UNIVERSAL MEDICINE

Last Name: _____

First Name: _____ MI: _____

Home Phone: _____ Work: _____

Cell: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Age: _____ Sex: M / F Marital Status: _____

Social Security #: _____ Email Address: _____

Referring Doctor: _____

Pharmacy Name: _____

Pharmacy Town & Phone (if applicable): _____

Patient's Employer: _____

Employer's Address: _____

In case of emergency, notify: _____

Past Medical History

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ AIDS/ HIV
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding Disorder
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Diabetes
- ☐ Depression
- ☐ Ear Problems
- ☐ Eating Disorders
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis A, B, or C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Joint Disorder
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Lung Disease
- ☐ Measles
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Stomach Ulcer
- ☐ Substance Abuse
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Venereal Disease

_____

_____

Hospitalizations and Surgeries

Reason:_____ Date:_____

Reason:_____Date:_____

Family History

☐ Alcoholism	☐ Cancer	☐ Joint Disorder
☐ Allergies	☐ Depression	☐ Kidney Disease
☐ Alzheimer's	☐ Diabetes	☐ Liver Disorder
☐ Anemia	☐ Epilepsy	☐ Lung Disorder
☐ Anxiety	☐ Genetic Disorder	☐ Migraines
☐ Arthritis	☐ Glaucoma	☐ Psychiatric Disorders
☐ Asthma	☐ Heart Disease	☐ Osteoporosis
☐ AIDS/HIV	☐ Hepatitis	☐ Stroke
☐ Bleeding Disorder	☐ High Cholesterol	☐ Substance Abuse
☐ Blood Disorder	☐ High Blood Pressure	☐ Thyroid Disorder

Details: _____
_____
_____

Allergies

- ☐ Adhesive Tap
- ☐ Sleeping Pills
- ☐ Codeine
- ☐ Antibiotics
- ☐ Aspirin
- ☐ Sulfa
- ☐ Latex
- ☐ Iodine
- ☐ Local Anesthetics

Other Allergies (Name/Reaction):_____
_____
_____

LIST OF MEDICATIONS

Medication	Strength	Directions
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

Lifestyle Factors

Are you sexually active? ☐Yes ☐No # of partners in past year_____

Do you wish to be checked for STDs? ☐Yes ☐No

Has anyone in your home ever physically or verbally hurt you? ☐Yes ☐No

Have you ever smoked? ☐Yes ☐No # of years _____ # packs/day _____

Do you smoke now? ☐Yes ☐No # packs/day _____

Do you use recreational drugs? ☐Yes ☐No types? _____ # times/week_____

How much alcohol do you drink per week? # drinks/ week_____

How much caffeine do you drink per day? _____ How often do you exercise? _____

Vaccination History ☐ Pneumonia (65+)*q5yrs ☐ PCV13(65+) ☐ Tdap*q10yrs ☐ Shingles (60+) ☐ Flu ☐ Covid

Date of your last: Colonoscopy _____ Dexa _____ Endoscopy _____ Mammogram _____ OBGYN _____

PATIENT HEALTH QUESTIONAIRE (PHQ-9)

Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Please circle your answer)

	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
2. Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**
3. Trouble falling asleep or staying asleep, or sleeping too much	**0**	**1**	**2**	**3**
4. Feeling tired or having little energy	**0**	**1**	**2**	**3**
5. Poor appetite or overeating	**0**	**1**	**2**	**3**
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	**0**	**1**	**2**	**3**
7. Trouble concentrating on things, such as reading the newspaper or watching television	**0**	**1**	**2**	**3**
8. Moving or speaking so slowly that other people noticed	**0**	**1**	**2**	**3**
9. Being so fidgety or restless that you have been moving around a lot more than usual	**0**	**1**	**2**	**3**
10. Thoughts that you would be better off dead, or of hurting yourself	**0**	**1**	**2**	**3**

Add Columns: _____+_____=_____

Total: _____

If you checked off any problems, how difficult have these problems made it for you to go to work, take care of things at home, or get along with other people?

Not Difficult at All _____ Somewhat Difficult _____ Very Difficult _____ Extremely Difficult _____

UNIVERSAL MEDICINE

Financial Policy

1. Universal Medicine will keep a current copy of your insurance card(s) on file. You may be asked to present your insurance card at each visit.

2. Co-pays and co-insurance fees are collected at the time of check-in. Any past due balances are due and payable at the time of check-in. If you are unable to pay your co-payment or past due balance at the time of service, and your appointment is not of an emergency nature, we reserve the right to reschedule your appointment.

3. Patients with balances may make payment arrangements, if necessary. In order to enter into a payment arrangement, you will be required to pay 50% of the past due balance with the remaining balance broken into payments over a 3 - 6-month period. A signed agreement will be kept on file. Please understand that it is ultimately the patients' responsibility for payment of services. If your insurance company or other benefit program does not cover the entire balance, you are responsible for the remainder. Payment is due within 30 days of being notified of your balance unless you have made prior arrangements. If a balance has been past due for 90 or more days, Universal Medicine will turn the account over to an outside collection agency for further action. The patient will be responsible for any charges incurred in such action. The patient will also be responsible for any and all legal fees.

