DEMOGRAPHICS

Patient Information

Name:_____ Date of Birth: _____

Address:_____ City:_____ State:_____ Zip:_____

Social Security Number: _____ Primary Phone Number: _____

Please circle all that apply: Male/Female Employed/Retired/Other Married/Single/Other

Companion/Relative Name:_____ Phone:_____

Insurance Information - Please provide Insurance card(s) and valid photo identifications with this completed form

Primary Insurance Name: _____

Secondary Insurance Information

Secondary Insurance Name: _____

Financial Agreement:

We participate in many different insurance plans. We will file your insurance claims for the companies with whom we are contracted. You will be responsible for any co-payments or deductibles at the time services are rendered. For some insurance we accept assignment of benefits but in all cases we require that the guarantor, the person who is financially responsible, is personally liable for all balances not covered by insurance. It is our responsibility to understand and comply with any predetermination of benefits or referral requirements. Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under the Medicare Program or by other medical insurance companies. You will be responsible for co-payment, deductibles, out-of-network amounts or any portion your insurance company indicates is your responsibility. Payment for co-pays are expected at the time of service. If this fee is not covered by insurance it will be your responsibility.

Assignment of Insurance Benefits:

I hereby authorize direct payment to Samuel D. Schenker, MD of any insurance or health benefits otherwise payable to or on behalf of the patient for examination, treatment or devices delivered to me by Samuel D. Schenker, MD, at the rate not to exceed Hearing Health's usual charges. I understand that verification of insurance coverage obtained over the phone or online is estimated and does not guarantee payment and that insurance coverage is a relationship between the patient and his or her insurance company(s). I agree to accept financial responsibility for any charges for goods and services rendered to the patient that are not paid by insurance or health benefit plan pursuant to this assignment of benefits.

Release of Information:

I hereby authorize Samuel D. Schenker, MD to release any medical information about the patient necessary to determine liability for payment and to process any claim for examination, treatment or devices received by the patient. I also authorize Samuel D. Schenker, MD to release the medical records of the patient to the patient's referring physician or family physician indicated on the first page of this form.

I have read and agree to the terms above:

_____

Signature of Patient or Legal Representative Date

SAMUEL D. SCHENKER, M.D.
437 LAKEHURST ROAD
TOMS RIVER NEW JERSEY 08755
P: (732) 341-2822 F: (732) 341-7087

MEDICAL HISTORY

Medical history is an essential tool for diagnosing and treating your condition(s). Some of the below questions may seem unrelated. However, every question is important and every detail matters. Please fill out the form completely and return to the front desk. Thank you.

NAME:_____ DATE OF BIRTH: _____

TODAY'S DATE:_____ SOCIAL SECURITY #: _____

REASON FOR TODAY'S VISIT:_____

DATE OF ONSET OF SYMPTOMS: _____

REFERRED TO DR. SCHENKER BY: _____

NAME OF YOUR MEDICAL DOCTOR: _____

SYMPTOMS

Please fill in the blanks with a number from 1 to 10 in the appropriate frequency box:

1 being mild pain and 10 being very severe pain.

		DAILY	WEEKLY	MONTHLY
HEADACHES:	BACK OF HEAD	_____	_____	_____
	TOP OF HEAD	_____	_____	_____
	FOREHEAD	_____	_____	_____
	AROUND THE EYES	_____	_____	_____
BLURRED VISION		_____	_____	_____
DIZZINESS / LIGHTHEADEDNESS		_____	_____	_____
RINGING IN EARS		_____	_____	_____
NECK PAIN		_____	_____	_____
SINUS PROBLEMS		_____	_____	_____
BACKACHES:	UPPER BACK	_____	_____	_____
	MIDDLE BACK	_____	_____	_____
	LOWER BACK	_____	_____	_____

PLEASE FILL IN BELOW WITH (R) FOR RIGHT, (L) FOR LEFT OR (B) FOR BOTH SIDES.

