TRI COUNTY
PAIN MANAGEMENT CENTERS
215-486-1800
TRICOUNTYPMC.COM

New Patient Intake

Name:_____ Age:_____ Date of birth:_____ Date: _____
LAST FIRST MIDDLE

Address:_____ Social Security #:_____ ☐ Male ☐ Female

City, State, Zip:_____ Marital Status: ☐ M ☐ S ☐ W ☐ D # of Children_____

Home Phone (____)_____ Work Phone (_____)_____

Cell Phone (____)_____ Email address: _____

Employer:_____ Occupation: _____

In case of emergency, notify_____ Relationship:_____ Phone (_____) _____

PLEASE PROVIDE US WITH THE APPROPRIATE INSURANCE INFORMATION:

1) YOUR HEALTH INSURANCE COMPANY: _____

Address:_____ Insured:_____

Date of Birth:_____ Policy #: _____ SS#:_____

Telephone: (_____)_____ Fax: (_____) _____

2) YOUR HEALTH INSURANCE COMPANY: _____

Address: _____ Insured:_____

Date of Birth:_____ Policy #:_____ SS#:_____

Telephone: (_____)_____ Fax: (_____) _____

Current Symptoms: 1._____ 2._____ 3._____ 4._____

5. _____ 6. _____ 7. _____ 8. _____

When did your symptoms begin? _____

In general what makes your symptoms better? _____

In general what makes your symptoms worse? _____

In general how would you describe your pain? (ache, burn, dull, sharp, throbbing): _____

Are your symptoms local or do they travel to another area? (If they travel, to where?) _____

Are symptoms; ☐Constant >76% ☐Frequent 51-75% ☐Occasional 26-50% ☐Intermittent <25% of your waking hours

---

3) YOUR CURRENT PHARMACY: _____

Pharmacy Phone:_____ **Pharmacy Address:** _____

TRI COUNTY
PAIN MANAGEMENT CENTERS
215-486-1800
TRICOUNTYPMC.COM

Patient's Name:_____ Date: _____

Please list all medications and dosage:

1._____ 2._____ 3._____

4._____ 5. _____ 6. _____

List any allergies to medications, foods or other: _____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?:

Tuberculosis	☐ Yes	Lung Disease	☐ Yes	Gout	☐ Yes	Diabetes	☐ Yes
Kidney Disease	☐ Yes	Stomach/Ulcer	☐ Yes	Heart Disease	☐ Yes	Hepatitis	☐ Yes
Sciatica	☐ Yes	High Blood Pressure	☐ Yes	Transfusion	☐ Yes	Polio / MS	☐ Yes
Colon Disease	☐ Yes	Stroke	☐ Yes	Cancer	☐ Yes	Bleeding	☐ Yes
Paralysis	☐ Yes	Seizures	☐ Yes	Arthritis	☐ Yes	Asthma	☐ Yes
Anemia	☐ Yes	Thyroid Disease	☐ Yes	Drug Dependence	☐ Yes	AIDS	☐ Yes
COPD	☐ Yes	Migraine Headaches	☐ Yes	Neck Pain	☐ Yes	Back Pain	☐ Yes

Past Surgical History: Date:_____ Procedure:_____

Date:_____ Procedure:_____

Date:_____ Procedure:_____

Date:_____ Procedure:_____

Family History

Please list any conditions your parents or siblings may have:_____

_____

_____

CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE NOTICED RECENTLY:

☐ *Headache*	☐ Middle Back Pain	☐ Lower Back Pain	☐ *Ears Ring*
☐ Neck Pain	☐ Chest Pain	☐ Lower Back Stiffness	☐ *Buzzing in Ears*
☐ Neck Stiffness	☐ *Bruised Chest*	☐ *Radiating Pain*	☐ *Dizziness*
☐ *Sleep Disruption*	☐ *Bruising Anywhere*	☐ Tingling in Legs	☐ *Loss of Smell*
☐ *Depression*	☐ *Blurred Vision*	☐ Tingling in Arms	☐ *Loss of Taste*
☐ *Anxiety*	☐ *Sensitivity to Light*	☐ *Jaw Pain (TMJ)*	☐ *increased Thirst*
☐ *Fainting*	☐ Upper Arm Pain	☐ Upper Leg Pain	☐ *Difficulty Walking*
☐ *Muscle Spasms*	☐ Lower Arm Pain	☐ Lower Leg Pain	☐ *Shortness of Breath*
☐ *Suicidal Thoughts*	☐ Fatigue	☐ Bowel/Bladder Changes	☐ Weight Change

Current Work Status: ☐ Retired ☐Working ☐ Disability ☐ Other:_____

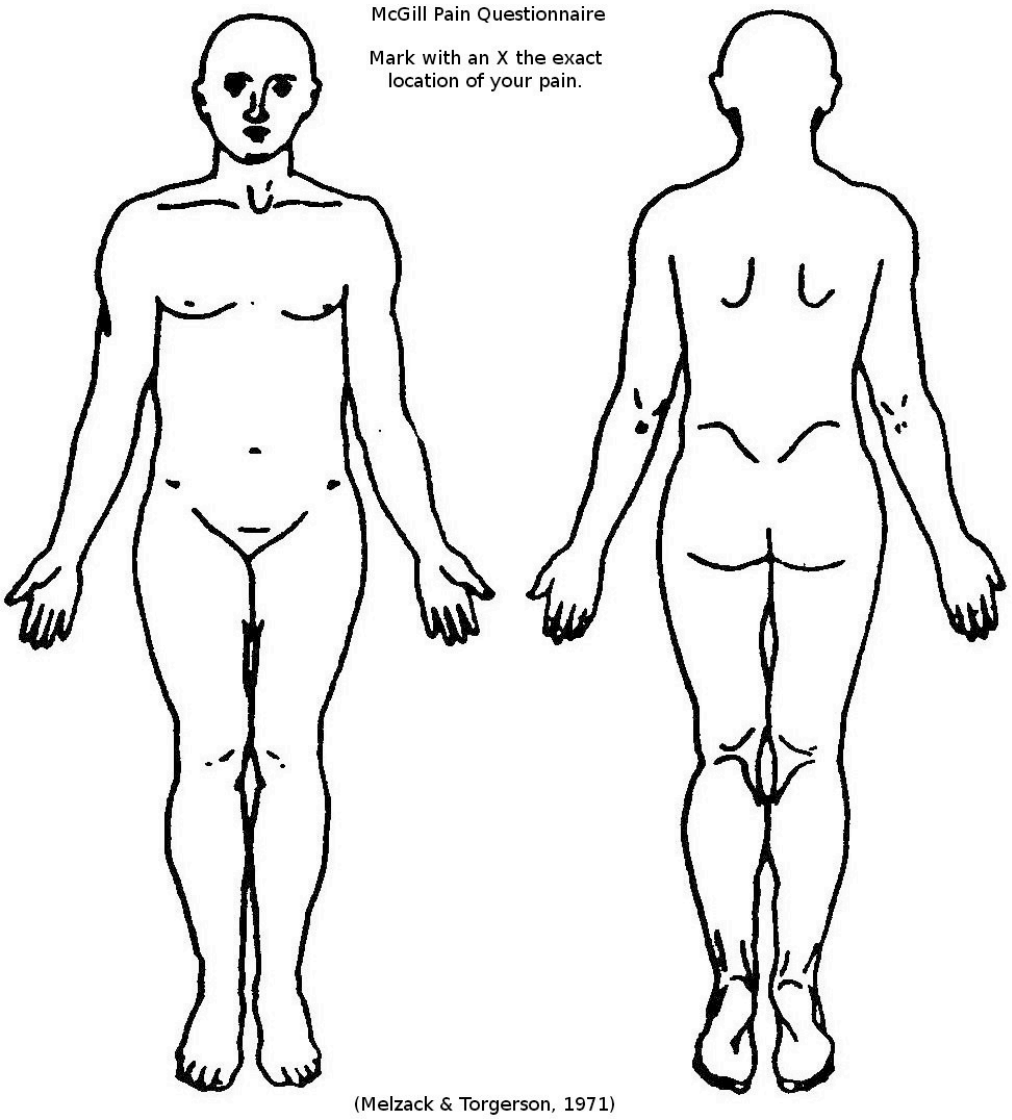
Do you smoke? ☐ Yes ☐ No;____pack(s) per day

Do you drink alcohol? ☐ Yes ☐ No;___drink(s) per day

Do you live in a: House___Apartment____; List other household members:_____

TRI COUNTY
PAIN MANAGEMENT CENTERS
PAIN CHART

Mark the diagram with an X over any area of pain.



