PAINLESS CENTER

2 Dean Drive Unit 1N
Tenafly, NJ 07670

PATIENT INFORMATION

Last name:	First:	Middle:	DOB:

Legal name, if applicable:	Social Security #:	Gender Identity: ☐ M ☐ F ☐non-binary ☐Prefer not to answer

Cell Phone #:	Home / Alternate Phone #:	Email Address:	* May we contact you via email/text message? ☐ Yes ☐ No

Street Address:	City, State, Zip:

Occupation:	Employer name / phone:	How you found us (please check one box): ☐ Insurance ☐ Family / Friend ☐ Internet ☐ Attorney ☐ Other: _____

Pharmacy:	City, State:	Phone #:

MEDICAL INSURANCE

Primary insurance carrier:	Subscriber's name / DOB:

Subscriber ID #:

Personal Injury & Workers Compensation

Auto Accident / Comp Insurance Carrier:	Claim #:	Policy Number:

Date of Accident:	Location of Accident *(city & state):*	Law Firm Name & City:

Attorney Email:	Phone:	Paralegal / legal assistant:

IN CASE OF EMERGENCY

Name of friend or relative:	Relationship to patient:	Phone #:

Disclosure: *In the event that any insurance payment is made directly to me, I understand that* ***it is my responsibility to forward any/all payments owed to the practice directly to The Painless Center****. I understand that The Painless Center is an out-of-network provider and that I may be responsible for any balance.*

_____ _____

Patient / Representative Signature Date

2 Dean Drive Unit 1N
Tenafly, NJ 07670

Evaluation Intake Form

Patient Name: _____ Date: _____

1. When did your pain start? _____

2. How did your pain start?
   ☐ Accident ☐ Cancer/Other Disease ☐ Surgery ☐ No obvious cause ☐ Other: _____

3. How often does your pain occur?
   ☐Continuous ☐Several times daily ☐Once daily ☐Several times weekly ☐Once weekly
   ☐Less than once weekly ☐Never

4. What is your average duration of pain?
   ☐Weeks ☐Days ☐Hours ☐Minutes ☐Seconds ☐None

5. Select all types of pain you are experiencing:
   ☐ Throbbing ☐ Shooting ☐ Stabbing ☐ Burning
   ☐ Gnawing ☐ Cramping ☐ Sharp

6. Indicate your **highest pain intensity** over the past week:

0	1	2	3	4	5	6	7	8	9	10
None										High
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

7. Indicate your **lowest pain intensity** over the past week:

0	1	2	3	4	5	6	7	8	9	10
None										High
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

8. Your pain is alleviated by:
   ☐ Sitting ☐ Standing ☐ Resting ☐ Medication
   ☐ Bending ☐ Lying Down ☐ Coughing ☐ Sneezing

9. Your pain is worsened by: (Check all that apply)
   ☐ Sitting ☐ Standing ☐ Walking ☐ Driving
   ☐ Bending ☐ Lying Down ☐ Coughing ☐ Sneezing

10. Please select all testing/procedures you have received because of your pain.
    ☐ X-Ray ☐ MRI ☐ CT ☐ Myelogram ☐ EMG ☐ Blood Tests ☐ Bone Scan ☐ Discogram

Location / Date / Body Part:_____

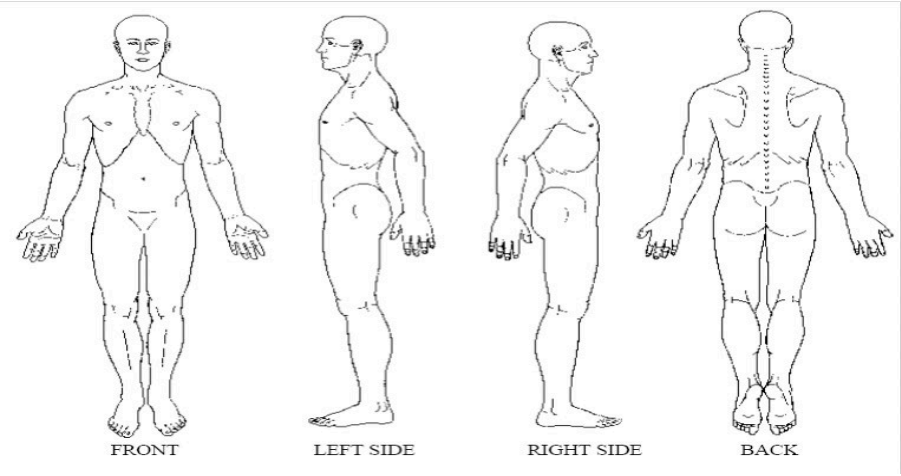
Tel: 201-592-PAIN (7246) Fax: 201-540-9978 www.thepainlesscenter.com

