David H. Kim, M.D.
Pain Management Solutions, Inc.

704 East Main St, Suite A, Moorestown, NJ 08057
856-608-1130 856- 608-7630 fax
www.GoneWithPain.com

Patient Name: _____
Last First MI

Address: _____

City: _____ State: _____ Zip: _____

Phone (cell): ( ) _____ - _____ Phone (home): ( )_____ - _____

Patient Date of Birth: ____/____/_____ Sex: ___female ___ male

Height _____ Weight _____ Current Smoker / Former smoker / Non Smoker

Marital Status: ___ single ___ married ___ divorced ___ other

Race: ___ Amer. Indian ___ Asian ___ Black ___ Caucasian
___ Pacific Islander ___ Other ___ Declined

Ethnicity: ___ Hispanic ___ Non-Hispanic ___Declined

Primary Language: ____English ___ Spanish ___ Other

Type of Injury: _____ work related ___auto accident ___other

Employment: _____
Employment status: ____ working ___ disabled ___ other

If disabled, date last worked: _____/_____/_____

Who referred you to our office? _____

Family Doctor: _____

Address: _____

City: _____ State:_____ Zip:_____

Telephone: ( ) _____ - _____

Please list other physicians, or other professionals who should receive copies of your medical reports below. Please include the name, address, telephone and fax numbers.

Please list all current prescription medications:

Please list any allergies to medications:

Or check _____No known drug allergies

Drug Policy

- Dr. Kim does not prescribe pain medications. The doctor who prescribed your medications will need to continue them.

Signature Acknowledgement

I authorize the release of any medical or other information necessary to process this claim. I also authorize assignment of government benefit payments directly to Pain Management Solutions, Inc., David H. Kim. M.D., or affiliated companies/corporations, for medical services rendered to the undersigned.

I also authorize payment of non-government sponsored medical insurance benefits to Pain Management Solutions, Inc., David H. Kim, M.D. or affiliated companies/corporations, for medical services rendered to the undersigned.

According to law, I will be responsible for all co-pays and portions of my bill not paid by my insurance company.

I understand the drug policy and agree with its implementation. Abuse of the drug policy will result in instant discharge from care. My doctors will be notified.

All the information given is correct to the best of my knowledge.

Signed: _____ Date: _____/_____/_____

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Trigger Point Needling Consent

Trigger Point Needling Consent (TPN) uses thin needles to release painful muscle spasms, otherwise known as trigger points. When a needle is inserted into a muscle spasm, the spasm is released quickly, sometimes instantly. The release of the muscle spasm will often relieve the pain, sometimes instantly. Others will usually get relief over the course of several treatments. Treatment sessions are usually up to 30 minutes and done on a weekly basis. In some cases, a small amount of Lidocaine or similar medication may be injected.

Like any medical procedure using needles, there are possible complications. These complications are extremely rare. Any time a needle is used, there is a risk of infection, but Dr. Kim uses new, sterile, disposable needles so infection has never happened. A needle may be placed inadvertently in an artery, nerve or vein. If an artery or vein is punctured with the needle, a hematoma (or bruise) may develop. If a nerve is punctured, it may cause parasthesias (a sensation of pain) which may continue for days. This has rarely if ever happened. The risk of permanent nerve damage is rarer, but possible, but has not happened in real practice. When a needle is placed close to the chest wall, there is a possibility of pneumothorax (air in the chest cavity). The small size of the needle usually means that no treatment should be necessary, except for continued observation using chest x-rays to monitor progress. In rare cases treatment using a tube to evacuate the air may be necessary. It is possible that this condition can progress and cause death, however this has not been reported in the literature. This complication is more common in patients with underlying lung disease or a history of smoking.

Trigger Point Needling Consent (TPN) may cause soreness for one or two days, followed by an overall improvement in the pain. This “treatment soreness” is different from the patients’ original pain. It is much more tolerable and often described as a dull ache like the feeling one gets after strenuous exercise. This soreness is usually caused by the treatment and muscle spasms that have not yet been released. In extremely rare cases, this “treatment soreness” may be severe and last more than one or two days. If that is the case, taking over-the-counter pain medication and applying heat or ice packs to the affected areas often helps. There is no reason for concern. The “treatment soreness” typically improves during the course of treatment and may become minimal by the end of the treatment course. The needle may cause some skin irritation, which typically goes away on its own. If it is bothersome, over the counter steroid cream may be applied.

My signature on this form indicates that I certify that the nature of the treatment, expected benefits, potential risks and complications, alternatives (and the risks and benefits of such alternatives), and the possible results of non-treatment have been covered in this consent form. Any other questions were answered to my satisfaction, and I give Dr. Kim informed consent to the treatment. He is therefore not liable for any consequences that may arise as a result of treatment.

I do not have any active infections, blood disease, nor active flu or cold symptoms. I am not allergic to Lidocaine or similar medications.

Signature_____ Date_____

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Office & Billing Policies

Patient Check In: Please present the following information:

1. **New Patient Forms** or Forms can be printed from the Forms Tab on our website.
2. **Insurance card or cards**. If you change insurance companies and do not notify us, you will be responsible for all unpaid charges.
3. **Referral if required**. If you forget your referral, you will be responsible for all unpaid charges.
4. **Co-pay** must be paid prior to being seen.

Billing Policy:

1. **Self Pay Patients:** Payment must be made at time of service by cash or credit card.
2. **Medicare Patients: Medicare usually covers 80% of the cost of treatments. Please provide us with your correct secondary insurance to cover the balance. If you do not have secondary insurance or your secondary insurance has co-pays, deductibles, or co-insurance, we will bill you for the remaining balance due. All patients will be billed for the annual Medicare deductible unless it is covered by your secondary insurance. If your Medicare claim is denied for medical necessity, you may be billed for the cost of treatment.**
3. **Insurance Patients:** We only submit to those insurance plans we participate with. Patients will be billed for all charges *not* paid by their carriers, (deductibles, copays, co-insurance, etc.)

Insurance information

It is your responsibility to give us the correct insurance information.

- It is your responsibility to obtain and track **referrals** from your Primary doctor if your insurance requires
- It is your responsibility to inform us if your insurance policy has changed during the course of treatment.
- It is your responsibility to inform us if you have been in an auto accident or this is worker's comp, as we do not submit to auto insurers nor worker's comp. insurers.

Missed Appointment Policy: Multiple missed appointments without a call at least 12 hours in advance will result in a $25 "no show" fee.

Medical Records or Reports:

1. We must have a signed release form for us to forward any records. There is a $1.00 per page charge for copying medical records for law offices and disability.
2. Any dictated letters are $25. Clinical summaries are $100. Extensive clinical summaries for patients who have been in our practice for over 6 months will vary according to the length and complexity.

Return Check Policy:

There will be a $25.00 administration fee for any returned checks. We do not re-deposit checks. It is required that payment for returned check and fee be made by cash at the office.

If we are not given the correct insurance information, we will bill you for any claims that are denied.
If you should have any further insurance or billing questions, please contact Stephanie in the billing department @ 856-608-1130.

Signature of patient or guardian required:

Name:_____ Date: _____