Jason Yu MD

INTERVENTIONAL PAIN MANAGEMENT

PATIENT INFORMATION

Date: _____

Patient Name: _____ Date of Birth: _____ Sex: _____ Marital Status: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____Social Security #: _____

State of Driver's License: _____ Driver's License Number: _____

Primary Care Physician: _____ Referring Physician: _____

Employer's Name & Address: _____ Employer's Phone: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____ City: _____ State: _____ Zip: _____

Emergency contact name/relationship/phone #: _____

Language: ☐ English ☐ Spanish ☐ Mandarin Chinese ☐ Cantonese ☐ Other: _____

Does the patient have health insurance? Please check one ☐ Yes ☐ No

Health Insurance:

Primary Health Insurance Carrier: _____

Policy/ID #: _____ Group #: _____

Policy Holders Name: _____ Date of Birth: _____

Secondary Health Insurance Carrier: _____

Policy/ID #: _____ Group #: _____

Policy Holders Name: _____ Date of Birth: _____

Is your pain being as a result of an AUTO accident ☐ Yes ☐ No

Name of Auto Insurance Carrier: _____

Auto Policy #: _____ Name of Insured: _____

Claim #: _____ Date of Accident: _____

Attorney Name: _____ Phone #: _____

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Is your pain being as a result of work related accident and do you have WORKERS COMPENSATION case: ☐ **Yes** ☐ **No**

Employer: _____ Date of Injury: _____

Claim #: _____ Workers' Comp. Insurance Name: _____

Adjuster's Name: _____ Adjuster's Phone #: _____

Adjuster's Fax #: _____

Emergency Contact: _____ Relationship to Patient: _____

Emergency Contact Phone: _____ Emergency Contact Cell: _____

Patient Signature: _____ **Date:** _____

Physician/provider Signature:_____ **Date:**_____

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HISTORY AND PHYSICAL INTAKE FORM

Name: _____ DOB: _____ Age: _____ Todays Date: _____

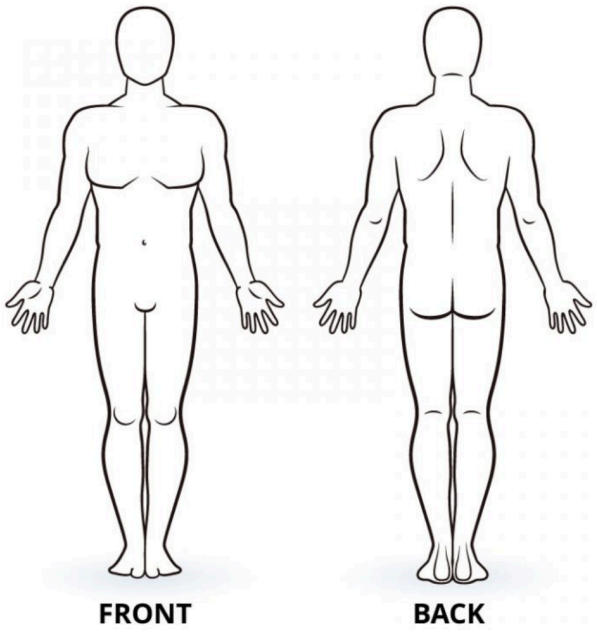
Height: _____ Weight: _____ Occupation: _____ Part-time ☐ Full-time ☐ Disabled ☐

Chief complaints: _____

When and how it started: _____

Does your pain radiate anywhere? _____

Please **CIRCLE** the areas where you are experiencing pain:



CIRCLE the most appropriate for **YOUR** pain TODAY with "0" meaning NO PAIN and "10" being the WORST PAIN experienced

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Describe your pain:

☐ Aching ☐ Burning ☐ Cramping ☐ Dull ☐ Electric-shock ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Throbbing

What makes the pain WORSE?

☐ Standing ☐ Sitting ☐ Walking ☐ Movement ☐ Lying Down ☐ Bending forward ☐ Arching backward ☐ Coughing ☐ Sneezing

☐ others _____

What makes the pain BETTER?

☐ Standing ☐ Sitting ☐ Walking ☐ Movement ☐ Lying Down ☐ Bending forward ☐ Arching backward ☐ Coughing ☐ Sneezing

☐ others _____

- Are you involved in any litigation or lawsuit regarding your pain? ☐ Yes ☐ No
- Are you seeking Worker's Compensation because of your pain? ☐ Yes ☐ No

Do you have any of the following symptoms associated with your pain?

Numbness/Tingling ☐ No ☐ Yes where? _____

Weakness ☐ No ☐ Yes where? _____

Bowel/Bladder Incontinence ☐ No ☐ yes when did it start? _____

- List the names of other doctors or specialists you have seen for your pain: _____

_____

- Have you had any treatments by another Pain Doctor? _____

_____

Did You have any tests done: ☐ X-Ray ☐ MRI ☐ CT-scan ☐ Nerve Studies ☐ Others _____

CURRENT MEDICATIONS: Check here if **NONE** ☐		**ALLERGIES**	**YES**	**NO**
Name of Pain Medication	Dosage	No Known Drug Allergies	☐	☐
_____	_____	IV Dye	☐	☐
_____	_____	Iodine	☐	☐
_____	_____	Seafood/Shellfish	☐	☐
Name of other Medication	Dosage	Adhesive Tape	☐	☐
_____	_____	NSAIDS	☐	☐
_____	_____	Penicillin	☐	☐
_____	_____	Other _____		

Are you taking any Blood thinner medications e.g. Plavix/Clopidogrel, Warfarin/Coumadin, Effient/Prasugrel or others? ☐ Yes ☐ No

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Patient Name: _____ DOB: _____

Medical History: Check here if none (☐)

	Yes	No		Yes	No		Yes	No
High blood pressure	☐	☐	Hepatitis/liver disease	☐	☐	Phlebitis/blood clots	☐	☐
Heart disease	☐	☐	Kidney problems/Stones	☐	☐	Stomach Ulcer disease	☐	☐
Heart attack	☐	☐	Thyroid disease	☐	☐	Bleeding disorder	☐	☐
Irregular heart rhythm	☐	☐	Diabetes	☐	☐	Asthma	☐	☐
Stroke	☐	☐	Osteoporosis	☐	☐	Emphysema/COPD	☐	☐
Seizures	☐	☐	Rheumatoid Arthritis	☐	☐	Cancer	☐	☐
Glaucoma	☐	☐	Depression	☐	☐	Trauma	☐	☐
Fibromyalgia	☐	☐	HIV positive	☐	☐	Other:		

Surgical History: Check here if none (☐)

☐ Low back surgery Date: _____ Surgeon: _____

☐ Neck surgery Date: _____ Surgeon: _____

☐ Heart surgery ☐ Joint replacement: Describe _____

☐ Cancer surgery: Describe _____

☐ Appendix ☐ Hernia ☐ Gallbladder ☐ Hysterectomy ☐ OTHER Surgeries_____

Social History: Right-handed ☐ Left-handed ☐

Alcohol	Yes ☐	No ☐	☐ Daily ☐ Few per week ☐ Once per week ☐ Few per month
Illicit Drug Use:	Yes ☐	No ☐	☐ Type _____
Drug/Alcohol treatment?	Yes ☐	No ☐	If yes, name of facility: _____ Year _____
Past Suicide Attempt?	Yes ☐	No ☐	If yes when _____
Smoker:	Yes ☐	No ☐	# packs daily: _____ How many years: _____
Occupation: _____ ☐ None ☐ Part-time ☐ Full-time ☐ Disabled ☐ Retired			

Family History:

Mother ☐ Alive ☐ Deceased Age: _____ Cause/medical conditions: _____

Father ☐ Alive ☐ Deceased Age: _____ Cause/medical conditions: _____

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Patient Name: _____ DOB: _____

Family Medical Problems: ☐ Diabetes ☐ Heart Disease ☐ Cancer type: _____

☐ Other(s): _____

Review of Systems: circle all that apply: Pregnant ☐ Yes ☐ No

- ☐ General: Weight changes, fatigue
- ☐ Lung: Chronic cough, Shortness of breath
- ☐ Heart: Chest pain, Palpitations
- ☐ Abdomen: Heartburn, Nausea, Constipation
- ☐ Neurology: Stroke, Seizures, Weakness
- ☐ Endocrine: Thyroid problems, Diabetes
- ☐ Skin: Bruising, rashes, sores
- ☐ Head/Eyes: Headache, Blurry vision
- ☐ Ear/Nose/Throat: Ringing in ears, Sinusitis, Sore throat
- ☐ Blood: Anemia, Easy bruising, Bleeding
- ☐ Urinary: Blood in urine, Painful urination
- ☐ Psychiatric.: Depression, Anxiety, Sleep problems
- ☐ Vascular: Leg cramps, Aneurysms
- ☐ Immunologic: Itching, Frequent colds or infections

I certify that the information given on the Initial Visit Intake is correct to the best of my knowledge. I will not hold my doctor or any member of his staff responsible for any errors or omissions that I may have made in the completion of this paperwork.

_____ _____

Patient/Family/Legal Guardian Signature **Date**

Physician/provider Signature:_____ **Date:**_____

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INTERVENTIONAL PAIN MANAGEMENT

CONSENT FOR TREATMENT

I hereby consent and authorize the performance of all appropriate procedures and courses of treatment, the administration of all anesthetics, and any and all medications which in the judgment of my provider may be considered necessary or advisable for my diagnosis and/or treatment at Jason Yu, M.D., P.C.

