The Center for the Functional Restoration of the Spine, LLC
Marc S. Menkowitz, MD, LLC
Marc S. Menkowitz, MD

Date:_____

LAST NAME | FIRST NAME | MIDDLE INITIAL | GENDER | CELL PHONE

STREET ADDRESS | CITY | STATE | ZIP

HOME PHONE | SOCIAL SECURITY # | DATE OF BIRTH | AGE | MARITAL STATUS

EMAIL ADDRESS

EMPLOYER | ADDRESS | WORK PHONE

SPOUSE'S NAME (OR PATIENT ACCOMPANYING MINOR) | DATE OF BIRTH | AGE

EMERGENCY CONTACT | RELATION | PHONE NUMBER

PRIMARY CARE PHYSICIAN | ADDRESS | PHONE NUMBER

PHARMACY | ADDRESS | PHONE NUMBER

ALLERGIES

INSURANCE INFORMATION: ____ MEDICARE ____PRIVATE ____MOTOR VEHICLE ____WORKER'S COMPENSATION

NAME OF COMPANY | ADDRESS, CITY, STATE, ZIP

INSURANCE PHONE # | INSURANCE ID/POLICY # | GROUP #

SUBSCRIBER NAME | SOCIAL SECURITY # | DATE OF BIRTH

SECONDARY INSURANCE: _____ YES _____ NO (IF YES, COMPLETE BELOW)

NAME OF COMPANY | ADDRESS, CITY, STATE, ZIP

INSURANCE PHONE # | INSURANCE ID/POLICY # | GROUP #

SUBSCRIBER NAME | SOCIAL SECURITY # | DATE OF BIRTH | GENDER | RELATIONSHIP TO PATIENT

The Center for the Functional Restoration of the Spine, LLC.
Steve J. Paragioudakis, MD
Marc S. Menkowitz, MD

1131 Broad Street
Shrewsbury, NJ 07702

Tel: 732-380-1212
Fax: 732-380-1372

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

Your protected health information will be used by Marc S Menkowitz, LLC (Marc S. Menkowitz, MD) or disclosed to others for the purpose of treatment, obtaining payment or supporting the day-to-day healthcare operations of the practice.

NOTICE OF PRIVACY PRACTICES

You should review the Notice of Privacy Practices for a more complete description of how your 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.
Marc S Menkowitz, LLC. (Marc S. Menkowitz MD) may or may not agree to restrict the use or disclosure of your protected health information.

If Marc S Menkowitz, LLC 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 federal standards.

REVOCATION OR 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

Marc S Menkowitz, LLC reserves the right to modify the privacy practices outlined in the notice.

SIGNATURE

I have reviewed this consent form and give my permission to Marc S Menkowitz, LLC Marc S. Menkowitz, MD) to use and disclose my health information in accordance with it.

Name of Patient (Print) _____

Signature of Patient _____ **Date:** _____

Signature of Patient Representative: _____

Relationship to Patient: _____

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LEGAL ASSIGNMENT OF BENEFITS & DESIGNATION OF AUTHORIZED REPRESENTATIVE

I, _____, represent that I have valid and in-force insurance and/or
Patient Name
employee health care benefits coverage, and hereby assign and convey directly to Dr. Paragioudakis M.D. and/or Marc S. Menkowitz, MD, the "provider(s)", as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from the provider(s), regardless of the provider's managed care network participation status. **I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments.** I hereby authorize the provider(s) to release all medical information necessary to process my claims under HIPAA, I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to the provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from the provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the provider(s), to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefit plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including but not limited to: (1) obtaining information about the claim to the same extent as the assignor: (2) submitting evidence; (3) making statement about facts or laws; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial action actions by the provider(s) to pursue such claim, chose in action or right against any liable party or employee group health benefit plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare, and applicable federal and state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Insured/Responsible Party: _____

Printed Name of Insured/Responsible Party: _____

Date: _____

MEDICAL INTAKE FORM

TODAY'S DATE: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

WHAT IS THE MAIN REASON FOR OUR VISIT?

