North Shore Pain Management

NSPM Beverly
900 Cummings Center, Suite 221U
Beverly, MA, 01915
Tel: (978) 927-7246

NSPM Woburn
800 West Cummings Park, Suite 1200
Woburn, MA, 01801
Tel: (781) 927-7246

New Patient Registration Packet

This New Patient Registration Packet contains:

1. Registration form
2. New patient questionnaire
3. Financial policy/HIPAA policy
4. Directions

Please complete the enclosed forms as accurately as possible and bring them with you to your appointment. To prevent any unnecessary delays please also bring with you:

- Medical records from other specialists (orthopedic surgeons, neurologists, pain specialists)
- MRI, CT scans and X--rays associated with your pain
- Prescription bottles for pain medicines you have been taking
- Insurance card(s)
- Insurance co--pay ($10 charge if not paid at time of visit)

At North Shore Pain Management your time is important to us. We greatly appreciate your arriving on time and will always do our best to stay on schedule so that you don't have to wait for your appointment. ***Please give 24 hour notice to cancel or reschedule your appointment. There is a $40.00 charge for all no show or canceled appointments without 24 hour notice.***

Thank you for choosing North Shore Pain Management.

Sincerely,
North Shore Pain Management

PATIENT REGISTRATION

Patient Name: _____
Address: _____
City: _____
State: _____
Zip: _____
Tel (home): _____
Tel (work): _____
Tel (cell): _____
E-mail: _____
Pharmacy: _____
Pharmacy Location: _____
Pharmacy Phone: _____
Date of Birth: _____
Age: _____
Sex: ○ Male ○ Female
SSN: _____
Marital Status: Marital status: ○ Single ○ Married ○ Domestic Partnership ○ Separated ○ Divorced ○ Widowed
Employer: _____
Employer Address: _____

Employer City: _____
Employer State: _____
Employer Zip: _____
Occupation: _____
Emergency Contact: _____
Relationship: _____
Tel (home): _____
Tel (work): _____
Tel (cell): _____

Referred By:_____ Phone Number: _____
Address:_____
Primary Care Physician: _____ Phone Number: _____
Address:_____

PRIMARY Insurance:

Insurance Carrier: _____ Subscriber:_____
Subscriber Relationship: _____
Certificate Number: _____ Group Number:_____ Co-Pay: _____
Please fill in the following information if the subscriber is NOT the patient:
Subscriber DOB: _____ Subscriber SSN: _____

SECONDARY Insurance:

Insurance Carrier: _____ **Subscriber:**_____
Subscriber Relationship: _____
Certificate Number: _____ Group Number:_____ Co-Pay: _____
Please fill in the following information if the subscriber is NOT the patient:
Subscriber DOB: _____ Subscriber SSN: _____

WORKMAN'S COMPENSATION:

Is this a work related injury? ○ Yes ○ No

MOTOR VEHICLE ACCIDENT:

Is this a motor vehicle accident? ○ Yes ○ No

CHARGES CANNOT BE BILLED TO YOUR HEALTH INSURANCE CARRIER.

IF WORKER'S COMPENSATION OR MVA INFORMATION IS NOT PROVIDED, YOU WILL BE RESPONSIBLE FOR ANY CHARGES INCURRED.

Signature of Patient or Authorized Individual: I authorize release of medical or other information necessary to process all Government, commercial and workers compensation insurance claims. I authorize the payment of medical benefits to the attending physician or supplier for services rendered. I understand that I am financially responsible for all charges not paid by my insurance and/or workers compensation carrier.

Name: _____ Age: _____ Date: _____
Referring MD: _____ PCP: _____

_____
Signature

New Patient Questionnaire

1. Where is your pain located (please describe based on diagram to the right; side, area of body)?

_____

2. When did your pain start (specific date if possible)? How long have you had the pain?

_____

3. How did your pain start (injury, at work, randomly started?)

_____

4. Explain what you believe is the cause of your pain? Please try to be specific (i.e. slipped disc, arthritis, etc).

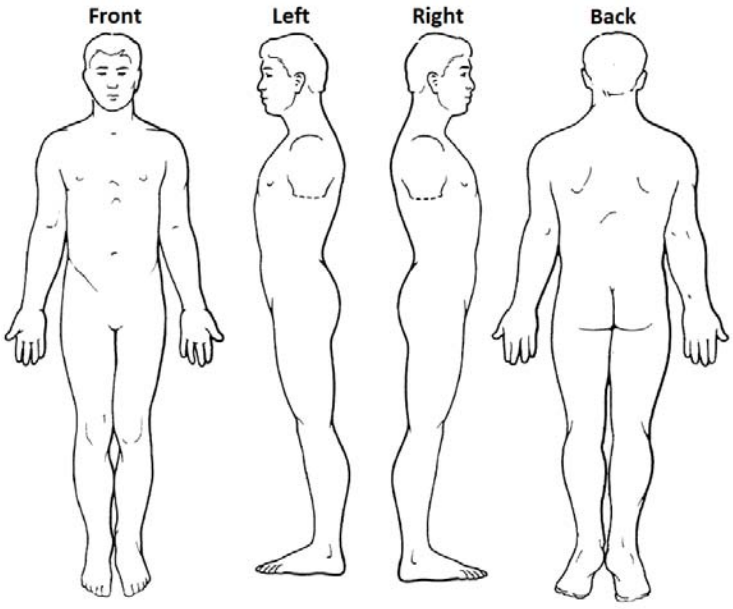
_____

5. How has your pain affected your life?

_____

6. If your pain were 50% less tomorrow, what would you be doing differently?

_____



Pain Score

7. Please indicate the number that best describes your baseline or constant level of pain over the past few days

○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

No Pain Worst Possible Pain

8. Please rate your worst pain

○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

No Pain Worst Possible Pain

9. On average over the past few days how many times did your worst pain occur?

○1-2 ○3-4 ○5-6 ○7-8 ○More than 8

10. Please indicate the number that represents the baseline level of pain you would like to achieve through treatment

○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10

No Pain Worst Possible Pain

11. Describe your present pain (i.e. aching, throbbing, sharp, hot, cold, etc.)?

☐ Throbbing	☐ Burning	☐ Numb	☐ Deep
☐ Shooting	☐ Sharp	☐ Tender	☐ Aching
☐ Stabbing	☐ Tingling	☐ Pressure	☐ Cramping
☐ Heaviness	☐ Hot	☐ Cold	☐ Other: _____

12. Describe the timing of your pain:

☐ Constant (Always there)
☐ Intermittent (Comes and goes)
☐ Gets worse as the day goes on

13. What do you do to ease or relieve your pain?

☐ Bed Rest	☐ Chiropractor	☐ Massage Therapy	☐ Physical Therapy
☐ Heat/Cold Therapy	☐ Counseling	☐ Biofeedback	☐ Relaxation Therapy
☐ Medication	☐ Exercise Program	☐ Acupuncture	☐ Trigger Point Injections

14. What makes your pain worse?

☐ Coughing/Sneezing	☐ Walking	☐ Exercise	☐ Stair Climbing
☐ Lifting	☐ Hot/Cold Water	☐ Sitting	☐ Standing
☐ Lying Down	☐ Bowel Movement	☐ Damp/Dry Weather	☐ Other: _____

16. What treatment do you think will help to improve your pain problem?

_____

17. What percentage improvement do you expect our program to make in your pain? _____

18. Current or former occupation: _____

Working now? ○ Yes ○ No
If no, last day you worked? _____
Are you receiving any kind of disability? _____
If so, what kind? _____

19. Please describe your activities in an average day.

_____

20. List the activities you can no longer do because of your pain problem:

_____

21. List any diagnostic tests (i.e. MRI, X-RAY, EMG, CT Scan, etc.) you have had related to your pain problem including dates and results: Where

Date	Exam	Performed	Results
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

22. Are you involved in a legal action related to your pain problem? ○ Yes ○ No

23. Any other legal problems? _____

24. Have you seen another pain doctor for your problem in the past 5 years? ○ Yes ○ No

If Yes, please list the pain doctors' names: _____

25. If you have seen a pain management doctor, have you ever had any of the following treatments for your pain problem and what was the result? Please check the appropriate box and give comments.

	Treatment Type	Improved	No Change	Worse	When?
○ Yes ○ No	Pain Management Doctor Office Visit	_____	_____	_____	_____
○ Yes ○ No	Trigger Point Injections	_____	_____	_____	_____
○ Yes ○ No	Epidural Steroid Injections	_____	_____	_____	_____
○ Yes ○ No	Facet Joint or MBB Injections	_____	_____	_____	_____
○ Yes ○ No	Radiofrequency Ablation	_____	_____	_____	_____
○ Yes ○ No	SI Joint Injections	_____	_____	_____	_____
○ Yes ○ No	Botox Injection	_____	_____	_____	_____
○ Yes ○ No	Spinal Cord Stimulation	_____	_____	_____	_____
○ Yes ○ No	Any other injections or procedures	_____	_____	_____	_____

26. Have you ever had any of the following treatments for your pain problem and what was the result? Please check the appropriate box and give comments.

	Treatment Type	Improved	No Change	Worse	How Long?	Last Visit When?
○ Yes ○ No	Physical therapy	_____	_____	_____	_____	_____
○ Yes ○ No	Occupational Therapy	_____	_____	_____	_____	_____
○ Yes ○ No	Aquatic/Pool therapy	_____	_____	_____	_____	_____
○ Yes ○ No	Passive (heat, ice, gentle massage, ultrasound)	_____	_____	_____	_____	_____
○ Yes ○ No	Mobilizations	_____	_____	_____	_____	_____
○ Yes ○ No	Traction	_____	_____	_____	_____	_____
○ Yes ○ No	Exercises/aerobic conditioning	_____	_____	_____	_____	_____
○ Yes ○ No	TENS	_____	_____	_____	_____	_____
○ Yes ○ No	Orthotics (i.e. corrective foot inserts)	_____	_____	_____	_____	_____
○ Yes ○ No	Prosthetics (braces, supports, etc)	_____	_____	_____	_____	_____
○ Yes ○ No	Chiropractic	_____	_____	_____	_____	_____
○ Yes ○ No	Deep tissue Massage	_____	_____	_____	_____	_____
○ Yes ○ No	Psychological counseling	_____	_____	_____	_____	_____
○ Yes ○ No	Alcohol/Drug Detoxification	_____	_____	_____	_____	_____
○ Yes ○ No	Extended Bed Rest	_____	_____	_____	_____	_____
○ Yes ○ No	Biofeedback or relaxation therapy	_____	_____	_____	_____	_____
○ Yes ○ No	Radiation treatment	_____	_____	_____	_____	_____
○ Yes ○ No	Acupuncture / Acupressure	_____	_____	_____	_____	_____
○ Yes ○ No	Pilates, Tai Chi, Home Exercise	_____	_____	_____	_____	_____
○ Yes ○ No	Other (Please describe)	_____	_____	_____	_____	_____

Medications - List all you are currently taking and dosages (prescriptions, over the counter, herbal):

	Medication	Dose	Frequency	Date Started	Prescribing Doctor
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____
7.	_____	_____	_____	_____	_____
8.	_____	_____	_____	_____	_____
9.	_____	_____	_____	_____	_____
10.	_____	_____	_____	_____	_____
11.	_____	_____	_____	_____	_____
12.	_____	_____	_____	_____	_____
13.	_____	_____	_____	_____	_____

Allergies – Have you ever had and allergic reaction to any medication?
(an allergy means a rash, swelling, difficulty in breathing. It does NOT mean causing a stomach upset or dizziness)

○ Yes ○ No

If YES please list them: _____

Past Medications (Medications you have previously tried for pain) Please check appropriate box

Tried /Used	Name of Medication	Still Taking	If Stopped, Why? Side Effects	Not Effective
	Pain Killers			
○ Yes ○ No	Codeine, Tylenol #3, #4	☐	☐	☐
○ Yes ○ No	Fentanyl patches (Duragesic)	☐	☐	☐
○ Yes ○ No	Hydrocodone (Vicodin, Lortab, Norco)	☐	☐	☐
○ Yes ○ No	Hydromorphone (Dilaudid)	☐	☐	☐
○ Yes ○ No	Methadone	☐	☐	☐
○ Yes ○ No	Morphine (MS Contin, Avinza, Kadian)	☐	☐	☐
○ Yes ○ No	Meperidine (Demerol)	☐	☐	☐
○ Yes ○ No	Oxycodone (Percocet, Oxycontin)	☐	☐	☐
○ Yes ○ No	Tapentadol (Nucynta)	☐	☐	☐
○ Yes ○ No	Buprenorphine (Butrans, Subutex, Suboxone)	☐	☐	☐
○ Yes ○ No	Other: _____	☐	☐	☐

