TRI COUNTY
PAIN MANAGEMENT CENTERS
215-486-1800
TriCountyPMC.com

New Patient Intake and Accident Questionnaire

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 AUTOMOBILE INSURANCE CARRIER: ____

Address:_____________________________________Telephone: (_____)_______________Insured:___________________

Claim #:_____________________________________Policy #: _______________________________________

Claim Representative: ____________________________

Telephone: (_______)____________________________Fax: (________) _____________________________

Med-Pay Benefits:____________Are you a full time Student? ☐ Yes ☐ No Do you reside with a relative? ☐ Yes ☐ No

Have you signed a selection waiver of benefits? ☐ Yes ☐ No ☐ Unsure

2) YOUR HEALTH INSURANCE COMPANY: ____

Address:_____________________________________Insured:____

Date of Birth:________________________________Policy #:____________________________SS#:____________________

Telephone: (_______)____________________________Fax: (________) _____________________________

3) ADVERSE OR THIRD PARTY AUTOMOBILE INSURANCE CARRIER: ____

Address:____________________________________Claims Rep: ____

Claim #:_____________________________________Policy #:___________________________Insured:__________________

Telephone: (_______)____________________________Fax: (________) _____________________________

4) ATTORNEY:____ Legal Assistant: ______________________________

Address:____

Telephone: (_______)____________________________Fax: (________) _____________________________

5) YOUR CURRENT PHARMACY: ____

Pharmacy Phone:_______________________________ **Pharmacy Address:** _________________________________

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Patient's Name:____**Date**: ____________________

Current Symptoms: 1.__________________2.__________________3.__________________4.__________________

5. __________________ 6. __________________ 7. __________________ 8. __________________

Date of Crash/Accident:________________________________Time:_____________o AM o PM

Specific Location of Crash/Accident: ____

Describe in detail, in your own words, how the crash/accident happened: _________________________________

____

____

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

Were there any symptoms which you had after the crash/accident that have now resolved? (please list)

____

AUTOMOBILE/MOTORCYCLE ONLY

In the crash/accident: Were you the ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other? ____________________________

Did your vehicle strike the other vehicle? ☐Yes ☐No Did the other vehicle strike your car? ☐Yes ☐No

Your vehicle: ☐ Car ☐ Pick-up Truck ☐ Van ☐ SUV **Other vehicle**: ☐ Car ☐ Pick-up Truck ☐ Van ☐ SUV

Were you struck from? ☐ Behind ☐ Front ☐ Driver Side ☐ Passenger Side **Motorcycle Only**: ☐Left Side ☐ Right

Were you rendered unconscious as result of accident? ☐ Yes ☐ No

Were you wearing a seatbelt? ☐ Yes ☐ No Did the airbags deploy? ☐ Yes ☐ No

Please list any recent x-rays, MRIs, lab or other tests: Date Facility/Doctor

____

____

Have you lost time from work? ☐ Yes ☐ No: If Yes, Dates:____________________to______________________

Where did you go after the crash/accident? ☐ Hospital ☐ Urgent Care ☐ Home ☐ Work ☐ Other ______________

Were you taken by ambulance? ☐Yes ☐ No **To which hospital?** _______________________________________

Have you done any of the following since the crash/accident?

☐ Ice ☐ Rest ☐ Medication (name) ____________________________________
☐ Heat (any kind) ☐ Exercise ☐ Other____

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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:_________________________________

Have you ever been involved in a previous Automobile or Work accidents? Please describe:

Date	**Injuries Sustained**
___/___/_____	____
___/___/_____	____
___/___/_____	____
___/___/_____	____