_____

IF YOU WERE REFERRED TO OUR PRACTICE PLEASE PROVIDE THE FOLLOWING:

NAME: _____ SPECIALTY (IF PROVIDER): _____ PHONE #: _____

PAST MEDICAL HISTORY

Circle YES or NO for any major, significant illnesses which apply to you.

ANEMIA:	YES NO	HAY FEVER/SINUS PROBLEMS:	YES NO
ASTHMA / BRONCHITIS / EMPHYSEMA:	YES NO	HEART DISEASE:	YES NO
ARTHRITIS:	YES NO	HEPATITIS:	YES NO
BLEEDING / BRUISING / BLOOD DISORDER:	YES NO	HIGH BLOOD PRESSURE:	YES NO
CANCER (TYPE):_____	YES NO	IMMUNE DISORDER:	YES NO
DEPRESSION:	YES NO	KIDNEY DISEASE:	YES NO
DIABETES: DO YOU TAKE INSULIN?	YES NO YES NO	LIVER DISEASE:	YES NO
DRUG ABUSE / ALCOHOL DEPENDENCY:	YES NO	STROKE:	YES NO
EPILEPSY / SEIZURES:	YES NO	THYROID DISEASE:	YES NO
OTHER (describe): _____		TUBERCULOSIS (TB):	YES NO

HOSPITALIZATIONS / SURGERIES / SERIOUS INJURIES:

DATE: _____ REASON: _____
DATE: _____ REASON: _____
DATE: _____ REASON: _____
DATE: _____ REASON: _____

MEDICATIONS (PRESCRIPTION AND OVER THE COUNTER/SUPPLEMENT):

MEDICATION: _____ DOSE: _____
MEDICATION: _____ DOSE: _____
MEDICATION: _____ DOSE: _____
MEDICATION: _____ DOSE: _____
MEDICATION: _____ DOSE: _____
MEDICATION: _____ DOSE: _____
ALLERGIES: _____

Please indicate anything else of importance the Doctor should know about you:

_____

FAMILY / SOCIAL HISTORY

TODAY'S DATE: _____

PATIENT NAME: _____ **DATE OF BIRTH:** _____

FAMILY HISTORY:

	AGE	MEDICAL PROBLEMS	CAUSE OF DEATH
FATHER			
MOTHER			
SIBLINGS			
CHILDREN			

SOCIAL HISTORY:

DO YOU (OR DID YOU IN THE PAST) SMOKE (PLEASE CIRCLE: CIGARETTES / MARIJUANA) ? YES / NO
HOW MUCH: _____ PACKS/ DAY / _____ YEARS
IF YOU HAVE QUIT, PLEASE SPECIFY WHEN YOU QUIT: _____

DO YOU DRINK ALCOHOL? YES / NO HOW OFTEN? _____

DO YOU USE ANY OTHER DRUGS OTHER THAN PRESCRIBED OR OVER THE COUNTER MEDICATION? YES / NO
IF YES, PLEASE LIST:
_____

DO YOU EAT A BALANCED DIET? YES / NO IS YOUR WEIGHT STABLE? YES / NO

HAVE YOU HAD SIGNIFICANT EXPOSURE TO: PESTICIDES? YES NO TOXIC WASTE? YES NO

HAVE YOU HAD PREVIOUS TREATMENT WITH OR EXPOSURE TO RADIATION? YES NO
IF YES, PLEASE EXPLAIN: _____

BIRTHPLACE: _____

CURRENT OCCUPATION: _____

WHO CURRENTLY LIVES AT HOME WITH YOU: _____

YEARS OF EDUCATION COMPLETED: _____

IS TODAY'S EVALUATION RELATED TO:

MOTOR VEHICLE ACCIDENT? YES / NO - IF YES, WHEN: _____
WORKMAN'S COMPENSATION? YES / NO - IF YES. WHEN: _____
LAWSUIT? YES / NO - IF YES, DESCRIBE: _____

HAVE YOU BEEN OUT OF WORK DUE TO YOUR SYMPTOMS? YES / NO
IF YES - WHAT WAS YOUR LAST DATE WORKED? _____

REVIEW OF SYSTEMS

TODAY'S DATE: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

DO YOU PRESENTLY HAVE ANY PROBLEMS OR SYSTEMS IN THE FOLLOWING AREAS? PLEASE CHECK OFF ALL THAT APPLY:

