

**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: _____

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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 <input type="radio"/> Yes	Lung Disease <input type="radio"/> Yes	Gout <input type="checkbox"/> Yes	Diabetes <input type="checkbox"/> Yes
Kidney Disease <input type="radio"/> Yes	Stomach/Ulcer <input type="radio"/> Yes	Heart Disease <input type="checkbox"/> Yes	Hepatitis <input type="checkbox"/> Yes
Sciatica <input type="radio"/> Yes	High Blood Pressure <input type="radio"/> Yes	Transfusion <input type="checkbox"/> Yes	Polio / MS <input type="checkbox"/> Yes
Colon Disease <input type="radio"/> Yes	Stroke <input type="radio"/> Yes	Cancer <input type="checkbox"/> Yes	Bleeding <input type="checkbox"/> Yes
Paralysis <input type="radio"/> Yes	Seizures <input type="radio"/> Yes	Arthritis <input type="checkbox"/> Yes	Asthma <input type="checkbox"/> Yes
Anemia <input type="radio"/> Yes	Thyroid Disease <input type="radio"/> Yes	Drug Dependence <input type="checkbox"/> Yes	AIDS <input type="checkbox"/> Yes
COPD <input type="radio"/> Yes	Migraine Headaches <input type="radio"/> Yes	Neck Pain <input type="checkbox"/> Yes	Back Pain <input type="checkbox"/> 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:

<input type="checkbox"/> Headache	<input type="checkbox"/> Middle Back Pain	<input type="checkbox"/> Lower Back Pain	<input type="checkbox"/> Ears Ring
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Lower Back Stiffness	<input type="checkbox"/> Buzzing in Ears
<input type="checkbox"/> Neck Stiffness	<input type="checkbox"/> Bruised Chest	<input type="checkbox"/> Radiating Pain	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Sleep Disruption	<input type="checkbox"/> Bruising Anywhere	<input type="checkbox"/> Tingling in Legs	<input type="checkbox"/> Loss of Smell
<input type="checkbox"/> Depression	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Tingling in Arms	<input type="checkbox"/> Loss of Taste
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Sensitivity to Light	<input type="checkbox"/> Jaw Pain (TMJ)	<input type="checkbox"/> increased Thirst
<input type="checkbox"/> Fainting	<input type="checkbox"/> Upper Arm Pain	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/> Difficulty Walking
<input type="checkbox"/> Muscle Spasms	<input type="checkbox"/> Lower Arm Pain	<input type="checkbox"/> Lower Leg Pain	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Suicidal Thoughts	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Bowel/Bladder Changes	<input type="checkbox"/> 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: House ___ Apartment ___; List other household members: _____

**Tri County
Pain Management Centers
WORK INJURY HISTORY**

Name _____ Date ___/___/___

Name of Employer at Time of Injury _____ Occupation _____

Type of Business _____ Length of Employment ___ _____

Date of Injury _____ Injured Area _____

Did you report your injury? Yes ___ No ___ Was an accident report filed? Yes ___ No ___

Type of work being done at time of injury: _____

In your own words, please describe accident _____

Did you have any time off because of this injury? No ___ Yes ___ If Yes when? _____

Are you currently working Yes No Are you: improved ___ unchanged ___ getting worse ___