	ARMS	HANDS	FINGERS	LEGS	FEET	TOES
NUMBNESS:	_____	_____	_____	_____	_____	_____
TINGLING:	_____	_____	_____	_____	_____	_____
PINS / NEEDLES:	_____	_____	_____	_____	_____	_____

DOES YOUR PAIN RADIATE TO ANY OTHER AREA? YES_____NO _____
IF YES, DOES IT RADIATE TO THE: BUTTOCKS_____THIGHS_____NECK_____CALVES_____
FEET_____SHOULDERS_____ARMS_____OTHER _____

PREVIOUS TESTS PERFORMED: X-RAYS_____CT SCANS_____MRI_____

MYELOGRAM_____EMG_____OTHER _____

WHEN?_____WHERE? _____

CHECK BELOW ONLY THOSE SYMPTOMS THAT APPLY TO YOU:

_____ARE YOU UNDER STRESS?

_____DO YOU HAVE DIFFICULTY THINKING?

_____DO YOU HAVE DIFFICULTY REMEMBERING?

_____DO YOU HAVE FATIGUE?

_____DO YOU HAVE CHANGE IN PERSONALITY?

_____DO YOU HAVE DIFFICULTY WALKING?

_____DO YOU HAVE DIFFICULTY SLEEPING?

_____OTHER DIFFICULTIES, PLEASE LIST: _____

PAST MEDICAL HISTORY

(CONTINUED NEXT PAGE)

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD:

_____HEART PROBLEMS

_____KIDNEY PROBLEMS

_____CANCER

_____DIABETES

_____HIGH BLOOD PRESSURE

_____MULTIPLE SCLEROSIS

_____ANEMIA

_____ASTHMA

_____OSTEOARTHRITIS

_____STROKE

_____SEIZURES

_____ENDOCRINE PROBLEMS

_____THYROID CONDITION

_____PACEMAKER INSERTION

_____NERVOUS DISORDERS

_____ULCER

_____DIGESTIVE PROBLEMS

_____MIGRAINES

OTHER_____

PREVIOUS ACCIDENTS _____

FEMALES: ARE YOU PRESENTLY PREGNANT? YES_____NO _____

ARE YOU PRESENTLY TAKING BIRTH CONTROL PILLS? YES_____NO _____

SOCIAL HISTORY

HOW MAY CUPS OF COFFEE DO YOU DRINK PER DAY?_____TEA _____

DO YOU SMOKE TOBACCO? NO_____YES_____IF YES, HOW MUCH _____

DO YOU DRINK ALCOHOL? DAILY_____OCCASIONALLY_____RARELY_____NEVER _____

MEDICATIONS

ARE YOU PRESENTLY TAKING ANY OF THESE TYPES OF MEDICATIONS?
IF SO, PLEASE FILL IN THE NAME OF THE DRUG AND THE DOSAGE (IF KNOWN).

SEDATIVES:_____ASPIRIN:_____

ANTIBIOTICS:_____MUSCLE RELAXANTS: _____

BLOOD PRESSURE PILLS: _____

HEART MEDICATIONS: _____

OTHER:_____

DRUG ALLERGIES: _____

EMPLOYMENT

ARE YOU PRESENTLY: RETIRED_____DISABLED_____WORKING_____

LAST DATE WORKED: _____

IF DISABLED, IS THIS RELATED TO:

WORKMAN'S COMPENSATION_____AUTO ACCIDENT _____

THANK YOU VERY MUCH FOR COMPLETING THIS INFORMATION.
IT WILL HELP DR. SCHENKER IN THE TREATMENT OF YOUR PROBLEM.

SAMUEL D. SCHENKER, M.D.
437 LAKEHURST ROAD
TOMS RIVER NEW JERSEY 08755
P: (732) 341-2822 F: (732) 341-7087

OFFICE POLICIES – AS POSTED IN THE OFFICE

APPOINTMENT CANCELLATION: This office provides an appointment card and a courtesy reminder phone call with regards to your next appointment. If you do not cancel your appointment 24 hours in advance or do not show, you will be charged a **$50 No Show Fee**.

As of December 1, 2017*: Patients who arrive 15 minutes or more after the scheduled appointment time without informing the office will be charged a **$25 fee.

OFF HOURS: Only absolute emergencies will be responded to during off hours. All other messages will be addressed on the next business day.

MEDICAL RECORDS: There will be a fee of $1.00 per page for any and all copied records, whether requested by the patient or a patient representative.

CONTROLLED MEDICATIONS: If you receive a controlled medication from this office, you are required to provide a blood or urine sample upon our request. You will **NOT** receive your prescription if you fail to do so.

RETURNED CHECKS: There will be a $35 fee for all returned checks plus the $20 blank fee **for a total of $55.**

LETTERS OF PROTECTION: This office does **NOT** accept Letters of Protection.