4. Please be aware that some services provided may be non-covered services under your policy. It is the patients' responsibility to be aware of the individuals' policy restrictions and guidelines. Universal Medicine will not enter into a dispute with an insurance company, but we can assist you if you are having difficulties.

5. Laboratory tests, injections, venipunctures, procedures, or tests may result in additional expenses.

6. Universal Medicine will file a claim for your office visit and any services provided to your primary insurance carrier. If you are a Medicare patient, please contact Medicare and your secondary carrier to set up a Coordination of Benefits. Once this is in place, Medicare will automatically forward your claim to your secondary carrier.

7. If you are a member of an insurance plan in which we do not participate the patient is expected to make payment in full at the time of service.

8. If a check is returned to the office due to insufficient funds, the original check amount plus a $50.00 returned check fee must be received within 30 days of the date that the check was originally returned to avoid further late fees or collection action.

9. Please help us better serve you and our other patients by keeping all scheduled appointments. If you must change an appointment, please do so within 24 hours of the appointment time. The charge is $50.00 for any missed appointment.

Please do not hesitate to contact our office with your billing questions or concerns at 201-308-8995.

I certify that I have read this form and understand its contents. I also acknowledge no guarantees have been made to me as to the results of examinations or treatment

Patient's Signature: _____ **Date:** _____

UNIVERSAL MEDICINE

GENERAL CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

1. **Consent:** I, the undersigned patient, or authorized representative of the patient, hereby voluntarily request, consent to, and authorize Universal Medicine ("Practice") and its staff to provide medical care including treatments, examinations, diagnostic procedures, and the administration of medications as deemed necessary and advisable by the Practice and its healthcare providers to me.

2. **Release of Information:** I hereby authorize the Practice to release and to disclose to any third-party payer, or its representative, which may be responsible for payment in my case, or as required by law, such information from my patient records as is necessary in order to receive reimbursement for any healthcare services rendered to me by the Practice. I also authorize the release and disclosure of my patient records to other healthcare providers who may, in the opinion of the Practice, be of assistance in providing treatment or the most appropriate medical care to me.

3. You authorize Universal Medicine to release to government agencies insurance carriers and others (including independent utilization review organization), Who may be financially liable for the services, all information necessary to pre-authorize services, determine medical in the Cecily and/or the extent or amount of liability and challenge denials of medical necessity. You here by the sign all amounts payable for services rendered to Universal Medicine. You understand that this constitute a waiver of confidentiality under 42 C> F.R. Part 2 (confidentiality of patients drugs and alcohol records) and N.J.S.A. 26: 5 c-i et seq. (Pertaining to FTW and AIDS records) and that this authorization is revocable, except to the extent that action has been taken in reliance there on and will otherwise remain in force in definitely in order to effectuate the purpose for which it is given.

4. **Physician Referral:** I understand that if my health insurance is provided by a managed care plan, I am responsible for contacting my primary care physician and obtaining necessary referrals for any services rendered at this office. Failure to do so will result in my being financially responsible for said services.

5. **Accuracy & Integrity:** I hereby acknowledge the information I provided on the patient information form and patient history to be true and correct and completed to the best of my ability.

6. **No Guarantees:** I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees are made as to the result of the care and treatment which I have hereby authorized.

7. **Contact Authorization:** ***I ____do ____do not (check one)*** authorize information to be left on my voice mail. We will ordinarily contact you using your home phone number and home address. If you want us to contact you in another manner, please provide us with specific instructions about how we may contact you.

I have read this form, or it has been read to me and I am satisfied that I understand the entire contents and significance of this form, and all my questions (if any) have been answered. Further, I understand that this consent will be deemed continuing, and I am free to revoke my consent at any time.

Patient's Signature: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Use and Disclaimer

Your protected health information may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment

Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment

Your health information may be used to seek payment from your health plan, from other sources of coverage such as automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and medical condition being treated.

Health Care Options:

Your health information may be used as necessary to support the day-to-day activities and management of SMG. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote equality.

Law Enforcement

Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigation, and to comply with government-mandated reporting.

Public Health Reporting

Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other Uses and Disclosures Require your Authorization

Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke the authorization.

Additional Uses of Information Appointment Reminders

Your health information will be used by our staff to send you appointment reminders and information about treatments. Your health information may be used to send you information that you may find interesting on the

treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Rights to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with its most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our Medical Records Department.

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

(Please Print Name)

_____

(Signature)

_____

(Date)

(FOR OFFICE USE ONLY)

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

[ ] Individual refused to sign

[ ] Communication barriers prohibited obtaining acknowledgement

[ ] An emergency situation prevented us from obtaining acknowledgement

[ ] Other (Please Specify) _____

_____

UNIVERSAL MEDICINE

PATIENT CONTROLLED SUBSTANCES AGREEMENT

Failure to comply with these guidelines will result in termination of treatment and your prescriptions will be revoked.