Do you have an Attorney Yes No If Yes, whom? _____

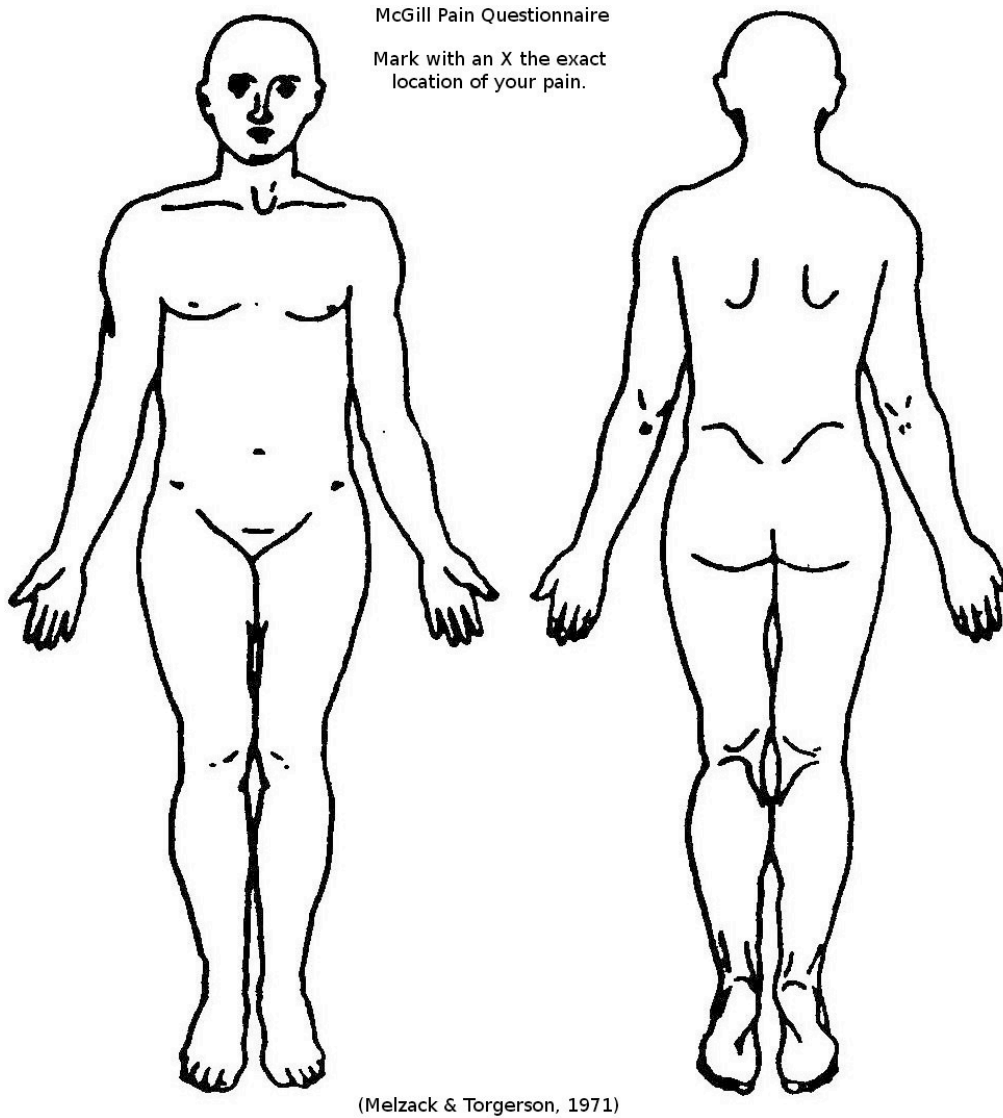
For this Injury: List previous Doctors and treatment

For this Injury: X-rays, MRIs or other imaging: _____

List any previous work or auto accidents and date:

TRI COUNTY PAIN MANAGEMENT CENTERS PAIN CHART

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



Patient Signature: _____ Date: ____ / ____ / ____

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 be 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 Centers 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 Centers 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 Centers 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: _____

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): _____

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** _____

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**TRI COUNTY PAIN MANAGEMENT CENTERS
3B PAIN MANAGEMENT
600 Louis Drive, Suite 202 Warminster, PA 18974
215-486-1800 FAX 877-884-6224**

BUREAU OF WORKERS COMPENSATION
NCP(NOTICE OF COMPENSATION PAYABLE) DEPARTMENT
1171 SOUTH CAMERON STREET
HARRISBURG, PA 17104-2501
Fax # 717-783-6365

RE: CLAIMANT-
SOCIAL SECURITY # -
DATE OF BIRTH –
CLAIM# =
DATE OF INJURY –

Dear Sir or Madam:

We are requesting Bureau form(s) that apply to the above cited worker:

LIBC-495 (NOTICE OF COMPENSATION PAYABLE)
LIBC-501(TEMPORARY NOTICE OF COMPENSATION PAYABLE)
LIBC-496(NOTICE OF COMPENSATION DENIAL) AND/OR
LIBC-336(AGREEMENT FOR COMPENSATION)

As instructed by your office, below please find the claimant's signed authorization enabling you to release this information to us.

Thank you for your anticipated cooperation in this matter.

Sincerely,

Sharon Kristoff

I, _____, hereby authorize the BWC to release the above applicable forms to Tri County Pain Management Center/3B Pain Management Center.

DATE

Claimant's Signature

Witness

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:


SCOTT PELLO M.D.


BRADLEY FERRARA M.D.