Patient/Relative or Legal Guardian: _____ _____

(Signature) (Print Name)

Relationship, if not the patient: _____

Office Witness: _____ _____

(Signature) (Print Name)

PATIENT RESPONSIBILITY AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substances medications (i.e. narcotics, tranquilizers, benzodiazepines, and barbiturates) are very useful for controlling both acute and chronic pain but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. They are intended to relieve pain, thus improving quality of life, function and/or ability to work. Because my physician is prescribing controlled substance medications to help manage my pain, I agree to the following conditions.

TREATMENT GOALS

I understand that the main treatment goal is to reduce the pain to a bearable level and improve the quality of my life. This includes the ability to function and/or work. I understand that in many cases the pain may not be completely eliminated. In consideration of this goal, and because of the fact that I am being given a potent medication to help me reach my goal, I agree to help myself by following better health habits. These include increase in activity and exercise, weight control, and avoidance of tobacco and alcohol. I must also comply with the treatment plan as prescribed by my physician. I understand that a successful outcome to my treatment will only be achieved by following a healthy lifestyle.

PATIENTS' RESPONSIBILITY

- I am responsible for the controlled substance medications prescribed to me. If my prescription is lost, misplaced, or stolen, or if I "run out early," I understand that it will not be replaced.
- I give permission for my physician to discuss all my diagnostic and treatment details with other physicians providing my medical care and with my pharmacists for purposes of maintaining accountability. This includes a copy of this contract.
- I will use only one pharmacy for all my prescription refills. I will register the name and phone number of this pharmacy with my physician.

Pharmacy_____ Town/State_____

Phone (if known) _____

- I understand that driving a motor vehicle may not be allowed while taking controlled substance medications and that it is my responsibility to comply with the laws of the State while taking the prescribed medications.
- I will comply with random PILL COUNTS. These will be performed during regular office hours. The purpose of the PILL COUNT is to monitor medication usage. The number of pills missing from the bottle must correlate to the number of days since the prescription has been filled. A discrepancy in the number of pills missing is to be considered a breach of this contract and thus grounds for termination. Patients who fail to show for random pill counts will be immediately terminated from the practice. The pill counts will be randomly scheduled by the pain staff.
- I agree to undergo random urine drug testing at the discretion of the pain staff. The test will show the presence of my prescribed medication but will also show any illicit drugs. The presence of illicit drugs or the absence of my prescribed medications will be considered a breach of this contract and therefore grounds for dismissal. Failure to comply with the test will be considered grounds for dismissal.

- I will not request or accept controlled substance medications from any other physician or individual while I am receiving such medications from pain management. I will not give, share or sell my medications to any other person.
- I also understand that I must maintain a primary care physician while being cared for in pain management. He/She will be used to care for my other medical needs and in special cases used to write prescriptions if/when the pain management physician may be unavailable.

REFILLS OF MEDICATIONS

- Will be made only during regular office hours Monday through Friday, in person. This will be done either monthly, bi-monthly, tri-monthly during a scheduled office visit. Refills will not be made after hours, on weekends, or on holidays.
- Will not be made if I "run out early," or "lose a prescription," or "spill or misplace my medication," or "they are stolen." I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. I am also responsible for keeping the medications in a secure location as to avoid their theft.
- Will not be made as an "emergency" such as on Friday afternoon because I suddenly realize I will "run out tomorrow." I will call at least 24 hour in advance to schedule an appointment for refills.

RISKS OF THE CHRONIC OPIOID USE

I understand that the long-term advantages and disadvantages of chronic opioid use have yet to be scientifically determined. My treatment may change at any time. I understand, accept, and agree that there may be unknown risks associated with the long term use of controlled substance, and that my physician will advise me of any advances in this field and will make treatment changes deemed appropriate. I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. If this occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond to opioids may force my doctor to choose another form of treatment. (Female patients only) I am aware that if I plan to get pregnant or believe that I have become pregnant while taking these medications, I will immediately call my obstetric doctor to inform them. I am aware that there could be some adverse effects on my baby. I know that some individuals may develop a tolerance to their medications, necessitating a dose increase to achieve the desired effect, and that there is a risk of becoming physically dependent on the medication. This can occur if I am on the medication even for a short period of time. Therefore, if and when I need to stop taking the medications, I must do so slowly and under the medical supervision or I may have withdrawal symptoms. I may be advised to participate in a formal out-patient/in-patient program to be tapered off the medications. My doctor is not responsible for withdrawal syndrome if the medications are used inappropriately.