You agree not to ask or to receive pain medication from any other physician. Refusal to comply with this will result in discharge from Universal Medicine. Only your pain doctor will prescribe controlled substance medications for you.

You agree to keep all scheduled appointments, not just with your physician, but also with recommended therapists and psychological counselors. Three or more missed appointments or same day cancellations will lead to patient dismissal.

No prescriptions will be refilled if you lose, destroy, or have any of your medication stolen. You agree to keep all controlled substance medications locked up and in a safe place. A written explanation is required for all thefts and lost medications, plus a police report for all thefts.

All prescriptions are written for a 30-day supply. No prescriptions will be refilled early. You will follow up every 30 days for evaluation by your physician while being prescribed controlled substances. Prescriptions will not be written greater than 7 days in advance.

You agree to random urine drug screenings. Any patient who refuses testing will not receive treatment and may be discharged. Positive tests for any illegal substances, or controlled substances not prescribed by your pain doctor, will result in your discontinuing of controlled substances and referral elsewhere or substance evaluation and management.

Prescriptions for controlled substances are issued only during appointments. They will not be mailed or left for patients to pick up or called in to your pharmacy.

You will only use one pharmacy for refilling controlled substances. Should the need arise to change pharmacies, our office must be notified.

Any unused medication must be returned to Universal Medicine. Prescriptions for different controlled substances will not be issued until remaining medication are accounted for.

No medication adjustments are permitted without prior approval from your physician. Development of another painful condition does not justify increased use of your medication without permission from Universal Medicine. Controlled substances will NOT be refilled early due to misuse.

You agree not to share or sell your medications. You acknowledge that we will contact Drug Enforcement Agency and or the Police if you violate the Federal Law regarding controlled substance medications.

You agree to comply fully with all aspects of your treatment program including behavioral medicine (psychology/psychiatry) and physical therapy, if recommended. Failure to do so may lead to discontinuation of your medication and referral to another provider or treatment center.

Successful pain management entails employing multiple interventions, including active participation in regular physical exercise, appropriate procedures, other treatment options and the use of psychological coping strategies. A pattern of passive reliance on medications, resistance to more physical treatments, and repeated failure to demonstrate the implementation of psychologically based coping strategies that have been taught to you may lead to discontinuation of medications and/or referral to another provider or treatment center.

Disruptive, threatening, or violent behavior, and persistent noncompliance with the prescribed pain treatment plan will lead to patient dismissal from our practice.

We understand that emergencies can occur and under some circumstances, exceptions to these guidelines may be made. Emergencies will be considered on an individual basis.

ACKNOWLEDGEMENT OF OPIOID WARNINGS AND SIDE EFFECTS

Opioids may cause drowsiness that can be worsened with alcohol, benzodiazepines, and other sedating medications. **We absolutely do not recommend driving an automobile or operating machinery while taking any opioid medication because they may alter judgment resulting in serious injury or death to you or anyone involved in an accident with you.** Furthermore, an overdose caused by opioids can cause severe side effects, such as respirator depression and even death. Opioids can alter hormonal levels leading to impotence, changes in personality and behavior, lowering of bone strength and increase tooth decay. Other common, usually temporary, side effects include nausea, itching, and sweating. Psychological depression and lowered testosterone levels may also occur. Sleep apnea, if present, may be worsened by opioids. Constipation commonly occurs, and often does not improve with time. It is impossible to predict side effects in any individual patient. Having side effects on one opioid does not necessarily mean there will be side effects on another opioid.

You must take opioids only as directed. Federal law prohibits giving this medication to anyone else. Physical dependence will develop with regular use but does not by itself indicate addiction; this means that a withdrawal syndrome will develop if you stop your medication abruptly. Tolerance may develop to the pain-relieving effects of opioids; this means that the relief may decrease over time, but in chronic pain states this usually occurs slowly, if at all. Not all pain conditions respond to opioids. Some pain may only be particularly responsive to opioid therapy. Total elimination of pain is an unrealistic goal. Escalating dosages may indicate that opioids are not effective or that there is an underlying problem with addiction or psychological dependence. Discontinuation of opioid medications may need to be done under these circumstances: not enough pain relief, persistent side effects, not achieving goals of opioid treatment (such as improvement in function), problematic does escalation, or inability to comply with the treatment agreement.

I, the undersigned, agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. I give permission to my pain doctor to contact any of my other healthcare providers, for the purposes of sharing information concerning my situation, as is deemed necessary for coordinated, high quality care. If I do not follow these guidelines fully, my doctor may taper and stop opioid treatment and refer me elsewhere for care.

A copy of this document has been given to me.

Patient Signature:_____

Date:_____

Witness Signature:_____

Date:_____

Doctor Signature:_____

Date:_____

Pharmacy and PCP information must be completed:

Name of Pharmacy:	Name of Primary Care Physician:
Address:	Address:
Phone Number:	Phone Number: