

PATIENT REGISTRATION DATE _____

NAME: _____ MARITAL STATUS _____ DATE OF BIRTH _____ AGE _____

EMAIL ADDRESS _____

STREET ADDRESS _____

CITY, STATE, ZIP _____

PHONE (Home) _____ (Cell) _____ (Work) _____

PHYSICIAN _____ PHONE# _____

PHARMACY _____ PHONE# _____

EMPLOYER _____ SPOUSE'S
EMPLOYER _____

SPOUSE NAME _____ IF UNDER 18 PARENT NAME _____

EMERGENCY CONTACT _____ ADDRESS/
(OTHER THAN SPOUSE) _____ PHONE _____

SOCIAL SECURITY# _____ REFERRED BY _____

 CHECK CASH CREDIT CARD INSURANCE WORKMAN'S COM. MVA/PIP
BILLING NAME

(IF OTHER THAN PATIENT) _____ RELATIONSHIP _____

BILLING
ADDRESS _____1) INSURANCE _____ EFFECTIVE
COMPANY _____ ADDRESS _____ DATE _____SUBSCRIBER'S
NAME _____ I.D. # _____ GROUP# _____2) INSURANCE _____ EFFECTIVE
COMPANY _____ ADDRESS _____ DATE _____SUBSCRIBER'S
NAME _____ I.D. # _____ GROUP# _____

CLAIM # _____ DATE OF ACCIDENT _____

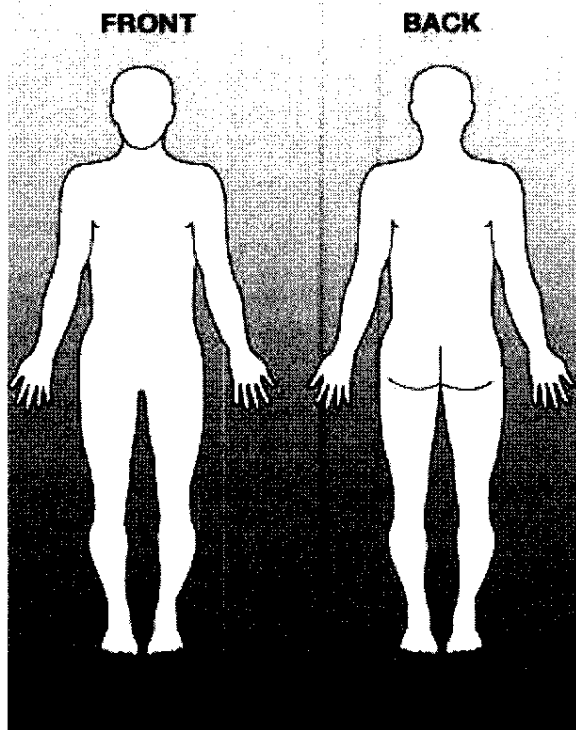
ADJUSTER NAME & PHONE NO. _____

Patient Name: _____

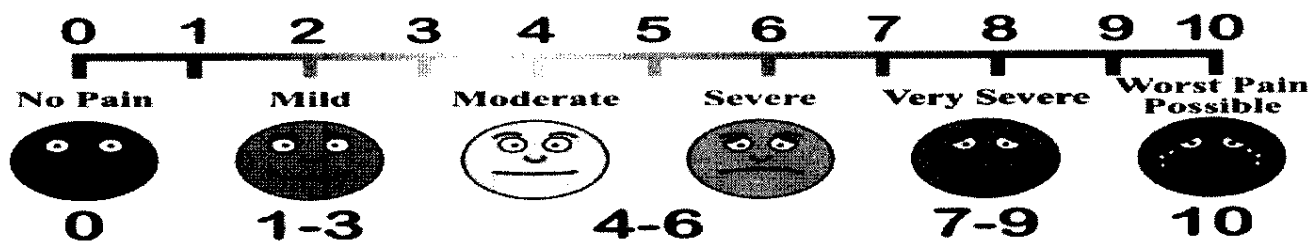
Date: _____

Completing this form can help you talk to your healthcare provider about your symptoms.

CIRCLE ALL OF THE AREAS WHERE YOU FEEL PAIN



USE SCALE TO RATE THE AVERAGE SEVERITY OF PAIN YOU FEEL



1. How long have you been experiencing chronic widespread pain? _____
2. How would you describe the type of pain you feel? _____
3. Is your daily functioning impacted?
a. Very much b. Somewhat c. A little d. Not at all
4. What other symptoms do you frequently experience? _____

HEALTH HISTORY

Date _____

Patient Name _____ Birthdate _____

Chief Complaint: _____

History of present illness:

Location: _____ **Quality:** _____
 (Where is the pain/problem?) (example: normal versus abnormal color, activity)

Severity _____ **Duration** _____
 (How severe is the pain/problem on a scale of 1-5 with 5 Being the most severe) (How long have you had this pain/problem or when did it start)

Timing _____ **Context** _____
 (Does the pain/problem occur at specific time?) (Where were you at the onset of this pain/problem?)

Associated signs/symptoms _____ **Modifying factors** _____

(What other associated problems have you been having?) (What makes the pain/problem worse or better or Have you had previous episodes?)

PAST MEDICAL HISTORY:

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

- Whooping Cough..... no yes Migraine Headaches... no yes Date of last chest x-ray_____ Bleeding Tendency...no yes
- Measles..... no yes Anemia..... no yes Back trouble..... No yes Hepatitis.....no yes
- Mumps..... no yes Bladder infections..... No yes High blood Pressure...no yes Ulcer.....no yes
- Chickenpox..... no yes Epilepsy.....no yes Low Blood Pressure.....no yes Kidney Disease.....no yes
- Scarlet Fever.....no yes Tuberculosis.....no yes Hemorrhoids.....no yes Thyroid Disease.....no yes
- Diphtheria.....no yes Diabetes.....no yes Asthma.....no yes Any other disease.....no yes
- Smallpox.....no yes Cancer.....no yes Hives /Eczema.....no yes (please list)
- Pneumonia.....no yes Polio.....no yes AIDS or HIV+.....no yes _____
- Rheumatic Fever.....no yes Glaucoma.....no yes Infectious Mono.....no yes _____
- Heart Disease.....no yes Hernia.....no yes Bronchitis.....no yes _____
- Arthritis.....no yes Blood or Plasma _____ Mitral Valve Prolapse.no yes _____
- Venereal Disease.....no yes Transfusions.....no yes Stroke.....no yes _____

Allergies (medication, food, environmental) : _____

When

Hospital, City, State

Surgical History: _____

Hospitalization: _____

Family medical history:

Age

Disease

if deceased, Cause of Death

Father _____

Mother _____

Siblings _____

Spouse _____

Children _____

Patient social history:

Marital status Single:___ Married___ Separated:___ Divorced:___ Widowed___

Use of alcohol: Never:___ Rarely___ Moderate:___ Daily:___

Use of tobacco: Never___ Previously, but quit___ Current packs/day:_____

Use of Drugs: Never:___ Type/Frequency:_____

HEIGHT: ___' ___" Weight: _____ lbs. Did you have a flu vaccine last fall? Yes no

Review of System: Please indicate any personal history below:

Constitutional Symptom

Good general health lately.....No Yes
 Recent weight change.....No Yes
 Fever.....No Yes
 Fatigue.....No Yes
 Headaches.....No Yes

Eyes

Eye disease or injury.....No Yes
 Wear glasses/contact lenses.....No Yes
 Blurred or double vision.....No Yes

Ears/Nose/Mouth/Throat

Hearing loss or ringing.....No Yes
 Earaches or drainage.....No Yes
 Chronic sinus problem / rhinitis...No Yes
 Nose Bleeds.....No Yes
 Mouth sores.....No Yes
 Bleeding gums.....No Yes
 Bad breath or bad taste.....No Yes
 Sore throat or voice change.....No Yes
 Swollen glands in neck.....No Yes

Cardiovascular

Heart trouble.....No Yes
 Chest pain or angina pectoris.....No Yes
 Palpitation.....No Yes
 Shortness of breath w/walking
 Or lying flat.....No Yes
 Swelling of feet/ankles/hands.....No Yes

Respiratory

Chronic or frequent coughs.....No Yes
 Spitting up blood.....No Yes
 Shortness of breath.....No Yes
 Wheezing.....No Yes

Gastrointestinal

Loss of appetite.....No Yes
 Change in bowel movements.....No Yes
 Nausea or vomiting.....No Yes
 Frequent diarrhea.....No Yes
 Painful bowel movements
 Or constipation.....No Yes
 Rectal bleeding or blood
 In stool.....No Yes

Genitourinary

Frequent urination.....No Yes
 Burning or painful urination.....No Yes
 Blood in urine.....No Yes
 Change in force strain
 when urinating.....No Yes
 Incontinence or dribbling.....No Yes
 Kidney stones.....No Yes
 Sexual difficulty.....No Yes
 Male - testicle painNo Yes
 Female - pain with periods.....No Yes
 Female - vaginal discharge.....No Yes
 Female - # of pregnancies.....
 Female - # of miscarriages.....
 Female - date of last pap smear _____

Musculoskeletal

Joint pain.....No Yes
 Joint stiffness or swelling.....No Yes
 Weakness of muscles or joints...No Yes
 Muscle pain or cramps.....No Yes
 Back pain.....No Yes
 Cold extremities.....No Yes
 Difficulty in walking.....No Yes

Integumentary (skin, breast)

Rash or itching.....No Yes
 Change in skin color.....No Yes
 Change in hair or nails.....No Yes
 Varicose veins.....No Yes
 Breast pain.....No Yes
 Breast lump.....No Yes
 Breast discharge.....No Yes

Neurological

Frequent or recurring
 Headaches.....No Yes
 Light headed or dizzy.....No Yes
 Convulsions or seizures.....No Yes
 Numbness or tingling sensation..No Yes
 Tremors.....No Yes
 Paralysis.....No Yes
 Head injury.....No Yes

Psychiatric

Memory loss or confusion.....No Yes
 Nervousness.....No Yes
 Depression.....No Yes
 Insomnia.....No Yes

Endocrine

Glandular or hormone problem.....No Yes
 Excessive thirst or urination.....No Yes
 Heat or cold intolerance.....No Yes
 Skin becoming dryer.....No Yes
 Change in hat or glove size.....No Yes

Hematologic/Lymphatic

Slow to heal after cuts.....No Yes
 Bleeding or bruising tendency.....No Yes
 Anemia.....No Yes
 Phlebitis.....No Yes
 Past transfusions.....No Yes
 Enlarged glands.....No Yes

Allergic/immunologic

History of skin reaction or other adverse
 reaction to:
 Penicillin or other antibiotics.....No Yes
 Morphine, Demerol,
 or other narcotics.....No Yes
 Novocain or other anesthetics...No Yes
 Aspirin or other pain remedies...No Yes
 Tetanus antitoxin
 or other serums.....No Yes
 Iodine, Merthiolate or
 other antiseptic.....No Yes
 Other drugs/medications _____

Known food allergies: _____

Environmental allergies: _____

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status, I also authorize the healthcare staf perform the necessary services I may need.

 Signature of Patient, Parent or Guardian

 Date

Doctor's Review

 Signature of Doctor

 Date

PATIENT REGISTRATION

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Dr.Dorota M Gribbin M.D., Comprehensive Pain and Rehabilitation Center, for services rendered by her in person or under her supervision. I understand that I am financially responsible for any balance not covered by my insurance

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr.Dorota M. Gribbin M.D., Comprehensive Pain and Rehabilitation Center, to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case

SIGNATURE OF PATIENT: _____ DATE: _____

MEDICARE

I certify that the information given by me in applying for payment is correct I authorize release of all my records on request. I request that payment of authorized benefits be made on my behalf

A photocopy of these assignments shall be valid as the original.

SIGNATURE OF PATIENT: _____ DATE: _____

COMPREHENSIVE PAIN AND REGENERATIVE CENTER P.A.

Dorota M. Gribbin, M.D., F.A.A.P.M.R.

Assistant Clinical Professor Columbia University College of Physicians and Surgeons
Department of Rehabilitation and Regenerative Medicine

ASSIGNMENT OF BENEFITS

Patients Name: _____
Accident Date: _____

I irrevocably assign to you, my medical provider, all of my rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me and this specifically includes filing arbitration/litigation in your name on my behalf against the PIP carrier/health care carrier. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills. I direct that all reimbursable medical payment go directly to you, my medical provider. I authorize you to act on my behalf. I consent to your action on my behalf in this regard and in regard to my general health insurance coverage pursuant to the "benefit denial appeals process" set forth in the NJ Administrative Code.

In the event the insurance carrier responsible for making medical payments in this matter does not accept my assignment, or my assignment is deemed invalid, I execute this limited/special power of attorney and appoint and authorize your collection attorney as my agent and attorney to collect arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me and designate your collection attorney as my attorney in fact. I further grant limited power of attorney to you as services rendered to me in this matter, and hereby instruct the insurance carrier to pay you directly any monies due you for medical services you rendered to me.

I authorize you and or your attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider(s) to release all such information to you about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my physical condition.

Dated:

Patients Signature

PATIENT RESPONSIBILITIES

- Provide accurate information on documents and a copy of your health insurance card, if you have one, as well as a photo ID.
- Report unexpected changes.
- Report whether you clearly understand your plan of care and what is expected of that plan.
- Be responsible for your actions. If you choose to refuse treatment or if you choose not to follow the medical provider's instructions, that is your option.
- Follow procedural rules and regulations.
- Be respectful of others' property.
- Fulfil all financial obligations.
- Keep all appointments.

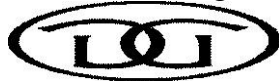
Print name: _____

Signature: _____ Date: _____

Preferred MRI/ X-Ray Imaging Name: _____

Preferred MRI/ X-Ray Imaging Location: _____

Comprehensive Pain and Regenerative Center



2333 Whitehorse-Mercerville Rd., Suite #8, Mercerville, N.J. 08619
60 Mt. Lucas Rd., Suite #600, Princeton, N.J. 08540
369 Applegarth Rd., Suite #4, Monroe, N.J. 08831
Ph: (609)588-0540 Fax: (609)588-0197

Policy of Cancellation, Rescheduling and not keeping Appointments

Our practice requires 3 (three) business days notice for appointments that must be cancelled or rescheduled. Cancellation of a Monday appointment must be done on the Friday before (not Saturday or Sunday). This gives the office the opportunity to schedule another patient who may be waiting for an appointment.

Please call to schedule your next appointment, making certain that the appointment accommodates your personal and business schedules. It is the policy of this office to charge \$100.00 for a no-show appointment and \$75.00 for an appointment cancelled on shorter notice than 3 (three) business days.

If your appointment is not kept without proper notification, we reserve the right to charge you for that missed appointment.

If you fail to keep 3 appointments without prior notice, Dr. Gribbin will provide your care for 30 days to allow you to find another physician. After that time, we will transfer your medical records to the Physiatrist of your choice.

Please call the office and speak to me directly with any questions or concerns.

Date: _____ Patient: _____

Please print your name:

Patient: _____

Please sign in agreement:

PATIENT CONSENT FORM

I understand that, under the health insurance Portability & Accountability Act of 1966(HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly
- Obtain payment form from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you or fo your *Notice Of Privacy Practices* containing a more complete description of the use and disclosures of my health information. I have been given the right to review such *Notice Of Privacy Practices* prior to signing this consent. I understand this organization has the right to change its *Notice Of Privacy Practices* from time to time and that I may contact this organization at any time to the address below to obtain a current copy of the *Notice Of Privacy Practices*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action replying on this consent

PATIENT NAME: _____

SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____

DATE: _____

COMPREHENSIVE PAIN AND REGENERATIVE CENTER

Agreement of Financial Responsibility

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider and are the designated Primary Care Provider (PCP), if applicable.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- We will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered after your visit. We are OON with all payers except Medicare, Horizon BCBS, and Cigna
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In- Network rate.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Signature of Patient /Responsible Party

Date

Name of Patient/Responsible Party (please print)

Relationship to Patient