GENERAL		SKIN	
FATIGUE	YES	RASH	YES
DECREASED APPETITE	YES	CHANGING MOLES	YES
FEVERS	YES	SKIN CANCER	YES
WEIGHT LOSS	YES	NON-HEALING WOUND	YES
WEIGHT GAIN	YES	BREAST PAIN/LUMP	YES
INSOMNIA	YES	CHANGE IN HAIR/NAILS	YES
		ITCHING	YES
CARDIOVASCULAR		HEMATOLOGICAL	
CHEST PAIN	YES	EASY BRUISING	YES
PALPITATIONS	YES	FREQUENT BLEEDING	YES
HIGH BLOOD PRESSURE	YES	ENLARGED LYMPH	YES
STROKE	YES	NODES	
SWELLING OF LEGS	YES		
HISTORY OF BLOOD CLOT	YES		
NEUROLOGICAL		MUSCULOSKELETAL	
HEADACHES	YES	JOINT STIFFNESS	YES
NUMBNESS OR TINGLING	YES	MUSCLE PAIN	YES
WEAKNESS	YES	MUSCLE CRAMPING	YES
PARALYSIS	YES	MUSCLE WEAKNESS	YES
CHANGE IN MEMORY	YES	BACK PAIN	YES
DIFFICULTY WALKING	YES	DIFFICULTY WALKING	YES
DIZZINESS	YES		
ENDOCRINE		EAR/ NOSE / THROAT	
HEAT INTOLERANCE	YES	VISUAL CHANGES	YES
COLD INTOLERANCE	YES	HEARING LOSS	YES
EXCESS THIRST	YES	SORE THROAT	YES
EXCESS URINATION	YES	NASAL CONGESTION	YES
THYROID PROBLEMS	YES	RUNNY NOSE	YES
		EAR PAIN	YES
GASTROINTESTINAL		GENITOURINARY	
CHANGE IN APPETITE	YES	PAINFUL URINATION	YES
HEARTBURN	YES	BLOODY URINE	YES
ULCERS	YES	INCREASED URINATION	YES
NAUSEA/VOMITING	YES	LEAKING URINE	YES
DIARRHEA	YES	ERECTILE DYSFUNCTION	YES
CONSTIPATION	YES		
BLOODY STOOLS	YES		
RECTAL BLEEDING	YES		
ABDOMINAL PAIN	YES		

PAIN DRAWING

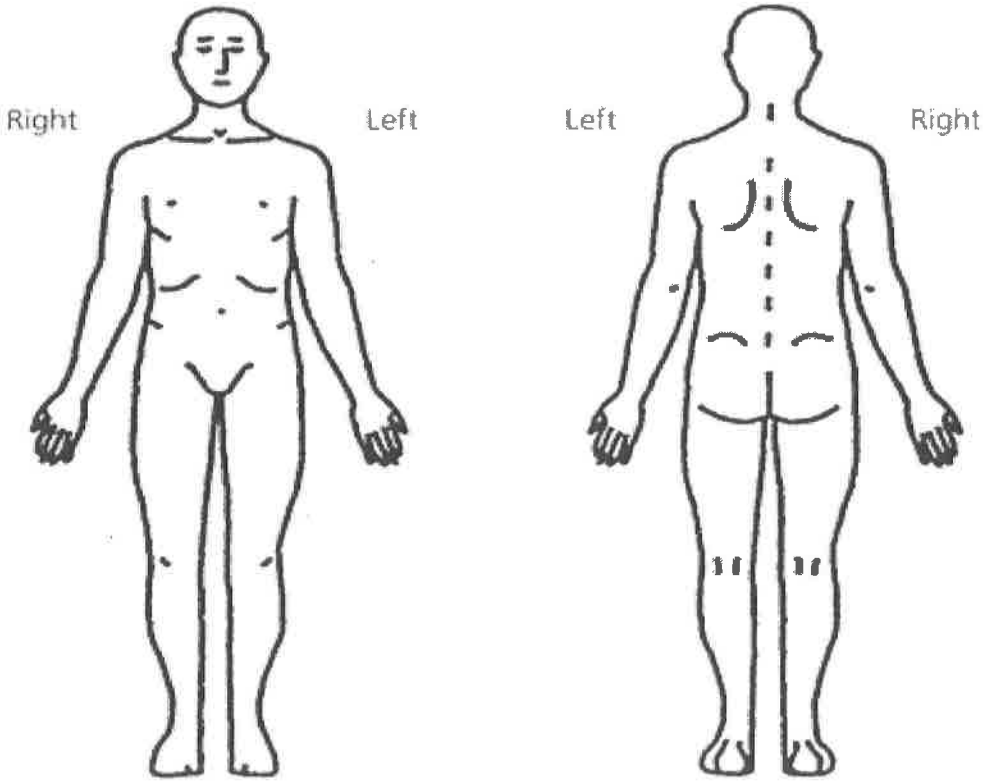
TODAY'S DATE: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

