Long Island Spine Specialists, P.C.

HIPAA NOTICE OF PRIVACY PRACTICES
As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of 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 organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization, or Opportunity to Object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with our Office Manager.

Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.

LONG ISLAND SPINE SPECIALISTS, P.C.
Committed to Excellence, Committed to You.

INSURANCE FORM

Date:_____

Referred By: Dr._____Attorney:_____ Physical Therapist:_____Chiropractor:_____

Friends/Family ❑ Zocdoc ❑ Other _____

Internet: Google❑ Facebook❑ Instagram❑ LISS website ❑ Healthgrades ❑ Yelp ❑ Vitals ❑

LAST NAME: _____ FIRST NAME: _____ SOCIAL SECURITY#:_____

Address: _____ Male ❑ Female ❑

_____ Age: _____ Date of Birth:_____

_____ Marital Status: Single □ Married □ Separated □ Divorced □ Widowed □

Telephone #: _____ Cell#: _____

E-mail Address: _____

Employer/Address/Phone

_____

_____

_____

Primary Care Physician/Address/Phone

_____

_____

_____

INSURANCE INFORMATION

PRIMARY:

INSURANCE NAME:_____
INSURANCE PHONE#:_____
POLICY HOLDER: _____

POLICY ID #: _____
GROUP #: _____
POLICY HOLDER'S DATE OF BIRTH: _____
RELATIONSHIP TO PATIENT: _____

SECONDARY:

INSURANCE NAME: _____
INSURANCE PHONE#:_____
POLICY HOLDER: _____

POLICY ID #: _____
GROUP #: _____
POLICY HOLDER'S DATE OF BIRTH: _____
RELATIONSHIP TO PATIENT: _____

WORKERS' COMPENSATION INFORMATION:

INSURANCE CARRIER: _____
INS. CO. ADDRESS#: _____

_____

WCB# _____
ADJUSTER'S NAME: _____
ADJUSTER'S PHONE #:_____

EMPLOYER AT THE TIME OF THIS INJURY: _____

_____

ADDRESS: _____

_____

PHONE #:_____
CARRIER CASE #: _____
LAST DATE WORKED: _____
DATE OF INJURY: _____

NO-FAULT INFORMATION:

YOU MUST ALSO PROVIDE YOUR PRIMARY INSURANCE. **NO EXCEPTIONS.**

INSURANCE CARRIER: _____
INS. CO. ADDRESS#: _____

_____

ADJUSTER NAME: _____
ADJUSTER/INS. PHONE #: _____

DATE OF ACCIDENT: _____
POLICY #: _____

CLAIM #: _____
INSURED'S NAME: _____

RELATIONSHIP TO INSURED: _____

GUARANTOR AGREEMENT- {INSURANCE/MEDICAL RECORD AGREEMENT}

Individual's Responsibility: In consideration of services rendered by *Long Island Spine Specialists, P.C.,* ("LISS") to the undersigned patient, the undersigned promise(s) to pay to Long Island Spine Specialists, P.C., any co-payment, co-insurance, or deductible required to be paid by my health insurance coverage. Please be advised there will be $5.00 process fee for non-payment. In addition, I promise to pay for all services that are not covered by my health insurance plan. In case of denial or termination of benefits, or in the event I fail to inform you of any change in my insurance coverage, I, the undersigned, understand that I am responsible for payment in full for services rendered. In the event that I default on my obligation to pay LISS for services received by LISS and LISS should employ attorneys or incur other expenses for the collection of the payments due to LISS, I agree to pay LISS the reasonable fees of such attorneys and such other expenses so incurred by LISS. Furthermore. I agree that any outstanding debt to LISS shall begin to accrue interest at a rate of 9% per annum, with interest beginning to accrue 30 days after receipt of a final notice from LISS regarding said debt

Non-Participating Plan (Out-of-Network): If Long Island Spine Specialists, P.C. does not participate with my plan, they will send a bill to my insurance carrier on my behalf. However, should my insurance carrier not pay my claim within 45 days, I will be responsible for the full amount due. Non-participating plan (Out-of-Network). If we are "Nonparticipating" with your insurance carrier, an agreed amount is expected at each visit. We accept cash, check, and credit card (*Visa, Discover & Mastercard*). Please be advised there will be $5.00 process fee for non-payment. It is imperative that you understand that due to non-participating, the EOB form (*Explanation of Benefits*) and checks will most likely be sent directly to your home. This check is for payment of services rendered by your LISS physician. We kindly ask you to endorse the check and write "***Pay to the Order of Long Island Spine Specialists, P.C.***", and then mail to LISS. It is very important that you submit the EOB and check to LISS within 5 days of receiving. If there is no check, it is still essential to submit the EOB so we may appeal the claim in a timely manner. It also allows us to correctly update your account. We anticipate no issues in this matter as you clearly understand your responsibility. You may also be responsible for deductibles, and/or coinsurance.

In the case of denial from No-Fault, the Workers' compensation Board, Workers' Compensation carrier, or termination of my orthopedic benefits, I, the undersigned, am responsible for payment in full of any and all services rendered.

Divorced/separated parents of a minor child; I understand that as the parent who consents to the treatment of a minor child, I am responsible for payment of services rendered. Long Island Spine Specialists, P.C., will not be involved with separation or divorce disputes.

MEDICARE: Long Island Spine Specialists, P.C. will submit claims to Medicare. I will be responsible for the deductible and the 20 percent co-insurance, which can be billed to a secondary insurance if I have one.

ASSIGNMENT OF BENEFIT PROCEEDS: I hereby assign to *Long Island Spine Specialists, P.C.,* all monies and/or benefits to which I am entitled from my insurer/HMO/third-party payor, Workers' Compensation policy, government agencies, or those who are financially liable for my medical care.

AUTHORIZATION TO RELEASE RECORDS: I hereby authorize *Long Island Spine Specialists, P.C.,* to release to my insurer/HMO/third-party payor, government agencies, or to whomever if financially responsible for my medical care, all information needed to substantiate payment for such medical care and, if required, of pre-certification /prior approval purposes. It is, however, expressly understood that there will be no obligation of the undersigned to pay for any services, which are improperly billed.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION {PHI}:

I hereby authorize *Long Island Spine Specialists, P.C.,* to use and disclose my individually identifiable Protected Health Information ("PHI") in the manner described. I understand that my PHI may be re-disclosed by the person or entity receiving my PHI from LISS, and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such re-disclosure by the person or entity receiving my PHI from LISS. I voluntarily sign this authorization. I have been provided the opportunity to review the PHI agreement in full and/or access it from the LISS website.

THIS AUTHORIZATION COVERS THE FOLLOWING PHI.

Claims/Billing Information, Drug/Alcohol Abuse, Mental Health Records, Sending Marketing Materials and/or Medical office correspondence to the e-mail address provided by me, Confirming Appointments via Message on answering machine, sign-in sheet.

AN ADDITIONAL AUTHORIZATION WILL BE NEEDED FOR: MEDICAL RECORDS • HIV TEST RESULTS RELEASE

Please limit use and disclosure of my PHI to: _____

_____	_____	_____
Signature of Patient or Authorized Representative	**Print Name**	**Date**

LONG ISLAND SPINE SPECIALISTS, P.C.
Committed to Excellence, Committed to You.

Appointment of Representative

I, _____, do hereby appoint
Patient Name

Long Island Spine Specialists, P.C., health care provider, and /or reimbursement specialist to act as my representative in connection with my claim.

I authorize the above-named provider to appeal any and all claims on my behalf, as well as, make any request, obtain appeal information, to conduct and issue said appeal, and to receive any notice in connection to my appeal.

I understand that personal medical information related to my appeal may be disclosed to the Long Island Spine Specialists representatives.

_____

_____

_____

_____

Patient Name, Address, & Phone Number

_____ _____

Patient Signature **Date Signed**

Commack · West Islip · West Hempstead · Riverhead · (631) 462-2225 · Fax (631) 462-2240 www.lispine.com

LONG ISLAND SPINE SPECIALISTS, P.C.