2 Dean Drive Unit 1N
Tenafly, NJ 07670

Evaluation Intake Form

Patient Name: _____ Date: _____

11. Please indicate where you have pain by marking the corresponding regions on the diagram below.



12. Please select treatments you have tried because of your pain.

Specialty	Pain Alleviated?
Acupuncture	☐ Yes ☐ No
Chiropractor	☐ Yes ☐ No
Biofeedback	☐ Yes ☐ No
Traction	☐ Yes ☐ No
Physical Therapy	☐ Yes ☐ No
Psychologist/Psychiatrist	☐ Yes ☐ No
Alternative Medicine	☐ Yes ☐ No
Surgery	☐ Yes ☐ No

13. Do you have a significant past medical history? ☐ No ☐ Yes _____

14. Past Surgical History, including pain management injections:

Surgery Type	Date	Surgeon

15. Allergies, including medications, latex, and foods. Please explain the type of reaction you experience: _____

16. Current Medications (Attach list if necessary):

Name	Dose	Times/Day

Tel: 201-592-PAIN (7246) Fax: 201-540-9978 www.thepainlesscenter.com

Evaluation Intake Form

Patient Name: _____ Date: _____

17. If you are currently taking blood-thinners, select all that apply:
☐ Enoxaparin (Lovenox) ☐ Heparin ☐ Clopidogrel (Plavix) ☐ Warfarin (Coumadin)
☐ Fondaparinux (Artixtra) ☐Dabigatran (Pradaxa) ☐ Apixaban (Eliguis)

18. What is your current mood?
☐Worse ☐Poor ☐Fair ☐Good

19. Please select mood altering factors.
☐ Sleep ☐ Mood ☐ Depression ☐ Self-worth ☐ Suicidal/Homicidal Thoughts

20. Family History: Please list medical history of immediate family members: _____
_____

- Mother: ☐ Living ☐ Deceased
- Father: ☐ Living ☐ Deceased

21. Review of symptoms (Select all that apply):
☐Abdominal Pain ☐Blood in stool ☐Chest pain ☐Cough ☐Diarrhea ☐Dizziness ☐Easy Bruising ☐Fever ☐Headache ☐Incontinence ☐Lightheadedness ☐Night Sweats ☐Nausea ☐Paralysis ☐Palpitations ☐Pregnancy ☐Rash ☐Swelling ☐Shortness of breath ☐Urinary Frequency ☐Vision Changes ☐Weakness ☐Weight Loss ☐Wheezing

Thank you for completing The Painless Center's Evaluation Intake Form. Please present your identification and insurance information to the front desk. The doctor will be with you shortly.

Tel: 201-592-PAIN (7246) Fax: 201-540-9978 www.thepainlesscenter.com

2 Dean Drive Unit 1N
Tenafly, NJ 07670

Medical Record Release Form

Send To: _____

Via Fax: _____

_____

_____

Patient Name: _____ DOB: _____

This shall serve as an authorization to release copies of my medical record to **The Painless Center, LLC.** I understand that the release of my information to **The Painless Center, LLC** will aid in the continuation of my care and allows me to receive further treatment if necessary. **The Painless Center, LLC** follows HIPAA compliance in the handling of pertinent patient medical information. I hereby authorize the release of my records including but not limited to the following:

- ☐ Demographic Information
- ☐ Clinical notes/Medication history/Operative reports
- ☐ Radiology/Imaging/MRI/CT Scan/X-ray
- ☐ Lab results/Urine drug screen/Routine blood test

- ☐ Other: _____

Patient Signature: _____ **Date**: _____

Please send records via fax**: 201-540-9978** or via email: **admin@thepainlesscenter.com**

Thank you, in advance, for your cooperation!