THE PAIN DRAWING WILL HELP US UNDERSTAND THE PAIN YOU HAVE BEEN EXPERIENCING. PLEASE DIAGRAM YOUR PAIN USING THE FOLLOWING SYMBOLS.

NUMBNESS: ------
BURNING: XXXX
PINS & NEEDLES: OOOO
STABBING: /////
OTHER: ***

HEIGHT: _____ WEIGHT: _____



DATE OF ACCIDENT(S) (Write "N/A" if not related to motor vehicle or workman's compensation):

_____

OUT OF WORK: DAYS: _____ MONTHS: _____ YEARS: _____

BACK PAIN / HIP PAIN / LEG PAIN QUESTIONNAIRE
(skip if you do not have back, leg, or hip pain)

TODAY'S DATE: _____

PATIENT NAME: _____ **DATE OF BIRTH:** _____

WHEN WERE YOU FIRST AWARE THERE WAS SOMETHING WRONG WITH YOUR BACK?

_____

HOW LONG HAVE YOU BEEN EXPERIENCING YOUR PRESENT ATTACK OF PAIN?

_____

HOW MANY ATTACKS OF PAIN HAVE YOU HAD PER YEAR?

_____

PAIN SCALE

ON A SCALE OF 1-10 WITH 0 BEING NO PAIN AND 10 BEING PAIN SO SEVERE THAT YOU COULD NOT LIVE WITH IT FOR MORE THAN A FEW MINUTES, HOW WOULD YOU RATE YOUR PAIN PRESENTLY?
BACK: _____ RIGHT LEG: _____ LEFT LEG: _____ RIGHT HIP: _____ LEFT HIP: _____

IF YOU HAVE LEG PAIN, DID THE BACK PAIN IMPROVE ONCE THE LEG PAIN BEGAN? _____

PAIN DESCRIPTION

IS YOUR PAIN: _____ INTERMITTENT / _____ CONSTANT
IS YOUR PAIN: _____ IMPROVING / _____ GETTING WORSE

PAIN INTERFERENCE

DOES YOUR PAIN AFFECT YOUR SLEEP IN ANY OF THE FOLLOWING WAYS?
_____ CANNOT SLEEP AT ALL BECAUSE OF PAIN
_____ I AM AWAKE THE SAME TIME EVERY NIGHT
_____ I MUST TAKE MEDICINE TO SLEEP
_____ I CANNOT SLEEP IN CERTAIN POSITIONS (SPECIFY): _____

ACTIVITY

HOW MUCH TIME DO YOU SPEND DURING THE DAY LAYING DOWN? _____
WHAT MAKES PAIN WORSE? _____
WHAT MAKES PAIN BETTER? _____
IS THE PAIN WORSE IN THE MORNING? YES / NO
IS THE PAIN WORSE TOWARD THE END OF THE DAY? YES / NO

DO YOU HAVE DIFFICULTY WALKING? YES / NO
IF YES, DO YOU STUMBLE DUE TO PAIN? YES / NO - PLEASE DESCRIBE: _____
DO YOU LIMP? YES / NO - PLEASE DESCRIBE: _____