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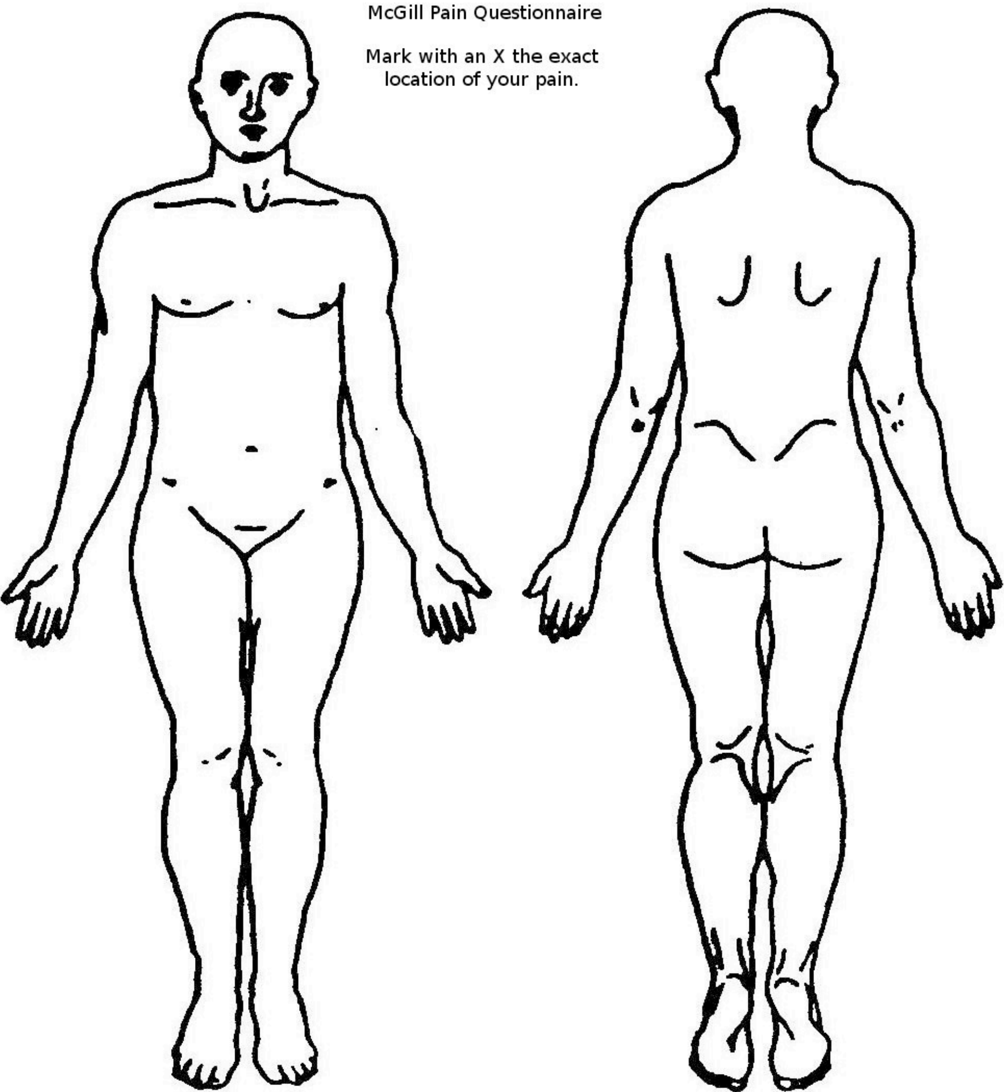
TRI COUNTY
PAIN MANAGEMENT CENTERS
Pain Chart

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



Patient Signature:____Date:____/____/_______

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TRI COUNTY
PAIN MANAGEMENT CENTERS

To our patients and their attorneys:

The doctors and staff at Tri County Pain Management Centers are dedicated to serving your medical needs related to your work and personal injuries. To help us with this endeavor we are asking that you sign this form. Your signature will help ensure that your outstanding balance with our Practice will be paid and appropriate medical treatment administered.

In the event that you make a claim for workers' compensation benefits or make a claim against a third party for personal injury compensation, your signature below will act as a guarantee that your outstanding balance with our Practice will be satisfied. By signing this form you agree to protect the interests of Tri County Pain Management Centers. Tri County Pain Management Centers will submit all your bills to the appropriate insurance company for payment. If for any reason the insurance company does not pay it will by your responsibility to submit your bills to your attorney.

Additionally, you agree and direct your attorney to submit the Practice's medical bills into evidence, pursuant to the applicable laws of any auto or workers' compensation proceeding or third party personal injury action.

By signing below, you also agree to pay any outstanding medical bills from any settlement or recovery you obtain in either your workers' compensation claim or your third party personal injury action. Payment will be made directly by your attorney to Tri County Pain Management Center upon distribution of the proceeds. Your signature below authorizes your attorney to distribute a payment, or direct distribution by another entity when applicable, to our Practice equal to your outstanding balance at the time of distribution.

I,____, agree and affirm that I, and my attorney, will protect the interests of Tri County Pain Management Center in any auto or workers' compensation proceeding or in any third party personal injury proceeding. My signature also authorizes and directs my attorney to submit payment equal to my outstanding balance with Tri County Pain Management Center at the time of distribution of my auto or workers' compensation settlement or recovery or my third party personal injury settlement or recovery. Regardless of the outcome of my case, I acknowledge that ultimately I am responsible for payment of services rendered.

____ ___________________________

Patient's Signature Date

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 Center: I authorize payment of health care benefits directly to Tri County Pain Management Center. In making this assignment, I understand and agree that I may be financially responsible to Tri County Pain Management Center 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:)_______________

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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):

- ❑ ____ /____ /____
- ❑ <u>**NO EXPIRATION**</u> 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____

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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: ______/______/______

TRI COUNTY
PAIN MANAGEMENT CENTERS 215-486-1800
TriCountyPMC.com

Acknowledgement of Physician's Financial Interest

Please read and complete the following form, which is part of the process for our medical practice to prescribe your medicines. Then sign at the bottom. If you have questions, contact 215-486-1800

I have been referred to Priority Care Rx, LLC, a licensed pharmacy, (the Pharmacy) by my physician, Scott Pello M.D. and/or Brad Ferrara, M.D., to fill the prescription(s) that my physician prescribed for me. I understand that my physician has a financial and/or ownership interest in the Pharmacy and that I am free to choose an alternate pharmacy to fill the prescription(s). This Acknowledgement of Physician's Financial Interest is provided to me in accordance with Pennsylvania Act 66 of 1988 and 49 Pa. Code section 25.291.

ENTER NAME:

Patient Name: ____

Name of Parent or Guardian, if Applicable: ____________________________

SIGN BELOW:

Signature of Patient or Parent/Guardian: ________________________________

Date of Signature: __________________________ (month, day, year, like 01/01/1999)

Prescribing Doctors: