pain management
AT GARDEN STATE MEDICAL CENTER

Dharam Mann, MD, DABA, DABPM
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Q_ k gp H_ I g KB* KNF*

Specializing in Minimally-Invasive Interventional Pain Management

Welcome to our Practice

How did you hear about us? Please check all that apply.

- ☐ My Physician told me about you
- ☐ Friend, family or co-worker
- ☐ Drive-by/Saw Sign
- ☐ Community Newsletter
- ☐ Lecture/Luncheon
- ☐ Website or Internet
- ☐ Newspaper: _____
- ☐ Other: _____

PATEINT DEMOGRAPHIC INFORMATION

Patient's Name			Date of Birth	Today's Date	
Social Security Number	Gender ☐M ☐F	Weight	Marital Status ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widdow		
Street Address, Apt			Home Phone	Prefer. Phone ☐Home ☐Cell	Leave Message ☐Yes ☐No
City, State, Zip Code			Cell Phone		
Emergency Contact Name			Phone #	Relationship to Patient	
Referring Physician Name, Phone #			Primary Care Physician Name, Phone #		
Employment Status ☐Employed ☐Unemployed ☐Student ☐Retired ☐Military ☐Disability				Employer/School Name	
Race ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐White ☐Hispanic ☐Other Race ☐No Answer					
Ethnicity ☐Hispanic or Latino ☐Not Hispanic or Latino ☐No Answer			Spoken Language ☐English ☐Spanish ☐Other	Email Address	

PRIMARY INSURANCE INFORMATION

Insurance Company Name, Phone #	ID#	Group #
Claims Address, City, State, Zip		
Policy Holder's Name, Phone #	Address, City, State, Zip	

SECONDARY INSURANCE INFORMATION

Insurance Company Name, Phone #	ID#	Group #
Claims Address, City, State, Zip		
Policy Holder's Name, Phone #	Address, City, State, Zip	

PRESCRIPTION PLAN

Insurance Company Name, Phone #	ID#	Group #
Claims Address, City, State, Zip		

IS THIS A WORKMAN'S COMPENSATION OR MOTOR VEHICLE CLAIM? ☐ Yes ☐ No

Date of Accident	Adjustor Name	Company Name, Phone #	Claim #

Understanding Your Rights

ASSIGNMENT OF BENEFITS AND MY FINANCIAL RESPONSIBILITY

It is the policy of Garden State Medical Center to collect payment at the time of visit. If you have a policy with a company with which we have a contract, we will gladly file your claim for you. However, you are expected to pay any co-pay or deductible at the time of service. If we do not participate in your network, you are expected to pay at time of service, unless arrangements have been made with the financial advocate. I understand that I am responsible for any co-insurance fees/charges, if it is not covered by a secondary. I understand that my insurance company may send payments for the rendered services to me. I hereby assign to Garden State Medical Center all surgical, medical Insurance and other benefits, if any, otherwise payable to me for the services. If I receive direct payments from my insurance company, I agree to hold such payment(s) in trust for Garden State Medical Center and agree to endorse over and send such payment(s) to Garden State Medical Center within one week after receipt. I hereby authorize and direct payment directly to Garden State Medical Center from the obligor of said benefits. Further, I hereby assign and convey Garden State Medical Center, unless charges for the services have been paid, so much of any cause of action or right of recovery and any payment proceeds relating thereto, that I may have against any third party and direct my attorney, if one has been retained as well as any person to insurance company obligated to pay damages or restitution to me, to deduct the amount of any outstanding bill for Garden State Medical Center any settlement proceeds or other proceeds to be paid directly to me prior to receiving said proceeds. I understand that payment is due when services are rendered unless prior arrangements have been made. I assign all medical and/or surgical benefits including major medical benefits for services provided to Garden State Medical Center. This assignment will remain in effect until revoked by me in writing. I am aware that any charges NOT COVERED by my insurance policy are my responsibility. I further agree that, should my account with Garden State Medical Center be turned over for collection purposes, I will pay an attorney and collection fee equal to 33 1/3% of the outstanding balance, plus court costs and other fees incurred.

IDENTIFICATION PHOTOGRAPH AUTHORIZATION

I [Initals] give permission for Garden State Medical Center to take an identification photograph to be maintained in my medical records. I understand that this picture will be used in a confidential manner related only to my personal care in the above named office.

PRIVACY PRACTICES

I have received a copy of Garden State Medical Center Privacy Practices. I have had the opportunity to have any questions answered regarding the privacy practices of the doctor's office.

Patient/Guardian Signature	Date

Legal Assignment of Benefits & Designation of Authorized Representative

I, _____, represent that I have valid and in-force insurance and/or employee health care benefits coverage, and hereby assign and convey directly to Dharam Mann, MD, DABA, DABPM and Garden State Medical Center (the "provider(s)"), as my Statutory Derivative Beneficiary (SDB), commonly known as an Designated Authorized Representative, and a Claimant under the "Patient Protection and Affordable Care Act" (PPACA), existing ERISA and other applicable federal and state laws, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from the provider(s), regardless of the provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to the provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from the provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the provider(s), to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by the provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, to bring suit by the provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Patient/Guardian Signature	Date
Printed Name	

Understanding Your Rights

PAIN MANAGEMENT AGREEMENT

The purpose of this agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals. I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this agreement

I understand that if I break this agreement, my doctor will stop prescribing these pain control medicines. In this case, my doctor could taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. **This is at the discretion of the physician**. Also, a drug dependence treatment program may be recommended.

I have communicated, and I will continue to communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

I will inform my doctor at Garden State Medical Center of all the medications I am presently taking, including all remaining refills, and I will not attempt to obtain any controlled medicines, including opioid pain medications, controlled stimulants, anti-anxiety and/or Suboxone medicine from any other doctor.

I authorize Garden State Medical Center and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this states' Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize Garden State Medical Center to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentially with respect to these authorizations.

- **I will not use any illegal controlled substances including: marijuana, cocaine, etc. I will not drink alcoholic beverages while taking narcotic medications. I will not share, sell or trade my medication with anyone. I will safeguard my pain medicine from loss or theft.**
- **Lost or stolen medicine will not be replaced, and I understand that Garden State Medical Center reserves the right to terminate my care if I fail to follow the protocol following such an incident.**
- **I Agree that I will submit to a blood, urine and/or oral swab test as well as random pill count, if requested by Garden State Medical Center, to determine my compliance with my treatment program. I understand that Garden State Medical Center reserves the right to terminate my care and treatment in this office if I fail to comply or refuse any type of screening.**
- **I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time or in termination of my medical care and treatment in this office.**
- **I will bring my pain medication to every office visit to be subject to a pill count.**
- **I agree that refills of my prescriptions for pain medicine will be made only at the time of a scheduled office visit. No refills will be made available during evenings or weekends.**

I AGREE TO ONLY USE THE FOLLOWING PHARMACY FOR FILLING PRESCRIPTIONS FOR ALL OF MY PAIN MEDICINE.

Pharmacy Name	Phone
Address, City, State, Zip	

I agree to follow these guidelines that have been fully explained to me, and I have received a copy of this agreement. All of my questions and concerns regarding treatment have been adequately answered. IF I FAIL TO COMPLY WITH ANY OF THE ABOVE, Garden State Medical Center RESERVES THE RIGHT TO TERMINATE MY MEDICAL CARE AND TREATMENT.

Patient/Guardian Signature	Date

Medical Release Form

PATIENT INFORMATION

Patient's Name	Today's Date
Social Security Number	Date of Birth

I grant my permission for Garden State Medical Center to speak with and/or release information regarding my medical treatment and/or condition to the following persons/medical offices:

Name	Phone #
Street Address, Apt	Relationship to Patient
City, State, Zip Code	

Name	Phone #
Street Address, Apt	Relationship to Patient
City, State, Zip Code	

Name	Phone #
Street Address, Apt	Relationship to Patient
City, State, Zip Code	

Name	Phone #
Street Address, Apt	Relationship to Patient
City, State, Zip Code	

Patient/Guardian Signature	Date

HIPAA AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

This form will allow us to obtain any necessary medical information necessary to diagnose and treat the listed patient.

PATIENT'S INFORMATION

Patient's Name	Date of Birth	Social Security Number
Street Address	City, State Zip	

INFORMATION TO BE RELEASED:
This authorization includes release of information concerning treatment of psychiatric/ psychological conditions, drug and/or alcohol related conditions, and HIV or AIDS related conditions.

- ☐ Discharge summary
- ☐ History & Physical
- ☐ Face sheet
- ☐ Emergency Department Record
- ☐ Operative reports
- ☐ Pathology reports
- ☐ Laboratory reports
- ☐ Immunization/shot records
- ☐ Outpatient records
- ☐ Itemized bill
- ☐ Neuropsychological reports
- ☐ Psychological reports
- ☐ X-ray/Medical Imaging Report
- ☐ Entire medical record
- ☐ Other:_____

THE ABOVE INFORMATION IS TO BE RELEASE TO:
Garden State Medical Center
1100 Route 70 West
Whiting, NJ 08759

FOR THE PURPOSE OF:

- ☐ Continued medical care
- ☐ Insurance claim processing
- ☐ Legal claim processing
- ☐ Other:_____
- ☐ External quality/ utilization review

Patient/Guardian Signature	Date
Patient Guardian/Authorized Representative	Relationship to Patient
Witness	

Authorization to Appeal & File Legal Action

PATIENT'S INFORMATION

Patient's Name	
Insurance Company	Policy #

I hereby authorize Garden State Medical Center and its representatives to appeal any adverse benefit determinations by my insurance company. This includes my authorize for Garden State Medical Center to exercise any of my rights under my plan or under the law including my right to file legal action against my insurance company. As my designated authorized representative and as part of the appeal, I hereby authorize my insurance company in its decision letter and in connection with the processing of my appeal to communicate with **Garden State Medical Center and its representatives** in all aspects of the appeal.

I understand that these communications may contain the following:

All medical and financial information contained in my insurance file including but not limited to treatment for pain management relating to my examination, treatment and hospital confinement in connection with the determination which is being appealed.

I understand this information is privileged and confidential and will only be released as specified in this authorization, or as required or permitted by law. This authorization is valid for as long as I am under the care of the providers of Garden State Medical Center.

A photocopy of this authorization shall be considered effective and valid as the original.

Patient/Guardian Signature	Date
Witness	

PATIENT NAME:	DOS:
DOB:	

****Please complete form****

Location of Pain:
Duration of pain:
Constant/Intermittent:
Describe the pain (Circle all that apply): ACHING, THROBBING, STIFFNESS, SPASMS, DULL, SHARP, BURNING
Tingling or Numbness:
Radiation of pain:
Aggravating Factors:
Alleviating factors:
Any Sleep Interference:
Home exercise (yes/no)/ Physical therapy (date/result):
NSAID's (Circle all that apply): ALEVE, ADVIL, TYLENOL, NONE
Muscle Relaxers:
Nerve Medication: LYRICA, GABAPENTIN, NONE
Past Pain Injections (dates):
Narcotic Medication:
Radiology Studies (date):

Surgeons/Orthopedists seen:
Height:
Weight:
Daily Medications:
Medical History:
Allergies:
Past Surgical History: