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SPECIALIST MEDICAL P.C.

Madan K. Raj M.D. FAAPMR
Interventional Spine Specialist
Board Certified in Pain Medicine
Board Certified in Physical Medicine & Rehabilitation

NAME _____ **DOB:**_____/_____/_____

ADDRESS _____ **City** _____ **State** _____ **Zip** _____

PHONE Home: _____ **Cell**: _____ **Work**: _____ **ext**_____

FEMALE □ **MALE** □ **STATUS:** *Married Single Widowed Divorced* **Other SS#**_____

Emergency Contact:_____ **Relationship**:_____ **Telephone**:_____

REFERRED BY: _____
Address: _____ **Telephone**:_____

PCP: _____
Address: _____ **Telephone**:_____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ **ID#:** _____
Policyholder Name: _____ **Relationship:**_____
Policyholder DOB: _____ **Policyholder SS#:** _____

SECONDARY INSURANCE: _____ **ID#:**_____
Policyholder Name: _____ **Relationship**: _____
Policyholders DOB: _____ **Policyholders SS#:** _____

→ **Please Circle:** *WORKERS COMPENSATION* **OR** *NO FAULT/MVA*

Occupation (at time of injury) _____
Employer name/address (at time of injury)
_____
Insurance Name: _____ **DATE OF ACCIDENT:** _____
Insurance Address: _____
Claim #: _____ **Carrier Case #:** _____ **WCB#:**_____
Case Manager:_____ **Telephone:** _____
Policyholder:_____

Attorney Name:_____ **Telephone:**_____
Address:_____

The above information is true and to the best of my knowledge. I authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits to Madan K. Raj, M.D. for professional services. I understand that I am responsible for any amount not covered by insurance.

Signature: _____ **Date:** _____

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To be completed by patient:

HISTORY OF PRESENT ILLNESS:

When did your pain first begin? _____

Were there any particular events that started your pain? _____

Was your pain the result of an accident?	Yes	No
Was your pain due to a work related injury? .....Yes		No
Is the pain sharp like a knife?	Yes	No
Dull/Achy?	.Yes	No
Pins and needles?	Yes	No
Hot/burning?	Yes	No
Does the area feel numb?	Yes	No
Does the pain feel like electric shock?	Yes	No
Does the pain radiate to arms or legs when coughing or sneezing? .	Yes	No
Is the pain worse with the touch of clothing or bed sheets?	Yes	No
Does the pain move from back to any part of your leg?	Yes	No
Does the pain move from neck to any part of your arm?	Yes	No
Does the area of your pain ever change color?	Yes	No
Numbness in arms, legs or buttock area? .... .Yes		No
Weakness in arms or legs? ....Yes		No

How strong is your pain? (circle number from 1-10)

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Unbearable Pain**

Any Urinary retention?	Yes	No
Urinary incontinence?	.Yes	No
Loss of bowel control?	Yes	No
Sexual Difficulty?	.Yes	No
Balance problem during walking?	Yes	No
Do you drop things from your hand?	Yes	No
Do you have any clumsiness of hand?	.Yes	No

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THE IMPACT OF YOUR PAIN:

What activities or movements bring on your pain?_____
What makes your pain better? _____
Does your pain interfere with your ability to fall asleep? O Yes O No Or awaken you from sleep? O Yes O No
Does your pain get better over the course of the day? O Yes O No Does pain affect your sexual activity? O Yes O No
Are you depressed because of your pain? O Yes O No

The following questions are given to all patients who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale: 0=Never, 1=Seldom, 2=Sometimes, 3=Often, 4=Very Often