PRIVACY NOTICE ACKNOWLEDGEMENT

During your treatment, it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared:

- During treatment, we may find it necessary to acquire a laboratory analysis.
- During your treatment, a referral to other services may be necessary.
- During health care operations, we may need a second opinion.
- During the payment process, we may need to release notes and other laboratory results.
- Release information to legal authorities or case workers.

I acknowledge that I have had the opportunity to review a copy of the **JASON YU, M.D., P.C. NOTICE OF PRIVACY PRACTICES**. I understand that I am responsible for reading this notice and for notifying JASON YU, M.D., P.C. in writing of any request for restrictions in the use or disclosure of my individually identifiable health information. I understand that the notice includes electronic access to my medication history. JASON YU, M.D., P.C. has the right to revise this notice at any time and will post a copy of the current notice in the office in a visible location at all times. JASON YU, M.D., P.C. may also provide me with a copy of its most recent notice upon my request.

CONSENT FOR DISCLOSURES

We understand that at times you may need members of your family or friends to contact the office to make inquiries about your health status, diagnosis, treatment options, schedule, reschedule, cancel appointments or to be contacted in the event of an emergency. To do so, please list the person, or persons you are authorizing to make such inquires or changes. Please be advised that we may require them to confirm personal information to verify their authorization, such as your date of birth.

Name: _____ Relationship: _____ Contact #: _____

Name: _____ Relationship: _____ Contact #: _____

I DO NOT give authorization for medical information, lab work results and any other information regarding my appointments or treatment to be released to anyone _____. (Your Initials)

MEDICAID INSURANCE WAIVER

This notice is to inform all patients that we are only ***** MEDICAID PROVIDERS**. If you decide to seek treatment at JASON YU, M.D., P.C. **you are required to sign this waiver in acknowledgment that you have received this waiver (even if you do not have Medicaid insurance)**, and that you will be responsible for any portion of your bill that is not covered by any other insurance.

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INTERVENTIONAL PAIN MANAGEMENT

FINANCIAL POLICY, ASSIGNMENT OF BENEFITS, AND AGREEMENT

I understand that in consideration of the services provided to me, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered by JASON YU, M.D., P.C. I am responsible for any applicable deductible, copayments and coinsurance prior to the provision of services. JASON YU, M.D., P.C. may file ALL claims for payment with my insurance company as a courtesy to me. If the insurance company fails to pay in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts due. If we do not receive a response from you after 90 days, your balance may be sent to a collection agency. Furthermore, you may also be charged any applicable attorney fees, processing fees, and other expenses acquired in order to collect outstanding balances from you.

I authorize JASON YU, M.D., P.C. to apply for benefits on my behalf for covered services rendered. I request that payment from Centers for Medicare & Medicaid Services or my insurance carrier to forward payment for medical benefits for all services be made directly to JASON YU, M.D., P.C. I certify that the information I have provided with regards to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be evoked by either me or my insurance provider at any given time with proper written notice. I hereby authorize JASON YU, M.D., P.C. to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by my insurance company or Medicare.

If my insurance company requires me to obtain referrals/authorizations, it is my responsibility to obtain such and if not, then I will be responsible for any unpaid balance.

By signing this agreement, I acknowledge that I have carefully read, understand and agree to the above terms and conditions. I also understand that it is mandatory to inform JASON YU, M.D., P.C. if another party is responsible for paying for my treatment i.e. Automobile Insurance, Workers' Compensation, slip and fall; Section 1128B of Social Security Act and 31 USC 38013812 provides penalties for withholding this information.

FEE POLICY

Appointment Cancellation/No Show Fees:

If you do not call within 24 hrs. of your scheduled appointment to cancel, reschedule, or if you "no show" for a scheduled appointment, the following fees will apply:

Follow up = $25.00 Procedure = $50.00

Paperwork Fees: Disability FMLA, etc.

Physician Progress Report or Functional Capacity Evaluation $50.00 per page

Medical Records Fees:

$.75 per page for the first 25 pages, $0.50 per page thereafter

By signing this agreement, I acknowledge that I have carefully read, understand, and agree to the terms and conditions of the Consent for Treatment Agreement, the Privacy Notice Acknowledgment, the Consent for Disclosure, the Financial Policy and Agreement, the Assignment of Benefits, the Medicaid Insurance Waiver, and the Fee Policy. I have completed these forms accurately and to the best of my knowledge and will be financially responsible if I have failed to provide JASON YU, M.D., P.C. with all of my applicable insurance information.