Tried /Used	Name of Medication	Still Taking	If Stopped, Why? Side Effects	Not Effective
	Anti-Seizure Medicines/Neuropathic Medications			
○ Yes ○ No	Carbamazepine (Tegretol)	☐	☐	☐
○ Yes ○ No	Duloxetine (Cymbalta)	☐	☐	☐
○ Yes ○ No	Gabapentin (Neurontin)	☐	☐	☐
○ Yes ○ No	Lamotrigine (Lamictal)	☐	☐	☐
○ Yes ○ No	Oxycarbazepine (Trileptal)	☐	☐	☐
○ Yes ○ No	Pregabalin (Lyrica)	☐	☐	☐
○ Yes ○ No	Tiagabine (Gabatril)	☐	☐	☐
○ Yes ○ No	Topiramate (Topamax)	☐	☐	☐
○ Yes ○ No	Zonisamide (Zonegram)	☐	☐	☐
	Muscle Relaxants			
○ Yes ○ No	Baclofen	☐	☐	☐
○ Yes ○ No	Carisprodol (Soma)	☐	☐	☐
○ Yes ○ No	Cyclobenzaprine (Flexeril)	☐	☐	☐
○ Yes ○ No	Diazepam (Valium)	☐	☐	☐
○ Yes ○ No	Metaxolone (Skelaxin)	☐	☐	☐
○ Yes ○ No	Methocarbamol (Robaxin)	☐	☐	☐
○ Yes ○ No	Tizanidine (Zanaflex)	☐	☐	☐
	Anti-Depressants			
○ Yes ○ No	Amitriptyline (Elavil)	☐	☐	☐
○ Yes ○ No	Buproprion (Wellbutrin)	☐	☐	☐
○ Yes ○ No	Citalopram (Celexa)	☐	☐	☐
○ Yes ○ No	Desipramine	☐	☐	☐
○ Yes ○ No	Duloxetine (Cymbalta)	☐	☐	☐
○ Yes ○ No	Escitalopram (Lexapro)	☐	☐	☐

Tried /Used		Name of Medication	Still Taking	If Stopped, Why? Side Effects	Not Effective
		Anti-Depressants			
○ Yes	○ No	Fluoxetine (Prozac)	☐	☐	☐
○ Yes	○ No	Hyp. Perforatum (St. John's Wort)	☐	☐	☐
○ Yes	○ No	Lisdexamfetamine (Vyvanse)	☐	☐	☐
○ Yes	○ No	Lurasidone (Latuda)	☐	☐	☐
○ Yes	○ No	Mitrazepine (Remoron)	☐	☐	☐
○ Yes	○ No	Nefazadone (Serzone)	☐	☐	☐
○ Yes	○ No	Nortriptyline (Pamelor)	☐	☐	☐
○ Yes	○ No	Paroxetine (Paxil)	☐	☐	☐
○ Yes	○ No	Sertraline (Zoloft)	☐	☐	☐
○ Yes	○ No	Venlafaxine (Effexor)	☐	☐	☐
		Anti-Anxiety			
○ Yes	○ No	Alprazolam (Xanax)	☐	☐	☐
○ Yes	○ No	Chlordiazepoxide (Librium)	☐	☐	☐
○ Yes	○ No	Clonazepam (Klonopin)	☐	☐	☐
○ Yes	○ No	Diazepam (Valium)	☐	☐	☐
○ Yes	○ No	Lithium (Eskalith)	☐	☐	☐
○ Yes	○ No	Lorazepam (Ativan)	☐	☐	☐
○ Yes	○ No	Oxazepam (Serax)	☐	☐	☐
○ Yes	○ No	Phenelzine (Nardil)	☐	☐	☐
○ Yes	○ No	Resperidone (Risperdal)	☐	☐	☐
○ Yes	○ No	Other: _____	☐	☐	☐
		Sleep			
○ Yes	○ No	Eszopiclone (Lunesta)	☐	☐	☐
○ Yes	○ No	Temazepam (Restoril)	☐	☐	☐
○ Yes	○ No	Trazodone (Deseryl)	☐	☐	☐
○ Yes	○ No	Triazolam (Halcion)	☐	☐	☐
○ Yes	○ No	Zaleplon (Sonata)	☐	☐	☐
○ Yes	○ No	Zolpidem (Ambien)	☐	☐	☐
		Anti-inflammatories			
○ Yes	○ No	Celecoxib (Celebrex)	☐	☐	☐
○ Yes	○ No	Diclofenac	☐	☐	☐
○ Yes	○ No	Etodolac	☐	☐	☐
○ Yes	○ No	Fenoprofen (Nalfon)	☐	☐	☐
○ Yes	○ No	Ibuprofen (Motrin, Advil)	☐	☐	☐
○ Yes	○ No	Indomethacin	☐	☐	☐
○ Yes	○ No	Ketoprofen	☐	☐	☐
○ Yes	○ No	Meloxicam (Mobic)	☐	☐	☐
○ Yes	○ No	Naproxen (Aleve, Naprosyn)	☐	☐	☐
○ Yes	○ No	Nabumetone (Relafen)	☐	☐	☐
○ Yes	○ No	Piroxicam (Feldene)	☐	☐	☐
○ Yes	○ No	Salsalate (Mono-Gesic, Salflex, Disalcid)	☐	☐	☐
○ Yes	○ No	Sulindac (Clinoril)	☐	☐	☐
○ Yes	○ No	Other: _____	☐	☐	☐

Narcotic (opioid) medication (Vicodin, Percocet, morphine, fentanyl, methadone, etc)

Have you been given opioid (narcotic) medication for your pain? ○ Yes ○ No

If YES, have they improved your activity or general level of function? ○ Yes ○ No

If you answered NO to last question, how did the opioid (narcotic) affect your pain level (please choose one):

○ "just take the edge off" ○ somewhat helpful ○ quite a bit ○ very much

Are you taking your pain medications any differently than prescribed by your doctor (i.e. taking more than prescribed, changing the dosing frequency, not taking them, etc.) ○ Yes ○ No

If yes, why: _____

Are you having any problematic side effects? ○ Yes ○ No

If so, please describe: _____

Have you or your doctor ever felt that you had a problem with narcotics? ○ Yes ○ No

Past Medical History Have you had any of these conditions either now or in the past?

Please check YES or NO

Heart:

○ Yes ○ No High blood pressure
○ Yes ○ No High cholesterol
○ Yes ○ No Angina
○ Yes ○ No Heart attack
○ Yes ○ No Congestive cardiac failure
○ Yes ○ No Cardiac surgery
○ Yes ○ No Irregular heart beat

Nervous system:

○ Yes ○ No Seizures
○ Yes ○ No Stroke
○ Yes ○ No Paralysis
○ Yes ○ No Peripheral neuropathy

Musculoskeletal:

○ Yes ○ No Arthritis
○ Yes ○ No Neck/back problems
○ Yes ○ No Artificial joints (replacement)
○ Yes ○ No Other: _____

Blood Disorder:

○ Yes ○ No Anemia
○ Yes ○ No Bruising
○ Yes ○ No Bleeding Problems

Immune Disorder:

○ Yes ○ No HIV
○ Yes ○ No MRSA
○ Yes ○ No Other: _____

Lungs:

○ Yes ○ No Bronchitis
○ Yes ○ No Asthma
○ Yes ○ No Shortness of Breath

Liver / Kidneys:

○ Yes ○ No Hepatitis
○ Yes ○ No Liver problems
○ Yes ○ No Kidney problems
○ Yes ○ No Bladder problems

Metabolic / Digestive:

○ Yes ○ No Diabetes: Insulin or Non-Insulin Dependent?
○ Yes ○ No Thyroid disease
○ Yes ○ No Acid reflux
○ Yes ○ No Stomach ulcer
○ Yes ○ No **Cancer:** _____
○ Yes ○ No **Alcohol/Drug Dependency or Addiction**

List:

Psychological/Psychiatric:

○ Yes ○ No Depression/Anxiety
○ Yes ○ No Panic Disorder
○ Yes ○ No Post-Traumatic Stress Disorder
○ Yes ○ No **Other Medical Problems**

(Please Describe):

ER visits

In the past year have you been treated in the Emergency Room for your pain problem: ○ Yes ○ No

If yes, please check the number of times: ○ 1 ○ 2-3 ○ 4-6 ○ 7-10 ○ More than 10 times

Health care visits

In the past three months, how many times have you been to your regular health care provider or specialist for your pain problem (MD, NP, PA)? ○ Yes ○ No

Please circle the number of times:: ○ 1 ○ 2-3 ○ 4-6 ○ 7-10 ○ More than 10 times

In the past three months how many times have you seen an alternative health care provider for your pain problem (chiropractor, homeopath, naturopath, acupuncturist)? ○ Yes ○ No