1. How often do you have mood swings? 0 1 2 3 4
2. How often do you smoke a cigarette within an hour after you wake up? 0 1 2 3 4
3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs? 0 1 2 3 4
4. How often have any of your close friends had a problem with alcohol or drugs? 0 1 2 3 4
5. How often have others suggested that you have a drug or alcohol problem? 0 1 2 3 4
6. How often have you attended an AA or NA meeting? 0 1 2 3 4
7. How often have you taken medication other than the way it was prescribed? 0 1 2 3 4
8. How often have you been treated for an alcohol or drug problem? 0 1 2 3 4
9. How often have your medications been lost or stolen? 0 1 2 3 4
10. How often have others expressed concern over your use of medication? 0 1 2 3 4
11. How often have you felt a craving for medication? 0 1 2 3 4
12. How often have you been asked to give a urine screen for substance abuse? 0 1 2 3 4
13. How often have you used illegal drugs (marijuana, cocaine, etc.) in the past five years? 0 1 2 3 4
14. How often, in your lifetime, have you had legal problems or been arrested? 0 1 2 3 4

PAST PAIN INTERVENTIONS:

Please check the type of treatments you have had:

O Acupuncture **Did this help with your pain? O Yes O No Doctors name** :_____
O Chiropractor **Did this help with your pain? O Yes O No Doctors name** :_____
O Pain management **Did this help with your pain? O Yes O No Doctors name** :_____
O Physiatrist **Did this help with your pain? O Yes O No Doctors name** :_____
O Neurosurgeon **Did this help with your pain? O Yes O No Doctors name** :_____
O Physical therapy **Did this help with your pain? O Yes O No Doctors name** :_____
O Others_____

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IMAGING STUDIES:

Please check the types of testing you have had:

O MRI **Where?**_____ **When?**_____
O CT Scan **Where?**_____ **When?**_____
O Bone Scan **Where?**_____ **When?**_____
O Plain X-ray **Where?**_____ **When?**_____
O EMG/NCV **Where?**_____ **When?**_____
O Discogram **Where?**_____ **When?**_____

PAIN MEDICATIONS:

Please make sure you write the correct name and dosage. Please write on separate sheet and attach to this form if your list is large.

Pain Medication:

_____Dosage:_____
_____Dosage:_____
_____Dosage:_____

Other daily medications/supplements:

_____Dosage:_____
_____Dosage:_____
_____Dosage:_____

Are you presently taking:

O Aspirin O Coumadin O Warafin O Plavix
O Herbal remedies? Please list: _____

Do you take any sleeping pills? O Yes O No Anti-depressants? O Yes O No

ALLERGIES:

Are you allergic to any medications or had any bad reactions from any medications?

Local Anesthetic (Novocain or Lidocaine) O Yes O No Penicillin O Yes O No
Steroids O Yes O No Antibiotics O Yes O No
Contrast dye/IVP dye O Yes O No Latex allergy O Yes O No
Other? **PLEASE LIST**_____

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Review of Systems: Have you had any of the following symptoms in the last few weeks?

General
Unexpected weight loss O Yes O No
Fever O Yes O No

GI/Abdomen
Nausea/vomiting O Yes O No
Constipation O Yes O No
Abdominal pain O Yes O No
Blood in Stool O Yes O No

Musculoskeletal
Muscle weakness O Yes O No
Swelling of extremities O Yes O No

Ear, Nose & Throat
Ringing in ears O Yes O No
Hearing disturbance O Yes O No
Bleeding gums O Yes O No

Endocrine
Appetite change O Yes O No
Cold Intolerance O Yes O No

Hematologic/Hepatic
Jaundice O Yes O No

Eyes
Visual disturbance O Yes O No

Cardiopulmonary
Chest pain O Yes O No
Fast heart rate O Yes O No
Cough O Yes O No
Wheezing O Yes O No
Shortness of breath O Yes O No

Skin
Rash O Yes O No

Neurological
Headaches O Yes O No
Dizziness O Yes O No

Genitourinary
Urinary O Yes O No
Blood in urine O Yes O No
Abnormal menstrual cycle O Yes O No

MEDICAL HISTORY:
Hypertension O Yes O No Diabetes O Yes O No Heart Disease O Yes O No
Atrial Fibrillation O Yes O No Cancer O Yes O No