Patient Signature:_____**Date**:___/____/_____

PATIENT RESPONSIBILITY FORM

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

- I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
- Co-payments are due at time of service.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to Tri County Pain Managment Centers on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize Tri County Pain Management Centers to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

4. MEDICARE REQUEST FOR PAYMENT

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in Tri County Pain Management Centers I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

_____ _____

Signature of Patient, Authorized Representative or Responsible Party Date

_____ _____

Print Name of Patient, Authorized Representative or Responsible Party Relationship to Patient

Tri County Pain Management Centers
CONSENT TO TREAT and ADMINISTRATIVE AUTHORIZATION

1. Authorization for Treatment and Diagnostic Procedures: I voluntarily authorize, request and consent to outpatient care services, including procedures, examinations, and medical treatment as ordered by my physicians, his/her assistants, or other health care provides. I understand that, except in emergency situations, this consent does not include surgical procedures or other procedures or treatment that may require separate consent. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made as to the results of any procedures, treatments or examinations.

2. Assignment of Insurance Benefits to Tri County Pain Management Centers: I authorize payment of health care benefits directly to Tri County Pain Management Centers. In making this assignment, I understand and agree that I may be financially responsible to Tri County Pain Management Centers for charges not paid under my insurance policy(ies). I permit a copy of this authorization to be used in place of the original. I authorize payment of authorized Medicare or other payor benefits to be made to me or on my behalf, to the physician or supplier for any services provided to me by the authorized physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I hereby certify that I have read and fully understand the above consent. I have sufficient opportunity to ask whatever questions I might have, and they have been answered to my satisfaction. I voluntarily and freely consent to the above and accept its term.

Signature:_____ Date: _____

Printed Name: _____

CONSENT TO TREAT A MINOR:

I hereby authorize the doctors of the Tri County Pain Management Centers, and/or whomever they may designate as assistants to administer treatment as deemed necessary to

_____

Signature of Parent or Legal Guardian: _____

Printed name:_____Date:_____Relationship:_____

Tri County Pain Management Centers
215-486-1800
www.TriCountyPMC.com

Notice of Privacy Practices Acknowledgement & Authorization

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of Tri County Pain Management Centers'* *Notice of Privacy Practices (NPP)*. I also understand that this practice has the right to change its *Notice of Privacy Practices* and that I may contact the practice at any time to obtain a current copy of the *Notice of Privacy Practices*.

_____ _____
Patient Name (print) Patient's Date of Birth

_____ _____
Patient Signature Date

If signed by a personal representative or legal guardian:

Name of Personal Representative: _____ _____
(Print) Date

Signature of Personal Representative: _____

Relationship to Patient: _____Driver's License Number: _____State____

Signing the *NPP Acknowledgement* does not mean that you have agreed to any special uses or disclosures (sharing) of your health records. Refusing to sign the acknowledgement does not prevent a provider or plan from using or disclosing health information as HIPAA permits. If you refuse to sign the acknowledgement, the provider must keep a record of this fact.

*All references to Tri County Pain Management Centers in this policy to include 3B Pain Management Center, PC; Precision Pain Management Center, PC; Neshaminy Valley Pain Management Center, PC; Greater Philadelphia Pain Management Center, PC; BEABB, Inc; West Philadelphia Pain Management Center, PC; Wilmington Physical Medicine and Rehabilitation; Monroeville-SCIC Inc; Steel City Injury Centers

OFFICE USE ONLY
We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Attempt 1 Date _____ Staff_____
- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency prevented us from obtaining acknowledgement
- ❑ Other (Specify:)_____

Attempt 2 Date _____ Staff _____
- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency prevented us from obtaining acknowledgement
- ❑ Other (Specify:)_____

Tri County Pain Management Centers
www.TriCountyPMC.com

PHI Use and Disclosure Authorization

If you wish to have your medical or billing information released to family members you must fill out the information and sign below. We have permission to (please check all that apply):

- ❑ Leave messages on home phone or with household members about appointments, and test results.
- ❑ Leave messages on work phone about appointments, and test results.
- ❑ Leave messages on cell phone about appointments, and test results.
- ❑ Email appointment reminders
- ❑ Confirm appointments by phone or text

This authorization is effective through (check one):

- ❑ ____ /____ /____

- ❑ **NO EXPIRATION** unless revoked or terminated by the patient or the patient's personal representative

I hereby authorize Tri County Pain Management Centers'* disclosure of my individually identifiable health information to the individuals listed below:

1. Name _____ Relationship to Patient _____

Authorization to:

- ❑ Disclose treatment plans and test results
- ❑ Billing information including statement balances
- ❑ Past and future Appointments
- ❑ Receive phone messages and/or email regarding appointments or test results
- ❑ Other _____

2. Name _____ Relationship to Patient _____

Authorization to:

- ❑ Disclose treatment plans and test results
- ❑ Billing information including statement balances
- ❑ Past and Future Appointments
- ❑ Receive Phone Messages or email regarding appointments or test results
- ❑ Other _____

I understand that I may revoke this authorization to disclose information at any time by notifying Tri County Pain Management Centers* in writing (*Termination of Disclosure Form* provided upon request). If I choose to do so, I am aware that my revocation will not affect any actions taken by Tri County Pain Management Centers* until the termination request is received in writing and processed.

Authorization to Disclose:

_____ _____
Patient Name (print) Patient's Date of Birth

_____ _____
Patient Signature Date

_____ _____
Signature of Personal Representative **Date**

Relationship to Patient: _____Driver's License Number: _____State____

All references to Tri County Pain Management Centers in this policy to include 3B Pain Management Center, PC; Precision Pain Management Center, PC; Neshaminy Valley Pain Management Center, PC; Greater Philadelphia Pain Management Center, PC; BEABB, Inc; West Philadelphia Pain Management Center, PC; Wilmington Physical Medicine and Rehabilitation; Monroeville-SCIC Inc; Steel City Injury Centers

COVID WAIVER

I acknowledge the contagious nature of the Coronavirus/COVID-19 and that the CDC and many other public health authorities still recommend practicing social distancing. I further acknowledge that Tri County Pain Management Centers has put in place preventative measures to reduce the spread of the Coronavirus/COVID-19.

I further acknowledge that Tri County Pain Management Centers cannot guarantee that I will not become infected with the Coronavirus/Covid-19. I understand that the risk of becoming exposed to and/or infected by the Coronavirus/COVID-19 may result from the actions, omissions, or negligence of myself and others, including, but not limited to, medical staff, and other medical patients and their families.

I voluntarily seek services provided by Tri County Pain Management Centers and acknowledge that I am increasing my risk to exposure to the Coronavirus/COVID-19. I acknowledge that I must comply with all set procedures to reduce the spread while attending my appointment.

I attest that:

* I am not experiencing any symptom of illness such as cough, shortness of breath or difficulty breathing, fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell. I will promptly inform the office should I experience any of these in the future.
* I have not traveled internationally within the last 14 days. I will promptly inform the office of any travel in the future.
* I have not traveled to a highly impacted area within the United States of America in the last 14 days. I will promptly inform the office of any travel in the future.
* I do not believe I have been exposed to someone with a suspected and/or confirmed case of the Coronavirus/COVID-19. I will promptly inform the office should I be exposed in the future.
* I have not been diagnosed with Coronavirus/Covid-19 and not yet cleared as non-contagious by state or local public health authorities. I will inform the office promptly should I be diagnosed with COVID- 19 in the future.
* I am following all CDC recommended guidelines as much as possible and limiting my exposure to the Coronavirus/COVID-19.

I hereby release and agree to hold Tri County Pain Management Centers harmless from, and waive on behalf of myself, my heirs, and any personal representatives any and all causes of action, claims, demands, damages, costs, expenses and compensation for damage or loss to myself and/or property that may be caused by any act, or failure to act of the Tri County Pain Management Centers, or that may otherwise arise in any way in connection with any services received from Tri County Pain Management Centers. I understand that this release discharges Tri County Pain Management Centers from any liability or claim that I, my heirs, or any personal representatives may have against them with respect to any bodily injury, illness, death, medical treatment, or property damage that may arise from, or in connection to, any services received from Tri County Pain Management Centers. This liability waiver and release extends to Tri County Pain Management Centers together with all owners, partners, and employees.

Signature _____ Date: ____/____/____