_____ FEELS LIKE YOU MUST URINATE BUT CANNOT _____ DRIBBLING
_____ LOSS OF FEELING OF VOIDING _____ INABILITY TO VOID
_____ URGENT DESIRE TO VOID AND CANNOT HOLD IT _____ CONSTIPATION
_____ DIFFICULTY WITH SEX

KNEE PAIN

DOES YOUR KNEE(S) GIVE WAY?	RIGHT KNEE	LEFT KNEE	NO
DO YOU HAVE WEAKNESS IN YOUR KNEE?	RIGHT KNEE	LEFT KNEE	NO
DO YOU HAVE NUMBNESS IN YOUR FOOT?	RIGHT FOOT	LEFT FOOT	NO

HAVE YOU BEEN EVALUATED BY A MEDICAL PROVIDER FOR YOUR PAIN? IF SO, LIST NAME AND SPECIALTY.

_____

TODAY'S DATE: _____

PATIENT NAME: _____ **DATE OF BIRTH:** _____

WHAT TREATMENTS HAVE YOU UNDERGONE AND HAVE THEY BEEN HELPFUL?

_____

_____

HOSPITALIZATIONS / SURGERIES FOR BACK PAIN

HAVE YOU EVER BEEN HOSPITALIZED FOR YOUR BACK / LEG / HIP PAIN? YES / NO
IF YES, LIST DATES: _____

HAVE YOU UNDERGONE ANY OF THE FOLLOWING TESTS FOR YOUR BACK PAIN? IF SO, LIST THE BODY AREA AND DATE(S):
MRI: _____ DATE(S): _____
CT SCAN: _____ DATE(S): _____
CT MYELOGRAM: _____ DATE(S): _____
BONE SCAN: _____ DATE(S): _____
OTHER (EMG, EPIDURAL VENOGRAM): _____ DATE(S): _____

HAVE YOU UNDERGONE ANY SURGERIES, THERAPEUTIC PROCEDURES ON YOUR BACK? YES / NO
IF YES, LIST DATES/ TYPE OF PROCEDURE: _____

CERVICAL SPINE QUESTIONNAIRE
(skip if you do not have neck pain, shoulder, or arm pain)

HOW LONG HAVE YOU BEEN EXPERIENCING NECK PAIN?

_____

DID IT BEGAN AFTER A SPECIFIC TRAUMA OR INJURY? YES / NO
IF YES, PLEASE DESCRIBE: _____

PAIN SCALE

ON A SCALE OF 1-10 WITH 0 BEING NO PAIN AND 10 BEING PAIN SO SEVERE THAT YOU COULD NOT LIVE WITH IT FOR MORE THAN A FEW MINUTES, HOW WOULD YOU RATE YOUR PAIN PRESENTLY?
NECK: _____ RIGHT SHOULDER: _____ LEFT SHOULDER: _____
HEADACHES: _____ RIGHT ARM: _____ LEFT ARM: _____

PAIN INTERFERENCE

DOES PAIN INTERFERE WITH YOUR SLEEP? YES / NO
DO YOU EXPERIENCE WEAKNESS? YES / NO - WHERE? _____
DO YOU EXPERIENCE CLUMSINESS? YES / NO - WHERE? _____
DO YOU EXPERIENCE NUMBNESS? YES / NO - WHERE? _____
DO YOU HAVE DIFFICULTY WALKING? YES / NO - HOW LONG CAN YOU WALK? _____

HAVE YOU UNDERGONE ANY OF THE FOLLOWING TESTS FOR YOUR PAIN? IF SO, LIST THE BODY AREA AND DATE(S):
MRI: _____ DATE(S): _____
CT SCAN: _____ DATE(S): _____
CT MYELOGRAM: _____ DATE(S): _____
BONE SCAN: _____ DATE(S): _____
OTHER (EMG, EPIDURAL VENOGRAM): _____ DATE(S): _____

HOSPITALIZATIONS / SURGERIES FOR NECK PAIN

HAVE YOU EVER BEEN HOSPITALIZED FOR YOUR NECK PAIN? YES / NO
IF YES, LIST DATES: _____

HAVE YOU UNDERGONE ANY SURGERIES, THERAPEUTIC PROCEDURES ON YOUR NECK? YES / NO
IF YES, LIST DATES/ TYPE OF PROCEDURE: _____

The Center for the Functional Restoration of the Spine
Pain Treatment with Opioid Medications: Patient Agreement

This agreement is essential to the trust and confidence necessary in a prescriber/patient relationship. My prescriber has discussed my treatment plan with me. I understand that there is a risk for psychological and/or physical dependence and addiction associated with chronic use of controlled substances for pain. I have been told about the side effects that I may experience.

