are things that may appear on your Explanation of Benefits (EOB):

1. You will receive an Explanation of benefits with the name of the provider listed as: Onyx Medial Practitioner PC Sekuleo Gathers, MD. Or Rehabilitation Offices of New York.
2. The billing code for the Trigger Point Injection is considered a 'surgical' code. We follow the **National standardized coding guidelines and there are only one set of codes.** Some say "injections" others will say "surgery." This is all done by your insurance company and we have no control over how they list the treatment.

In the event that your Insurance Company makes payment directly to you:

Your Insurance Company **may send payment directly to you.** (Especially true for **BCBS, GHI, Oxford)**

We ask that should you receive a check (&EOB) that you kindly bring it in during your next treatment or mail it directly to Onyx Medical Practitioner PC, at the **address above**. If you have one of the insurances above (**BCBS, GHI, & Oxford)** we ask that you send in your EOB, **even if NO PAYMENT WAS MADE,** so that we may note your account. This can be done by mail, drop off at your Trigger Point office, fax or email for your convenience.

I have read and understood the above.

Signature:_____ Name:_____