Other Medical problems?_____

PAST SURGICAL INTERVENTIONS:
Pain Injections: O Yes O No Type of injection?:_____How many?_____
Date of Injections:_____

Back Surgery?_____Surgeon:_____

Any other surgeries? _____

Implantable devices? (pacemaker, spinal cord stimulator, cochlear implants, etc.),
please explain:_____

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FAMILY HISTORY:

Please check if anyone in your family (mother, father, siblings) has had any of the following conditions:

Rheumatoid Arthritis	_____	Blood Disorder	_____
Cancer	_____	Heart Disease	_____
Lupus	_____	Fibromyalgia	_____
Diabetes	_____	Headaches	_____

Other Diseases_____

Deceased - age at death and cause:_____

SOCIAL HISTORY:

Occupation: _____

Are you currently working? O Yes O No If no ,are you collecting unemployment benefits O Yes O No

Married? O Yes O No Are you pregnant, or think you might be? O Yes O No

Present living situation:_____

Do you feel safe at home? O Yes O No If no why not?_____

Do you drink alcohol on a regular basis? O Yes O No

Substance intake per day:

Nicotine (cigars, cigarettes, pipe, etc) _____ pk/day _____ years

Recreational substances;

(marijuana, cocaine, heroin, hallucinogens, methyl amphetamine, etc). O Yes O No Former Abuser: O Yes O No

Do you find life particularly stressful? O Yes O No

Has a psychiatrist, for any reason, ever treated you? O Yes O No

Are you involved in any lawsuits concerning your pain? O Yes O No

Are you considering suing someone for your pain? O Yes O No

Please sign your name below, verifying that the above medical history is correct:

Patient name: _____Signature:_____

Thank you for taking the time to complete this questionnaire.

Madan K. Raj, M.D. F.A.A.P.M.R.

Physician Signature_____ Date: _____

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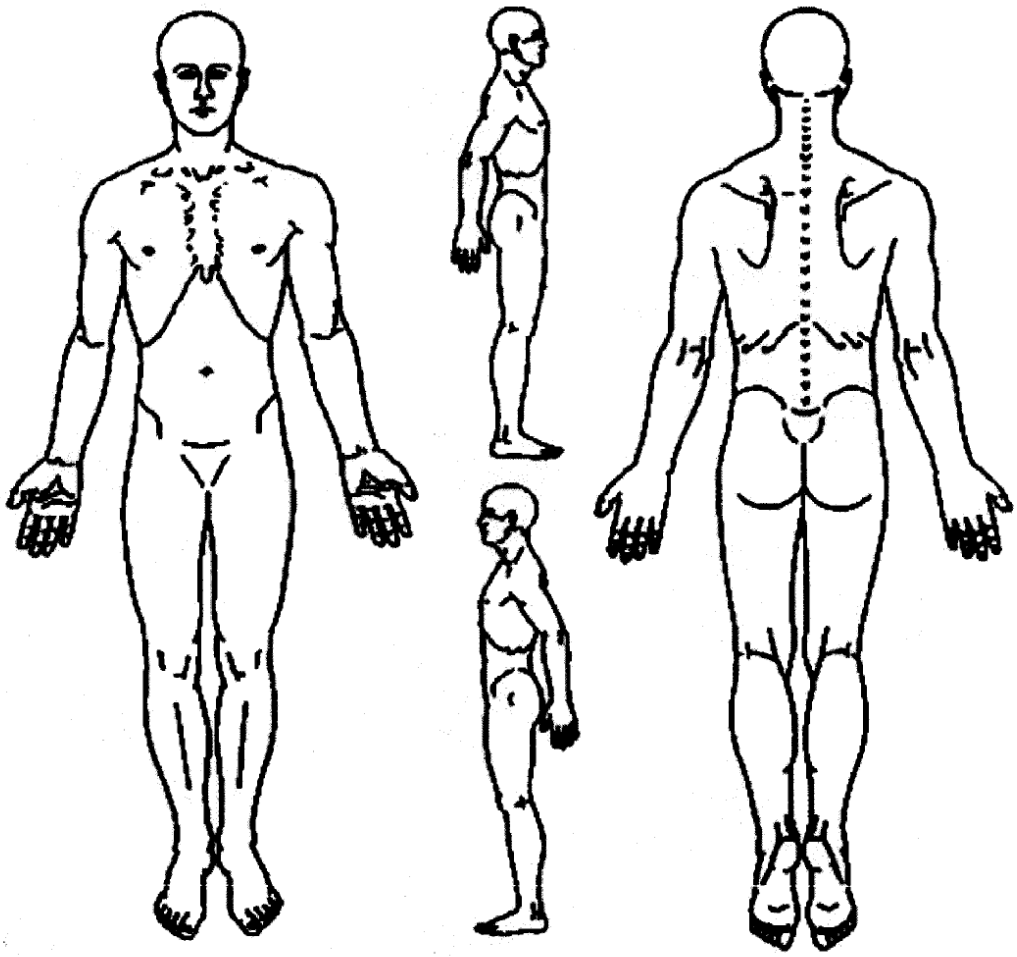
PAIN DIAGRAM