I, _____ understand and voluntarily agree to the following (initial each statement after reviewing):

☐ I have told my prescriber about other medications I am taking and my medical history, including my prior experience with pain medications or other drugs. Throughout my treatment I will communicate fully with my prescriber about the character and intensity of my pain, effect of pain on my daily life and how well the medication is helping to relieve pain.

☐ I will take my medication as instructed and not change the way I take it without first talking to my prescriber or other members of the treatment team. I understand that my prescriber may change this medication during the course of treatment.

☐ I will not attempt to obtain pain medications from any other prescribers.

☐ I agree not to use illegal drugs or alcohol while on these medications.

☐ I will use one pharmacy to get all my medications (pharmacy name and phone)_____

☐ I understand that I should not drive a motor vehicle or operate machinery if the medication causes dizziness or drowsiness.

☐ I understand that I may be referred to other healthcare professions for other modes of treatment such as physical therapy, exercise, relaxation techniques, psychological counseling, diagnostic tests and that my prescriber may speak with other health care professionals about my treatment plan.

☐ I will keep the medicine safe, secure and out of reach of others and will dispose of unused medications in a Project Medicine Drop Box, through a Take-Back Program or in a drug disposal pouch.

☐ I will not sell this medicine or share it with others. If my medicine or prescription is lost or stolen, I understand that it may not be replaced.

☐ I understand that I may need to submit to random urine drug testing and pill counts if requested by my prescriber and that my prescriber will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by utilizing the Prescription Monitoring Program website.

☐ I understand that if I do not follow all terms of this Agreement, my prescriber may stop prescribing pain medications and/or I may be required to find another prescriber or health care professional for my future medical treatment.

☐ I will keep all scheduled appointments, including appointments for refills. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.

☐ I will not call between appointments, at night or on the weekends looking for refills. I understand that prescriptions will only be filled during scheduled office visits with the treatment team or during regular office hours. **Office policy requires 48 hours notice for refills.**

_____	_____	_____
Patient Signature	Patient Name Printed	Date
COURTNEY ELLENBERGER, NP-C NURSE PRACTITIONER	Courtney Ellenberger NP-C	
Prescriber Signature	Prescriber Name Printed	Date

Healthcare Information HIPAA Correspondence Form

THE CENTER FOR THE
FUNCTIONAL RESTORATION
OF THE SPINE, LLC

STEVE J. PARAGIOUDAKIS, MD MBA FAAOS
BOARD CERTIFIED ORTHOPAEDIC SPINE SURGEON
ORTHOPAEDIC SPINE SPECIALISTS OF NJ, LLC

MARC S. MENKOWITZ, MD, FAAOS
BOARD CERTIFIED ORTHOPAEDIC SPINE SURGEON
MARC S. MENKOWITZ, MD LLC

Patient's Name: _____ Date of Birth: _____

RELEASE OF INFORMATION:

Healthcare information may include but is not limited to: patient history and physicals, appointments, procedures, surgeries, diagnostic imaging/lab results, outside provider consultations/referrals, insurance claims/billing information,

I hereby authorize the staff at The Center for Functional Restoration of the Spine, LLC. to release and discuss healthcare information of the patient named above to:

SPOUSE: _____ Contact #: _____

CHILD(REN): _____ Contact #: _____

OTHER (specify): _____ Contact #: _____

OTHER (specify): _____ Contact #: _____

CORRESPONDENCE:

If unable to reach me:

- ❑ You may leave a detailed message including protected health information
- ❑ Leave a message requesting a callback

Patient Signature: _____ Date: _____

This authorization may be revoked at any time with submission of a written request