CONTINUED FROM PAGE PRIOR

TERMINATION OF CARE

I understand that if I violate any of the above conditions, my treatment with controlled substance medications will be terminated immediately, without a 30-day notice. If the violation involves obtaining controlled substance medications from another person, or selling them to another individual, or the concomitant use of non-prescribed illicit (illegal) drugs, the situation will be reported to all my physicians, medical facilities, and appropriated legal authorities. I am responsible for any withdrawal syndrome that may occur to do my misuse of the narcotic medications and/or termination of my care. I have read this contract and the same has been explained to me by Dr. Schenker. All my questions have been answered to my satisfaction. I agree to comply fully with this contract. In addition, I fully accept the consequences of violating this agreement.

Signature

I have reviewed this contract and consent with the terms presented. I recognize that noncompliance to any of the above will result in dismissal from the Pain Institute of Central Jersey and Neurology and the care of Dr. Samuel D. Schenker.

Name of Patient (Print) _____

Signature of Patient _____

Date_____

Office Witness _____

FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)
FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS (TPO)

I,_____understand that as part of my healthcare, the Pain Institute of Central Jersey originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment. I also understand this information serves as:

I understand that I have the right to restrict as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice is not required to agree to the restrictions requested, but if it does, it is bound by this agreement. I understand that I may revoke this consent in writing, except to the extent that the practice has already taken action in reliance thereon.

With this consent, Pain Institute of Central Jersey may call my home or other designated 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 call pertaining to my clinical care, including laboratory results, among others. Any materials sent to my home other than regular billing statements, will be marked Personal and Confidential.

By signing this agreement I am consenting to the Pain Institute of Central Jersey to use and disclose my PHI to carry out my TPO.

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by Pain Institute of Central Jersey & Neurology or disclosed to others for the purposes of treatment, obtaining payment or supporting the day-to• day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information.

Pain Institute of Central Jersey & Neurology may or may not agree to restrict the use of disclosure of your protected health information.

If **Pain Institute of Central Jersey & Neurology** agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent **in writing**. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Pain Institute of Central Jersey & Neurology reserves the right to modify the privacy practices outlined in the notice.

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (CONTINUED)

Signature

I have reviewed this consent form and give my permission to **Pain Institute of Central Jersey & Neurology** to use and disclose my health information in accordance with it.

Name of Patient (Print) _____

Signature of Patient _____

Date _____

Signature of Patient Representative _____

Relationship of Patient Representative to Patient _____

PATIENT RESPONSIBILITY FOR FOLLOW-UP CARE
ACKNOWLEDGMENT AND PROMISE

I,_____(print full name), acknowledge and understand that even with the exercise of good medical care, a physician cannot always assure the successful treatment and resolution of my medical problems. Therefore, I understand it is important that any and all recommendations by my physician are followed promptly and completely in order to increase the likelihood of a positive and healthy treatment/outcome.

I acknowledge and understand that if my physician prescribes medicine, it is my sole responsibility to fill the prescription promptly and to take the medicine as directed to completion.

I also understand that if my physician refers me to see another doctor or for a test, such as a blood test, an MRI, a CT scan or other diagnostic study, this recommendation is important and essential to the ultimate success of my treatment/outcome. I understand that it is my sole responsibility to see the consulting physician or to obtain the recommended test as promptly as possible. I recognize that it is not possible for my physician or his office to follow up to ensure that I have followed his recommendations. Therefore, I understand that if I fail to promptly see the recommended specialist or obtain the testing for which I was referred, this may compromise my current health or increase future health risks as the result of the failure to follow the advice of my doctors.

Signature of Patient or Guardian_____Date _____

ABOUT FINANCIAL ARRANGEMENTS AND INSURANCE/NON-COVERED SERVICES

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless our staff has approved payment arrangements in advance or if we are a participating provider with your insurance carrier. It is your responsibility to know whether we are in your policy. We accept cash, checks, Visa and MasterCard. We will be happy to help you process your insurance claim form for your reimbursement. We accept assignment of most insurance benefits, provided your yearly deductible has been met.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1- Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

2- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the service is rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

I understand and agree that regardless of my insurance status I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the inforn1ation on this sheet, and I understand the information presented to me. I agree to comply with your office policy, and I will notify you of any changes in my status.

NON-COVERED SERVICES

I am aware that my insurance company may not cover the entire payment for the service that I am about to receive today. I take full financial responsibility for any uncovered fees and guarantee payment to Dr. Samuel D. Schenker for any unpaid balances, whether they be partial or full. I am also aware that there will be a 1.5% monthly interest charge added on to any unpaid balances past 60 days.

Name:_____

Signature of Patient or Parent (if minor): _____

Date: _____