NAME _____ DATE _____

How long have you had pain _____ years _____ months _____ weeks

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now. Please complete both sides of this form.



A = ACHE **B** = BURNING **N** = NUMBNESS
P = PINS & NEEDLES **S** = STABBING **O** = OTHER

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HIPAA SIGNATURE PAGE

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices and have therefore been advised of how medical information about me may be used and disclosed by Madan K. Raj, M.D. and how I may obtain access to this information

_____

Signature of Patient/Personal Representative

_____

Print Name of Patient or Personal Representative

Date_____

Many times family members of patients will call to obtain and discuss treatment records on behalf of the patient. If there are only certain family members that you would wish Dr. Raj to discuss your care with, please indicate their names below. Dr. Raj will not speak with any other family member other than those listed.

Name_____ Relation to Patient_____

Name_____ Relation to Patient_____

Name_____ Relation to Patient_____

Name_____ Relation to Patient_____

Your Name (print)_____

Signature_____ Date_____

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Medical Records Release Authorization

To: _____

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO/FROM:

Madan K. Raj, M.D.

600 Northern Blvd, Suite 113
Great Neck, NY 11021
Tel (516)441-5739 Fax (516)441-5743

Madan K. Raj, M.D.

353 Veterans Memorial Hwy, Ste 303
Commack, NY 11725
Tel (631)864-3900 Fax (631)864-2954

THE **COMPLETE** HISTORY OF RECORDS IN YOUR
POSSESSION CONCERNING MY
ILLNESS AND/OR TREATMENT DURING THE PERIOD

FROM: _____TO: _____

Your Name: _____

Address: _____

_____

Signature (or authorized representatives' signature)

_____

Name of authorized representative (if signed above)

_____

Date: _____

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Long-term Controlled Substances Therapy for Pain

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

The goal of my therapy is to reduce my pain to a level that is tolerable and will allow me to improve my ability to perform daily activities. I understand that daily use of a narcotic increases certain risks, which include but are not limited to:

- Addiction
- Allergic reactions, overdose and/or fatal complications
- Breathing problems
- Drowsiness, dizziness and/or confusion
- Impaired judgement and inability to operate machines or drive motor vehicles
- Nausea, vomiting, and/or constipation
- Development of tolerance

1. I will take this medication only as prescribed and I will not change the amount or frequency without authorization from my physician. Unauthorized changes may result in my running out of medication early, and early refills will not be allowed.

2. I am expected to inform the office of any new medications or medical conditions, and of any adverse effects I may experience from any of the medications.

3. I understand that due to the high potential for abuse of these medications, the following rules apply: I may not share, sell, or otherwise permit others to have access to these medications. The drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child. Medications will NOT be replaced if they are lost or stolen.

4. I will obtain ALL of my pain prescriptions through Madan K. Raj, MD and will fill ALL of my pain prescriptions at (*pharmacy name and phone*) _____

5. In an acute emergency, another provider may prescribe medications for me. If this occurs, I will notify Dr. Madan K. Raj as soon as possible.

6. I will submit to random urine or serum toxicology screens if requested to access my compliance. Presence of unauthorized substances may prompt referral for assessment for addictive disorder or termination.

7. I agree to see Madan K. Raj, MD for ongoing case management and will keep regularly scheduled appointments as long as I am taking this narcotic medication.

8. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.

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9. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.

10. It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit.

You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

_____	_____
Physician Signature	Patient Signature
_____	_____
Date	Patient Name (Printed)

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FINANCIAL TERMS

Depending on your health insurance policy, you will be responsible for the following:

COPAYS AND DEDUCTIBLES for Office visits and/or Injection procedures.

If you are scheduled for an injection procedure and Dr Raj is **NOT** in your insurance network but your insurance policy allows out of network benefits:

***We will generally accept what the insurance policy allows**.

**That amount varies from insurance company to insurance company and may be augmented by a secondary insurance.*

***You will be billed for any balance over and beyond the insurance payment(s) *as required by law*.**

***We will not impose any financial hardship on any patient.**

**We understand that different individuals have different financial obligations.*

Questions regarding management of any balance can be discussed with the physician or his billing representative.

The billing department has flexible terms and will cooperate with you to provide a fair and reasonable financial settlement of your obligations to New York iSpine Specialist Medical, PC. The amount, or estimated amount, that you will be billed is available upon request.

We can help you by submitting your insurance claim in your behalf once your insurance has received and processed your claim, they should send you a statement ("Explanation of Benefits") within 30-45 days.

YOU AGREE TO FULLY COOPERATE WITH US IN COLLECTING THE INSURANCE PAYMENT(S) and provide us with a copy of the summary of benefits and coverage for your plan ("Summary Plan Description") if requested.

NAME:_____**SIGNATURE:**_____

DATE;_____

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We've found the following policies to be helpful in providing our patients with the best possible service.

Your cooperation is appreciated and we look forward to seeing you at your visit!

Patient Satisfaction

We always strive to provide our patients with the nest possible patient experience. We understand your pain and want your time with us to be as pleasant as possible. If you ever have concerns about any aspect of our services, do not hesitate to speak directly to the Office Manager.

Medical Records

You have the right to request a copy of your medical records. Please contact the office and complete a medical records request form. It usually takes approximately 7-10 business days to process these requests. There may also be a nominal charge associated with this service.

Late Arrival Policy

Please call if you are running late. Medical evaluations and treatments may be shortened for patients arriving 10-15 minutes late but patients arriving more than 15 minutes late may be asked to reschedule. If our office is responsible for a delay, your session will be completed in its entirety.

Missed Appointment Policy

In order to best serve all of our patients, we require a 24 hours notification should you need to cancel or reschedule your appointment. Should you miss or reschedule you appointment with less than 24 hour notice, you may be charged a fee of $25 for an office visit and a fee of $100 for an office injection procedure with fluoroscopy.

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Methods of Payment

NY iSpine Specialist Medical P.C. accepts cash, checks, Visa, MasterCard and Discover.

Please write check to New York iSpine Specialist Medical P.C.

Co-Payments

Co-payments and deductibles are due at the time of your scheduled appointment. If you are paying cash, we would greatly appreciate exact change.

Miscellaneous Charges

Returned Check Fee: A returned check fee of $35 will be collected for any check returned to us unpaid.

Payment for Medical Services

It is important that you understand you are assuming financial responsibility for all charges incurred for service rendered. You will be required to pay co-pays, amounts applied to deductibles and balances of bills mot paid in accordance with the benefits of your insurance policy. If you are unable to make payment in full for your medical treatment within 30 days, you must contact our office at 516-441-5739 to make payment arrangements.