Please circle the number of times:: ○ 1 ○ 2-3 ○ 4-6 ○ 7-10 ○ More than 10 times

Surgical History

Have you had any surgeries? ○ Yes ○ No

(If yes, please complete the information below)

Name and year of surgery (i.e. lumbar fusion, abdominal surgery)

	Name of Surgery	Year of Surgery
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Social History

Did you have a happy childhood?	○ Yes ○ No
Have you ever been sexually and or physically abused?	○ Yes ○ No
Have you ever seriously considered or attempted suicide?	○ Yes ○ No
Have you ever been psychiatrically hospitalized?	○ Yes ○ No
Have you ever participated in psychotherapy?	○ Yes ○ No
Are you currently participating in psychotherapy? If YES to the above, through which provider(s)? _____	○ Yes ○ No
Do you smoke?	○ Yes ○ No
If yes, how much per day?	_____
Do you drink alcohol?	○ Yes ○ No
If yes, how many drinks per day/week?	_____
If yes, do you drink to intoxication or binge drink?	○ Yes ○ No
If yes, do you drink to decrease your pain?	○ Yes ○ No
In the past 10 years have you ever tried street drugs?	○ Yes ○ No
Have you or anyone around you ever felt you had a problem with alcohol or drugs?	○ Yes ○ No
Have you ever received alcohol or drug treatment?	○ Yes ○ No
Have you felt you should cut down on your alcohol or drug use?	○ Yes ○ No
Have people annoyed you by criticizing your alcohol or drug use?	○ Yes ○ No
Have you ever felt bad or guilty about your alcohol or drug use?	○ Yes ○ No
Have you had a drink or used drugs first thing in the morning to steady your nerves or get rid of hangover? (eye opener)	○ Yes ○ No

Review of Systems

Do you have any of these symptoms? (Please check all that apply)

General:	**Gastrointestinal:**	**Neurologic:**
☐ Fever	☐ Anorexia	☐ Weakness
☐ Chills	☐ Nausea	☐ Seizures
☐ Sweats	☐ Vomiting	☐ Tremors

Patient Signature

☐ Night Sweats
☐ Anorexia
☐ Fatigue

Eyes:

☐ Pain
☐ Redness
☐ Blurred Vision
☐ Loss of Vision
☐ Photophobia

Ear/Nose/Throat:

☐ Ear Pain
☐ Ringing in Ears
☐ Hearing Loss
☐ Sore Throat
☐ Hoarseness

Cardiovascular:

☐ Chest Pain
☐ Palpitations
☐ Shortness of Breath: Exertion
☐ Shortness of Breath: Lying Flat
☐ Claudication, Syncope/Fainting

Respiratory:

☐ Cough
☐ Wheezing
☐ Excessive mucous
☐ Shortness of Breath: Exertion
☐ Shortness of Breath: Rest

☐ Diarrhea
☐ Constipation
☐ Change in Bowel Habits
☐ Abdominal Pain
☐ Bloody Stools
☐ Indigestion
☐ Weight Loss

Genitourinary:

☐ Painful Urination
☐ Blood in Urine
☐ Urinary Frequency
☐ Incontinence
☐ Decreased Sex Drive

Musculoskeletal:

☐ Joint Pain
☐ Joint Swelling
☐ Muscle Cramps
☐ Muscle Aches
☐ Muscle Weakness

Skin:

☐ Rash
☐ Itching
☐ Dry Skin

Hematologic:

☐ Bleeding
☐ Easy Bruising

☐ Vertigo
☐ Headaches
☐ Tingling
☐ Numbness
☐ Visual Disturbance
☐ Incontinence

Mental Health:

☐ Sleep Problems
☐ Mood Swings
☐ Depressed Mood
☐ Confusion
☐ Suicidal Thoughts
☐ Increased Irritability/Anger
☐ Anxiety/Panic Attacks
☐ Difficulty Concentrating
☐ Hallucinations

Endocrine:

☐ Heat Intolerance
☐ Cold Intolerance
☐ Excessive Thirst
☐ Excessive Urination
☐ Constipation
☐ Diarrhea
☐ Dry Skin
☐ Tremor
☐ Excessive Sweating
☐ Changing Menstrual Patterns