Notice of Referred Outside Provider Disclosure Acknowledgement

HEALTH PLAN, HOSPITAL, AND OTHER PROVIDER

Effective April 1, 2015 - The N.Y. Surprise Law.

I hereby acknowledge receipt of notice by Long Island Spine Specialists, P.C. of the health plans the *Practice* and each Practice healthcare practitioner is a participating provider with, as well as, notice of those hospitals with which the Practice, and in particular, my healthcare practitioner, is affiliated.

LISS participates with: **MEDICARE, AGEWELL, MAGNACARE, NYSHIP,** and **NORTH SHORE LIJ UNITED HEALTHCARE.**

If my plan is not listed, then Long Island Spine Specialists, PC. **does not** participate with my plan. I understand that as a patient of the Practice, I may be scheduled to receive or may be referred to, or require additional services or testing with outside providers or facilities, to include laboratory work, pathology, radiology, anesthesiology, intraoperative monitoring, and possible outside co-assistant surgeons.

I hereby acknowledge that it is my responsibility to call for fees and determination of responsibility for co or assistant surgeon, anesthesiology, and intraoperative monitoring, if a procedure or surgery is scheduled. I hereby acknowledge that I may request the amount or an estimated amount the Practice or its affiliates will bill me. You should contact the affiliates directly to review their fees. To discuss LISS fees please see our Patient Accounts Liaison in our Commack office, or call 631-462-2225, ext. 246. I hereby acknowledge that services rendered by a non-participating provider may result in costs not covered by my health care plan. I am aware that the Practice and its healthcare practitioners reserve the right to change its/their affiliations (with third party payors, hospitals, or other providers) at any time. I am also aware that I may request an updated list of health plans with which the Practice and each Practice healthcare practitioner is a participating provider, as well as, their affiliated hospitals and other providers.

Long Island Spine Specialists, P.C. (the Practice) is affiliated with the medical facilities below. If you are scheduled at one of these facilities you are responsible to contact them regarding any fees or participation in your insurance plans.

- HUNTINGTON HOSPITAL
  270 PARK AVENUE
  HUNTINGTON, NY 11743
  631-351-2000
- ST. CATHERINE OF SIENA MEDICAL CENTER
  50 ROUTE 25 A
  SMITHTOWN, NEW YORK 11787
  631-862-3000
- GOOD SAMARITAN HOSPITAL MEDICAL CENTER
  1000 MONTAUK HIGHWAY
  WEST ISLIP, NEW YORK 11795
  631-376-3000
- NORTH SHORE SURGI-CENTER
  989 WEST JERICHO TURNPIKE
  SMITHTOWN, NEW YORK 11787
  631-864-7100
- SOUTH SHORE SURGI-CENTER
  53 BRENTWOOD ROAD, SUITE F
  BAY SHORE, NEW YORK 11706
  631-647-5550
- ST. FRANCIS HOSPITAL
  100 PORT WASHINGTON BLVD.
  ROSLYN, NEW YORK 11576
  516-562-6000
- PECONIC BAY MEDICAL CENTER
  1300 ROANOKE AVENUE
  RIVERHEAD, NEW YORK 11901
  631-548-6000
- SUFFOLK SURGERY CENTER
  1500 WILLIAM FLOYD PARKWAY
  SHIRLEY, NEW YORK 11967
  631-205-9090

_____

Signature of Patient or Legal Guardian

_____

Patient's Name

_____

Date

LONG ISLAND SPINE SPECIALISTS, P.C.
Committed to Excellence, Committed to You
631-462-2225 www.lispine.com

NEW PATIENT INFORMATION FORM

Please print all Information. All blanks must be filled to allow us to serve you quickly and efficiently.
Thank you for your cooperation.

Name: _____ **Date of Birth:** _____/_____/_____

Where is your problem located? ❑ Neck ❑ Upper Back ❑ Arm ❑ Lower Back ❑ Hip ❑ Leg

How long have you had this problem? _____

Briefly, please give the details of how this problem originally started: _____

_____

What is your pain level today?