Patient/Legal Guardian Name print: _____

Patient/Legal Guardian Signature: _____ **Date:** _____

Physician/provider Signature:_____ **Date:**_____

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NARCOTIC MEDICATION POLICY/CONTRACT

We are committed to doing all we can to treat your chronic pain condition. In some cases, opioids and other controlled substances are used as a therapeutic option in the management of chronic pain and related conditions all of which are strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and the physician by establishing guidelines, within the laws for proper controlled substance use.

According to New York State Law Article 33 (New York State Controlled Substances Act, Section 3397, it is illegal for persons to see multiple physicians to obtain a controlled substance medication. You can be arrested for this violation.

JASON YU, M.D., P.C. will assist the authorities in all aspects regarding this law.

I give consent to **JASON YU, M.D., P.C.** and all its employee to make a report to, or otherwise cooperate with any law enforcement officials or regulatory agencies in any investigation which may arise as a result of or related to my receiving prescriptions as a patient of **JASON YU, M.D., P.C.** I waive any and all rights of privacy and privilege in this regard and these authorities may be given full access to my medical record without order of the clerk of court.

1. All controlled substances have a potential for dependency, addiction and other side effects.
2. All controlled substances must come from the physician whose signature appears below, or during his absence, by the covering provider, unless specific authorization is obtained for an exception.
3. All controlled substances must be obtained at the same pharmacy, where possible.
4. The Pharmacy I have selected is _____ Phone#: _____
5. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purpose of maintaining accountability.
6. I will never share, sell or otherwise, permit other including family members to have access to these medications.
7. Unannounced urine or serum toxicology screens may be requested, and your cooperation is required. Presence of unauthorized or illegal substances may result in your discharge from the facility.
8. I will not consume any alcohol or operate heavy machinery in conjunction with narcotics and I will not use any illegal drugs.
9. Medications may not be replaced if they are lost or stolen. If your medication has been stolen it will not be replaced unless explicit proof is provided with direct evidence from authorities. A report narrating what you told will not be enough.
10. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived, and these authorities may be given full access to our records of controlled substances administration.
11. Early refills will not be given. Renewals are based upon keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.
12. In the event you are arrested or incarcerated related to legal or illegal drugs, refills on controlled substances will not be given and may result in your discharge from the facility.
13. If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately notify Jason Yu, M.D., P.C. and my physicians. I am aware that should I become pregnant I will be given a weaning dose of medications and will be released from this facility and will be followed by my Obstetric physician for any medication requirement. I will be able to resume pain management care at Jason Yu, M.D., P.C. after delivery.
14. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribed by the physician.
15. By signing this agreement, I affirm that I have read, understand and accept all of the terms of this Narcotic Medication Contract. I affirm that I have full right and power to sign and be bound by this agreement.

Patient Name: _____ **Patient Signature:** _____ **Date:** _____

Physician/provider Signature:_____ **Date:**_____

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INTERVENTIONAL PAIN MANAGEMENT

Opioid Risk Tool

Patient Name: _____ Date _____

Mark each box that applies		Female	Male
Family history of substance abuse			
Alcohol	( )	1	3
Illegal drugs	( )	2	3
Rx drugs	( )	4	4
Personal history of substance abuse			
Alcohol	( )	3	3
Illegal drugs	( )	4	4
Rx drugs	( )	5	5
Age between 16—45 years	( )	1	1
History of preadolescent sexual abuse	( )	3	0
Psychological disease			
Attention deficit disorder, Bipolar, Obsessive compulsive, Schizophrenia	( )	2	2
Depression	( )	1	1
Scoring totals	( )		

For office use only:

Risk Assessment: Low risk (0-3) Moderate risk (4-7) High risk (> 8)

PHYSICIAN SIGNATURE _____ Date: _____

Physician/provider Signature:_____ **Date:**_____

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Acknowledgment of Receipt of Notice of Privacy Practices

PATIENT:

I certify that I have been offered to receive a copy of the Notice of Privacy Practices and I have had an opportunity to review this document and ask questions to assist me in understanding my rights relative to the protection of my health information.

***Printed Patient Name: _____ Patient Date of Birth: _____

***Patient Signature: _____ Date: _____

AUTHORIZED PATIENT REPRESENTATIVE:

I certify that I am the authorized representative of the abovementioned Patient and I have received the Notice of Privacy Practices on behalf of this individual. I had the opportunity to review this document and ask questions to assist me in understanding his/her rights relative to the protection of his/her health information.

Representative Name: _____

Representative Signature: _____

Printed Patient Name: _____

Relationship to Patient: _____

Date: _____

Patient or Representative refused to sign or declined Acknowledgement of Privacy Notice.

***Patient Signature or Representative Signature: _____

***Date: _____

Physician/provider Signature:_____

Date:_____

FOR OFFICE USE ONLY:

Witness, Office Personnel Printed Name: _____

Date: _____