PAINLESS CENTER

2 Dean Drive Unit 1N
Tenafly, NJ 07670

HIPAA Acknowledgement and Consent Form

I understand that I, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), have certain rights to privacy regarding my protected health information ("PHI"). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Conduct, plan and direct my treatment, and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- To obtain payment from designated third-party payers (e.g. my insurance company).
- Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed of the Notice of Privacy Practices of The Painless Center. I have reviewed such Notice of Privacy Practices prior to signing this consent. I understand that The Painless Center has the right to change its Notice of Privacy Practices from time to time, and that I may contact The Painless Center at any time to obtain a current copy of the Notices of Privacy Practices.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions; however, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time; however, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name _____

Signature _____

Signature Date _____

Relationship to Patient (if patient unable to sign) _____

New Jersey Department of Banking and Insurance

CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary.* This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY, does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS

I, PRINT NAME, by marking [√] (or [x]) and signing below, agree to:

☐ representation by [ ] in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.

☐ release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program or the Chapter 32 Independent Arbitration System, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: _____ Ins. ID#:_____ Date: _____

Relationship to Patient: ☐ I am the Patient ☐ I am the Personal Representative (provide contact information on back)

* If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.

The Painless Center
ASSIGNMENT OF BENEFITS
&
LTD. POWER OF ATTORNEY

I irrevocably assign to you, my medical provider, all of my rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize and consent to your acting on my behalf in this regard and in regard to my general health insurance coverage pursuant to the "benefit denial appeals process" as set forth in the NJ Administrative Code.

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is challenged or deemed invalid, I execute this **limited/special power of attorney** and appoint and authorize your collection attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case, in my name, including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact. I further grant limited power of attorney to you as my medical provider to receive and collect directly from the insurance carrier money due you for services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me. I authorize you and or your attorney to receive from my insurer, immediately upon verbal request, all information regarding last payment made by said insurer on my claim, including date of payment and balance of benefits remaining.

I authorize you and or your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to you about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my physical condition.

I authorize **The Painless Center** to furnish my records of medical history for services rendered or treatment given to me for the purpose of review of filing a claim with my insurance carrier. If applicable, I also request payment of government benefits to the part who accepts assignment.

I understand that I am responsible for all deductibles, co-insurance, co-payments or any portion of the bill that my insurance company does not approve/deny. I understand that if required, a valid referral is due at the time of services; otherwise my appointment will be rescheduled.

Dated: _____ **X**_____

Patient's Signature

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

Claim Number: _____

I, _____ , ("Assignor") hereby assign to THE PAINLESS CENTER **, ("Assignee")**
(Print patient's name) (Print hospital or health care provider name)
all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____ , not withstanding any other agreement
(Print accident date)
to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

(Print name of Patient)	**(Signature of Patient)**
	(Date of signature)
(Address of Patient)	
The Painless Center	Jason Chiu
(Print name of Provider)	**(Signature of Provider)**
	(Date of signature)
2 DEAN DRIVE UNIT 1N TENAFLY NJ 07670	
(Address of Provider)	

NYS FORM NF-AOB (Rev 1/2004)

The Painless Center
2 Dean Drive Unit 1N Tenafly, NJ 07670
Tel: 201-592-7246 Fax: 201-540-9978

Out-of-Network Acknowledgement & Waiver

Patient Name: _____

Your signature below signifies that you clearly understand and acknowledge the following:

1. Dr. Jason Chiu, The Painless Center, and all NP/PAs are **NOT** participating providers with your insurance plan.

2. You knowingly and voluntarily elect, on behalf of yourself, your child, or such other individual on whose behalf you are acting as legal guardian, to obtain medical care from the non-participating providers listed above.

3. You understand that if you do not have out-of-network benefits, you may be responsible for payment in full on the date of service, or in appropriate circumstances you could arrange a payment plan with the provider's billing office.

4. You understand that, except in special circumstances (e.g., financial hardship), the non-participating provider is prohibited from waiving copayments, deductibles, coinsurance, or other member cost sharing amounts.

5. You understand that if you have out-of-network benefits, the provider will submit medical claims on your behalf to your insurance carrier as a courtesy. You may be responsible for any out-of-network copay, coinsurance or deductible after your insurance processes your claim.

6. You understand that you may be responsible for payment in full, for all services provided by the non-participating provider, that are not covered by your insurance.

_____ _____
Patient / Representative Signature Date

*Estimated cost of treatment available upon request