0	1	2	3	4	5	6	7	8	9	10

Please describe the quality of your pain: ❑aching ❑burning ❑stabbing ❑throbbing ❑tingling

Work History:

Occupation: _____

Are you currently working? ❑No ❑Yes ❑ full duty ❑ restricted duty (since _____)

❑ Retired ❑ Unemployed ❑ Student ❑ Homemaker ❑ Caregiver

Disabled through Social Security (SSDI) since _____.

Was this from a work-related injury? ❑ No ❑ Yes Is it under Workers' Compensation? ❑ No ❑ Yes

Date of injury:_____/_____/_____ How did the injury happen?_____

_____

Have you missed any work because of this problem? ❑ No ❑ Yes How much?_____

First date missed: _____ Job title when injured: _____

Usual work activities: _____

Employer at the time of injury: _____ Employer's phone: _____

Employer's address: _____

Was this from a motor vehicle accident? ❑ No ❑ Yes Date of Accident: _____/_____/_____

HIPAA:

I authorize Long Island Spine Specialists to discuss my medical care /billing information with person(s) designated below:

Name: _____ **Phone:**_____ **Relationship to you:** _____

Name: _____ **Phone:**_____ **Relationship to you:** _____

Signature: _____ *(Continued on next page)*

Name:_____

CURRENT MEDICATIONS- Including *Over-The-Counter/* Vitamins & Supplements		
Name	**Dose**	**Directions on Use**

ALLERGIES	
Substance	**Reaction**

Current Pharmacy: _____ **Town:** _____

Do you have a Pain Management Doctor? ❑ No ❑ Yes **Doctor's Name**: _____

MEDICAL HISTORY

❑ No significant medical history. Are you pregnant/possibly pregnant? ❑ No ❑ Yes Last Menstrual Period_____

❑ CANCER/type _____

CARDIOVASCULAR:
- ❑ heart attack
- ❑ hypertension
- ❑ high cholesterol
- ❑ heart murmur
- ❑ mitral valve prolapse
- ❑ blood clot legs/lungs
- ❑ Raynaud's

DERMATOLOGIC:_____

HEMATOLOGIC:
- ❑ anemia
- ❑ bleeding disorder

GASTROENTEROLOGIC:
- ❑ GERD
- ❑ diverticulitis
- ❑ hernia _____
- ❑ IBS

Genitourinary:
- ❑ kidney stones
- ❑ renal failure
- ❑ UTI

HEENT:_____
- ❑ cataracts
- ❑ deafness
- ❑ deviated septum

Immunologic:_____
- ❑ lupus
- ❑ HIV
- ❑ hepatitis
- ❑ TB
- ❑ STD

Metabolic/ ENDOCRINOLOGIC:
- ❑ diabetes
- ❑ thyroid disease

Musculoskeletal:
- ❑ osteoporosis
- ❑ osteopenia
- ❑ carpal tunnel
- ❑ fibromyalgia
- ❑ fracture

Neurologic:_____
- ❑ migraines
- ❑ Alzheimer's
- ❑ TIA
- ❑ seizures
- ❑ anxiety
- ❑ depression
- ❑ PTSD

Respiratory:
- ❑ asthma
- ❑ bronchitis
- ❑ emphysema
- ❑ pneumonia
- ❑ sleep apnea
- ❑ lung disease

REPRODUCTIVE:
- ❑ endometriosis
- ❑ ovarian cysts

OTHER:
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____
- ❑

(Continued on next page)

Name:_____

GENERAL SURGICAL HISTORY

❑ No significant surgical history.

Please choose all additional surgeries you have had and date of procedure.

❑ angioplasty/Stent _____
❑ AAA _____
❑ pacemaker _____
❑ CABG _____
❑ valve replacement _____
❑ removal of appendix _____
❑ removal of gallbladder _____
❑ hernia repair _____
❑ colon resection _____
❑ gastric band/bypass _____
❑ kidney, bladder_____
❑ lithotripsy_____
❑ eyes _____
❑ ears_____
❑ nose _____
❑ throat _____
❑ thyroid _____
❑ hips, knees, legs, feet _____
❑ shoulders, arms, hands_____
❑ cardiac _____
❑ Joint replacement_____
❑ fracture repair _____
❑ biopsy/excision _____
❑ brain _____
❑ lung _____
❑ C-section, tubal ligation _____
❑ hysterectomy, D&C_____
❑ prostate/ TURP _____
❑ Other: _____
❑ Other: _____

SPINE SURGERY / PAIN MANAGEMENT PROCEDURES

❑ I never had a pain management procedure. ❑ I have had: (indicate date)_____

❑ Epidural Steroid Injections _____ ❑ Medial Branch Blocks _____ ❑ Facet Blocks _____
❑ SI Joint Injections _____ ❑ Trigger Point Injections _____ ❑ Radiofrequency Ablation _____

❑ I never had spine surgery. ❑ Yes, I had spine surgery. Date: _____Please indicate type below.

❑ CERVICAL (NECK) ❑ THORACIC (MID BACK) ❑ LUMBAR (LOW BACK)

❑ Discectomy _____ ❑ Laminectomy _____ ❑ Fusion _____ ❑ Spinal Cord Stimulator

❑ Kyphoplasty _____ ❑ Disc Replacement_____ ❑ Other:_____

Did your condition improve after your surgery? _____

SOCIAL HISTORY

TOBACCO USE:

Have you ever used tobacco ❑ No ❑ Never ❑ Yes Cigarettes smoked daily _____ cigarettes/packs_____

How many years? _____. Age started? _____. Age quit?_____ Cigars ❑ Pipe ❑

Non-smoking chewing tobacco ❑ Smokeless ❑ Snuff ❑ Age started____ Age quit? _____

Marital status ❑Single ❑Married ❑Divorced ❑Widowed Number of Children: _____

I live: ❑alone ❑with family ❑housemate ❑aide I live in: ❑House ❑Apartment ❑Assisted living ❑ Nursing facility

Do you drink any alcoholic beverages? ❑ No ❑ Yes Type: _____ ❑ former ❑ year quit
If yes, frequency: ❑daily ❑socially ❑occasionally ❑rarely

Have you ever had a problem with illicit drug use? ❑ No ❑ Yes ❑ former
Addiction treatment? ❑ No ❑ Yes _____

(Continued on next page)

Name:

FAMILY HISTORY

NO RELEVANT FAMILY HISTORY: _____ ADOPTED (UNKNOWN) _____

Family Spinal History: (Please indicate which family member)

- ❑ Degenerative Disc _____
- ❑ Herniated Disc _____
- ❑ Arthritis _____
- ❑ Osteoporosis _____
- ❑ Scoliosis _____
- ❑ Spondylolisthesis _____
- ❑ Stenosis _____
- ❑ Cancer/type _____

PREVIOUS DIAGNOSTIC STUDIES

Please indicate whether you have had any of the following studies and write when/where the most recent was:

	No	Yes	When /Where		No	Yes	When /Where
Regular X-ray of Spine	❑	❑	_____	Myelogram	❑	❑	_____
CT Scan of spine	❑	❑	_____	Discogram	❑	❑	_____
EMG	❑	❑	_____	MRI of spine	❑	❑	_____
Bone Scan	❑	❑	_____	Bone Density/DEXA	❑	❑	_____

REVIEW OF SYSTEMS

Please check off any problems you have had in the last two months

GENERAL
- ❑ Unexplained weight loss
- ❑ Appetite change
- ❑ Fevers or chills
- ❑ Night sweats
- ❑ Marked fatigue
- ❑ Difficulty sleeping

EYES, EARS, NOSE, THROAT
- ❑ Difficulty swallowing
- ❑ Hoarseness
- ❑ Hearing loss
- ❑ Vision change

CARDIOVASCULAR
- ❑ Chest pain
- ❑ Edema

RESPIRATORY
- ❑ Cough/productive cough
- ❑ Shortness of breath

DIGESTIVE
- ❑ Nausea or vomiting
- ❑ Abdominal pain
- ❑ Frequent diarrhea
- ❑ Frequent constipation
- ❑ Uncontrolled loss of stool
- ❑ Blood in stool

SKIN
- ❑ Frequent rashes
- ❑ Frequent itchiness

NEUROLOGICAL
- ❑ Seizures
- ❑ Blackouts/fainting
- ❑ Vertigo
- ❑ Headaches/migraines

MUSCULOSKELETAL
- ❑ Joint pains/swelling
- ❑ Muscle Aches

GENITOURINARY
- ❑ Burning on urination
- ❑ Blood in urine
- ❑ Urinary incontinence
- ❑ Frequent urination
- ❑ Urinary urgency

(Continued on next page)

HEMATOLOGIC
- ❑ Easy bruising
- ❑ Easy bleeding

METABOLIC
- ❑ Cold or Heat Intolerance
- ❑ Increased thirst

IMMUNOLOGIC
- ❑ Hay Fever
- ❑ Environmental Allergies
- ❑ Food Allergies_____
- ❑ Bee Stings, etc._____

HAND DOMINANCE
- ❑ Right-handed
- ❑ Left-handed
- ❑ Ambidextrous

CORRECTIVE LENSES
- ❑ Glasses
- ❑ Contacts

Name: _____

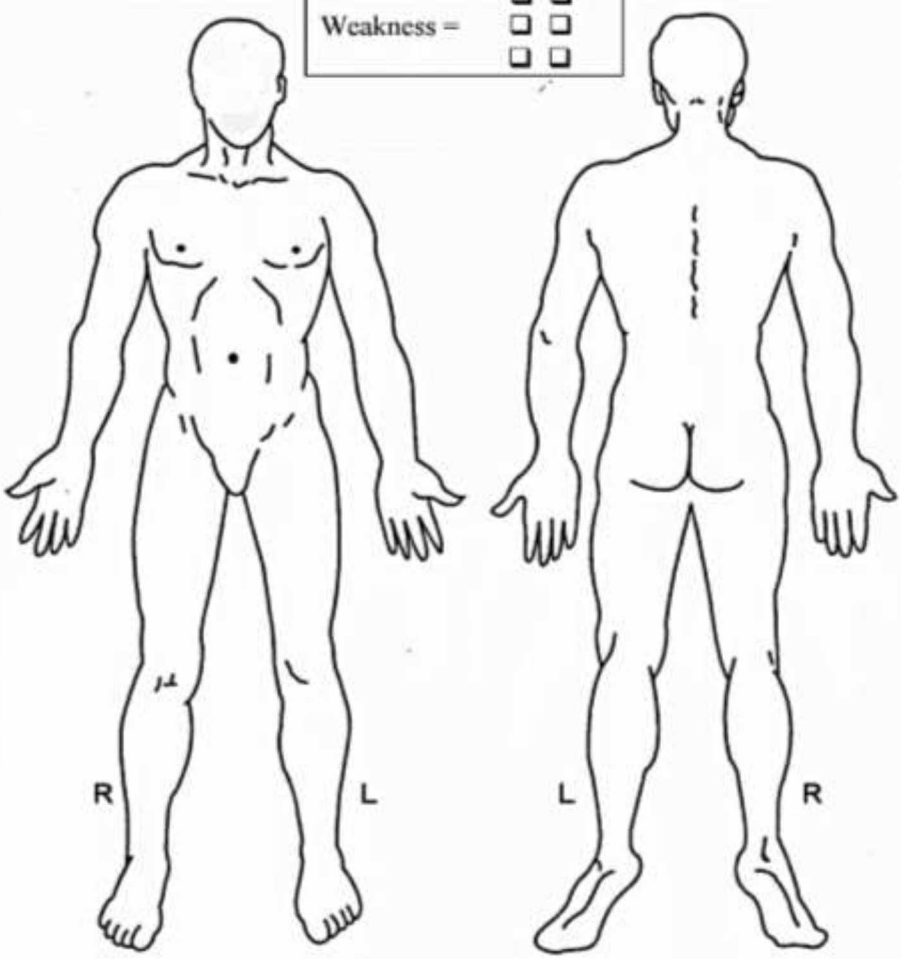
PAIN CHART

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol from the list below.

Please include all affected areas.