Family History (Indicate for biologically related family members if known)

Family Member	Age (or age at death)	Sex	Living?	Medical Problems
Grandparent #1	_____	○ M ○ F	○ Yes ○ No	_____
Grandparent #2	_____	○ M ○ F	○ Yes ○ No	_____
Grandparent #3	_____	○ M ○ F	○ Yes ○ No	_____
Grandparent #4	_____	○ M ○ F	○ Yes ○ No	_____
Father	_____	○ M ○ F	○ Yes ○ No	_____
Mother	_____	○ M ○ F	○ Yes ○ No	_____
Sibling #1	_____	○ M ○ F	○ Yes ○ No	_____
Sibling #2	_____	○ M ○ F	○ Yes ○ No	_____
Sibling #3	_____	○ M ○ F	○ Yes ○ No	_____
Children (Child #1)	_____	○ M ○ F	○ Yes ○ No	_____
Children (Child #2)	_____	○ M ○ F	○ Yes ○ No	_____
Children (Child #3)	_____	○ M ○ F	○ Yes ○ No	_____

Form Completed by: _____ Relationship to Patient: _____ Date: _____

_____

Signature

FINANCIAL POLICY:

North Shore Pain Management participates with most insurance plans including Workman's Compensation, with the exception of MassHealth/Medicaid. Motor Vehicle Accidents (MVA) and liens are not acceptable forms of insurance. You must have active health insurance coverage as well.

- **"SELF PAY" patients must pay cash for the initial visit, and any consecutive visits, in full at the time of the visit.**
- **CO-PAYS ARE DUE AT THE TIME OF SERVICE.**
- **FOR HMO's - A VALID REFERRAL MUST BE OBTAINED PRIOR TO YOUR VISIT. (Without a valid referral, your appointment may be cancelled and/or rescheduled until the appropriate referral is obtained. Payment for unauthorized services will be required at the time of service.)**
- **PAYMENT CAN BE IN THE FORM OF CASH, CREDIT CARD, CHECK OR MONEY ORDER.**
- **You are responsible for any charges incurred in the collection of your account, including, but not limited to legal fees, collection fees, interest or late charges.**

INSURANCE:
Insurance is a contract between you and your insurance company. We are not a party to this contract. We file insurance claims on behalf of our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, pre-existing conditions, etc. other than to supply factual information as necessary. **You are responsible for the timely payment of your account.**

WORKERS COMPENSATION:
We will submit claims on your behalf for open workers compensation claims only. It is your responsibility to provide the office staff with accurate workers compensation insurance information as well as your current claims adjuster's phone number. We will bill your private health insurance if your claim should be denied. Any balance not paid by the worker's compensation carrier or your private health insurance will be your responsibility.

RETURNED CHECKS:
A fee of $25 will be charged to your account for any/all returned checks(s). All future payments must be made by way of cash or credit card.

PAST DUE BALANCES:
To avoid interruption in your plan of care, all past due balances are expected to be paid in full prior to future treatment, unless you have established a mutually agreed upon payment plan.

PPO/HMO:
Each time you make an appointment with any physician, it is your responsibility to make sure your physician is currently under contract with your plan and to obtain the appropriate referral or authorization for your visit. **Verification of your insurance plan is required. Therefore, you must provide current insurance information and/or inform our office if there have been any changes to your insurance plan or benefits prior to your appointment date.**

CANCELLATION POLICY:
We require 24-hour notice for any appointment cancellations. **A fee of $40** will be charged to your account for no shows or cancellations of **office visits** without 24 hour notice. A fee of **$100** will be charged to your account for no shows or cancellations of **procedures** without 24 hour notice. Repeated cancellations or no shows for appointments could result in discharge from the practice.

Your signature below indicates that you have read and understand our **Financial Policy**. If you have any questions, or need any further information, please let us know.

DOB: _____ Date:_____ Print Name: _____

_____

Patient Signature

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. 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 related to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, 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 physician's practice 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, 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 our health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:
We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. We may call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: 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, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosure. 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 the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:
The 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 administration action or proceeding, and protected health information that are 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.

Your physician is not required to agree to a restriction that you may request. If physician 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 alternative i.e. electronically.

You may have the right to have your physician 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.

This notice was published and becomes effective on/or before **April 14, 2003.**

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 objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 978-927-7246.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

DOB: _____ Date:_____ Print Name: _____

_____

Signature