Numbness =	= = = = = = = = =	Pin & Needles =	o o o o o o o o o	Burning Aching =	x x x x x x x x x	Stabbing =	//// //// ////

Weakness = ❑ ❑ ❑ ❑ ❑ ❑



CURRENT PAIN PROFILE

9.) **How long can you sit?** ❑Unable to tolerate ❑ 15 minutes ❑ 30 minutes ❑ 45 minutes ❑ over one hour

How long can you stand? ❑Unable to tolerate ❑ 15 minutes ❑ 30 minutes ❑ 45 minutes ❑ over one hour

How long can you walk? ❑Unable to tolerate ❑ 15 minutes ❑ 30 minutes ❑ 45 minutes ❑ over one hour

(Continued on next page)

Name: _____

10.) Which of the following activities change the nature of your pain?

	Aggravates Pain	Relieves Pain	Neither
Sitting	❑	❑	❑
Standing	❑	❑	❑
Walking	❑	❑	❑
Leaning forward (brushing teeth)	❑	❑	❑
Bending forward	❑	❑	❑
Lying in your side	❑	❑	❑
Lying on your back	❑	❑	❑
Lying on your stomach	❑	❑	❑
Rising from sitting	❑	❑	❑
Changing positions	❑	❑	❑
Coughing / Sneezing	❑	❑	❑
Driving	❑	❑	❑

11.) Do you require assistance for ambulation? ❑ No ❑ Yes **If yes**, ❑cane ❑walker ❑wheelchair

THERAPIES

Please check all that apply:

	Comments	Helpful	No Help	Not Used
Pain Medications	_____	❑	❑	❑
Hot Packs	_____	❑	❑	❑
Ice applications	_____	❑	❑	❑
Ultrasound	_____	❑	❑	❑
TENS Unit/muscle stimulation	_____	❑	❑	❑
Physical therapy	_____	❑	❑	❑
Back / Neck exercises	_____	❑	❑	❑
Chiropractic treatment	_____	❑	❑	❑
Acupuncture	_____	❑	❑	❑
Traction/VAX-D	_____	❑	❑	❑
Other -	_____	❑	❑	❑

Name: _____ Date: _____

OPIOID RISK TOOL

Please select your gender: ☐ Female ☐ Male

Check Each Box That Applies: Patient Signature: _____

Family history of substance abuse:

- Alcohol ☐
- Illegal Drugs ☐
- Prescription Drugs ☐
- None ☐

Personal history of substance abuse:

- Alcohol ☐
- Illegal Drugs ☐
- Prescription ☐
- None ☐
- Age (check box if 16 - 45) ☐
- N/A ☐

- History of preadolescent sexual abuse ☐
- N/A ☐

Psychological Disease:

- ADD, OCD, bipolar, schizophrenia ☐
- Depression ☐
- None ☐

Questionnaire developed by Lynn R. Webster, M.D. to assess risk of opioid addition. Webster LR, Webster RM. Predicting aberrant behaviors in opioid-treated patients: preliminary validation of the Opioid risk tool. Pain Medicine 2005; 6 (6); 432-42

105ETSCLR0005001-01930-05

UnitedHealthcare® Designation of Authorized Representative

Member Name (*please print*)	Date of Birth	Member ID number	
Member's Street Address	City	State	Phone
Name of Individual/Company/Law Firm being designated as the authorized representative			
Designated Representative's Address	City	State	Phone
Provider of Service			
Date(s) of Service or Proposed Service			

I, _____, do hereby name
Print the name of the member who is receiving the service or supply

_____
Print the name of the person who is being authorized to act on the member's behalf
to act as my authorized representative in requesting (*check all that apply*)
a complaint an appeal documents
from UnitedHealthcare regarding the above-noted service or proposed service.

I understand and agree that:

- This authorization is voluntary;
- my health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information:
- I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form;
- my health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulation;
- this authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying UnitedHealthcare in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

Signature of Member	Date
If person signing this authorization is not the member, describe relationship to the Member(i.e. Parent, Legal Representative)	

Legal Representatives signing this authorization on behalf of a member must furnish a copy of a health care power of attorney, or other relevant document that grants the applicable legal authority