GERSHON PAIN SPECIALISTS
YOUR PATH TO PAIN RELIEF

Dear Patient,

Please review the attached paperwork and fill out all forms in their entirety in the privacy of your home. Bring all completed paperwork to your initial appointment. Should you have any questions regarding this paperwork, please do not hesitate to contact our office for assistance. This information will allow us to treat you effectively and safely.

Please bring shorts and a t-shirt (sports bra or tank top for women) with you for your exam. **We also ask that you do not wear any perfumes, colognes, or scented lotions on the day of your visit.**

If possible, please have your referring physician's office fax your pertinent medical records and/or testing to our office at (757) 689-4357 prior to your scheduled appointment date. If you have had any diagnostic testing preformed it would be very helpful for us to have those reports as well.

When you come to your appointment, please make sure to bring your photo ID, your insurance card(s), your co-pay, and a referral from your primary care physician if your insurance company requires one.

If you have any questions, please feel free to contact us at (757) 496-2050.

Sincerely,

Dr. Gershon and Staff

Date _____

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Patient Questionnaire

Name _____ Age _____ □ Right Handed □ Left Handed

Referring Physician/Primary Care Physician: _____

When did your pain first begin? _____

Who have you seen for this pain? _____

_____

What treatment and/or tests have you undergone? _____

_____

_____

_____

Describe your pain (Please check all that apply):

□ Sharp	□ Dull	□ Burning	□ Aching	□ Knife-like
□ Pulsating	□ Pressure	□ Deep	□ Throbbing	□ Stinging

Where is your pain currently located? _____

_____

Does it shoot or refer anywhere? _____

Is your pain present constantly or intermittently? If you answer intermittently, how long does it last and is there a time of day that is better or worse? _____

_____

_____

Name _____

Patient Questionnaire (continued)

How severe is your pain?

0 No Pain

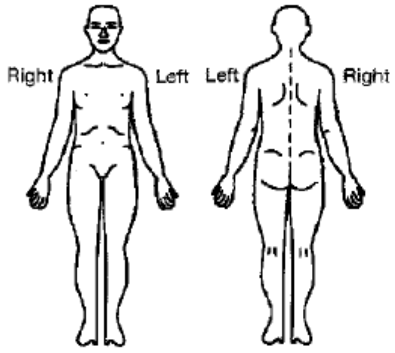
1-2 Mild pain, requires no medication

3-4 Mild-moderate pain, requires mild medications

5-6 Moderate pain, requires strong medication

7-8 Moderate-Severe, constant pain, requires narcotic or ER visit

9-10 Severe, constant pain, requires admission to hospital



PLEASE DRAW AN ARROW TO THE LOCATION OF YOUR PAIN USING THE ABOVE ILLUSTRATION

What makes your pain better? (Examples: rest, stretching, changing positions) _____

_____

What makes your pain worse? (Examples: activity, prolonged sitting/standing) _____

_____

Do you experience any of the following? (Please check all that apply)

□ Numbness □ Tingling □ Pins & Needles □ Burning
□ Weakness □ Sleep Disturbance □ Sexual Dysfunction □ Incontinence

Past Medical History: Please list any medical problems that you have or have been treated for in the past.

(Examples: diabetes, heart disease, lung disease, hypertension, high cholesterol, vascular disease, cancer, etc.)

_____

_____

Please list any surgeries: _____

_____

Preferred Pharmacy: _____

Please list current medications: _____

_____

Please list any allergies to medications: _____

_____

Name _____

Patient Questionnaire (continued)

REVIEW OF SYSTEMS: (Please check all that apply)

Constitutional: □Fever □Chills □Sweats □Anorexia □Fatigue □Malaise □Weight loss □Weight Gain □Insomnia

Eyes: □Blurring □Double Vision □Irritation □Discharge □Vision Loss □Eye Pain □Photophobia

ENT: □Ear Pain □Tinnitus □Decreased Hearing □Nosebleeds □Sore Throat □Hoarseness □Difficulty Swallowing

CV: □Chest Pain □Palpitations □Syncope □PND □Orthopnea □Peripheral Edema □Cold Hands/Feet

Resp: □Cough □Dyspnea □Excessive Sputum □Coughing up Blood □Wheezing □ Asthma □ Emphysema

GI: □Nausea □Vomiting □Diarrhea □Constipation □Abdominal pain □Melena □Blood in Stool □Jaundice

GU: □Pain with urination □Frequent nighttime urination □Urinating blood □Impotence □Incontinence □Genital Sores □Decreased Libido

MSK: □Back Pain □Joint Pain □Joint Swelling □Muscle Cramps □Muscle Weakness □Stiffness Arthritis

Neuro: □Transient Paralysis □Weakness □Paresthesias □Seizures □Syncope □Tremors □Vertigo □Headaches

Psych: □Depression □Anxiety □Memory Loss □Mental Disturbance □Suicidal Ideation □ _____

Endo: □Cold Intolerance □Heat Intolerance □Polydipsia □Polyphagia □Polyuria □ _____

Heme: □Abnormal Bruising □Bleeding □Enlarged Lymph Nodes □ Sickle Cell □ _____

Immun: □Urticaria □Hay Fever □Persistent Infections □HIV Exposure □ _____

Integ: □Itching □Rash □Hives □Skin Cancer □Dermatitis □Eczema □ _____

Please list job title and employer: _____

□ Single □ Married □ Widowed □ Separated □ Divorced

Please list ages of children (if applicable):_____

Do you smoke? Y / N Have you ever smoked in the past? Y / N Quit Date _____

How much alcohol do you drink per week? _____

Please list major medical problems of family members (such as hypertension, diabetes, heart disease, strokes, cancer, etc.)_____

_____

_____

Personal history of illicit drug or prescription drug or alcohol overuse / abuse? Y / N

Family history of illicit drug or prescription drug or alcohol overuse / abuse? Y / N

What do you hope to accomplish with this visit today? _____

_____

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Patient Information

Patient Name: _____
Last **First** **M.** **Previous Name (if applicable)**

Social Security Number: _____ **Date of Birth:** ____/____/____ **Gender:** **M** **F**

Home Address: _____
Street Address **City** **State** **Zip**

Contact: **Home:** _____ **Work:** _____

Cell: _____ **Email:** _____

Employer: _____ **Employer Address:** _____

Emergency Contact Information

Emergency Contact: _____ **Phone:** _____

Insurance Information

Primary Insurance: _____

Subscriber: _____ **Subscriber DOB:** ____/____/____ **Subscriber SSN:** _____

Secondary Insurance: _____

Subscriber: _____ **Subscriber DOB:** ____/____/____ **Subscriber SSN:** _____

Disclosure to Family Members/Friends

Please list any person(s) that you would like to grant permission to your provider to discuss your medical record, plan of care, and/or financial information:

1. Name: _____ Relationship: _____

   Phone Number: _____

2. Name: _____ Relationship: _____

   Phone Number: _____

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand that I have a right to revoke this authorization at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that authorizing the disclosure of this health information is voluntary.

Patient Signature: _____ **Date:** _____

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Policies

INSURANCE:
If you have insurance, we will help you receive maximum benefits. Insurance is a contract between you and your insurance company. We are not a party to this contract. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary.

FINANCIAL:
You are responsible for the timely payment of your account. We expect payment in full or payment arrangements at the time of service. If your insurance company has not paid the full balance within 45 days, you have 15 days to pay the balance. When the insurance company makes payment on the submitted charge, you will be sent a notice of this payment. Any remaining balance will be due at that time. If making a credit card payment by mail or phone, I authorize Gershon Pain Specialists to process my payment using the credit card information provided. If the balance is not paid within 30 days, the account will be turned over to our collection agency for collection. All accounts turned over to our collection agency for collection will be responsible and billed for attorney fees (33.3%) and court cost.

APPOINTMENTS:
Our goal at Gershon Pain Specialists is to make sure that all patients are seen in a timely manner. Therefore any patient that fails to show up for their regularly scheduled office appointment time or give 24 hours advance notice for a cancellation or reschedule will be assessed a $25.00 fee. EMG and procedure appointments that fail to show or give 24 hours advance notice for a cancellation or reschedule will be assessed a $50.00 fee.

RETURNED CHECK POLICY:
In the event that a check is returned for insufficient funds, a $50.00 charge will be added to your account. If any balance is not paid in full within 3 business days, an additional $55.00 fee will be added, and we will forward your returned check to Harvey L. Bryant, Commonwealth Attorney – City of Virginia Beach, for prosecution.

COLLECTIONS:

I, _____, hereby authorize Gershon Pain Specialists to apply and receive benefits on my behalf for services rendered. I request that payment be made directly to Gershon Pain Specialists. I certify that the information provided herein regarding insurance coverage is current, true, and accurate, to the best of my knowledge. I further authorize the release of any necessary medical or other relevant information for this or any related claim to my insurance company(ies), including Workers' Compensation carriers who either have a pending or accepted case. I permit a copy of this authorization and assignment to be used in place of the original. This will remain in force and effect unless and until revoked by me in writing. I understand and agree that I am financially responsible for all charges whether or not billed to or paid by said insurance. I agree to assume responsibility for all charges incurred should collection of this balance become necessary, including court costs and attorneys' fees of 33.3%.

BLOOD TESTING:
If health care workers are accidently exposed to my blood or other bodily fluids in the course of providing health care to me, I agree to have my blood tested for any infectious diseases which might be transmitted to them through this exposure, including HIV/AIDS and hepatitis.

PRESCRIPTION MONITORING PROGRAM:
I understand that Gershon Pain Specialists utilizes the Prescription Monitoring Program.

URINE DRUG SCREENING:
Through technological advances in medicinal pain management, it is the policy of Gershon Pain Specialists to provide and mandate urine monitoring for all of our patients when prescribing scheduled medications. Periodic urine monitoring is a significant breakthrough technology that will assist your provider in determining your individual course of therapy. By monitoring quantitative drug levels, your treatment will be maximized by potentially eliminating drug-to-drug interactions, the possibility of unwanted side effects, and to assist your provider in proper titration of prescribed medications.

Policies (continued)

TREATMENT:
I hereby consent to treatment by the Gershon Pain Specialists and/or affiliated medical staff members on behalf of my minor child/children and myself. I accept responsibility for payment of fees for such medical services. I understand that treatment may include injections, manipulations, medication management, and/or other procedures as deemed necessary and appropriate.

RELEASE OF INFORMATION:
I hereby authorize the release of any and all medical and/or charge information as is necessary for third-party reimbursement from any governmental agency or insurance payer involved in the payment of my or my child's/children's treatment. I authorize the release of any and all medical information to any physician and/or hospital involved in my or my child's/children's care. I authorize the use of limited medical information for the purpose of improving healthcare operations and clinical care when such information is utilized within the law. I further authorize representatives of Gershon Pain Specialists to leave appointment and testing reminders on my answering machine.

ACKNOWLEDGEMENTS/CERTIFICATIONS:
I, Parent/Guardian/Patient, acknowledge that I was provided with Gershon Pain Specialists' Patients Rights & Responsibilities and given an opportunity to ask questions about the information provided. I have read and agree to the terms of the Patient Financial Policy. I certify that I understood the contents of this form. Furthermore, I permit a copy of this document to be used in place of the original. I acknowledge that I have read the Notice of Privacy Practices for Gershon Pain Specialists.

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE POLICIES.

_____ _____
Patient Signature (Parent or Guardian, if under 18) Date

_____ _____
Witness Date

Notice and Acknowledgement

I acknowledge that I have read the Notice of Privacy Practices (always available for review on request) for Gershon Pain Specialists.

_____ _____
Patient Signature or Personal Representative's Signature Date

*If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient: _____

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Authorization for Release of Information

Patient Name: _____
Last First M.

Social Security Number: _____Date of Birth: _____/_____/_____

I hereby authorize the disclosure of my individually identifiable health information as described below.

I understand that this information will be used by the providers of Gershon Pain Specialists to aid in my treatment plan and care.

I understand that I have the right to revoke this authorization in writing at any time.

Patient Signature: _____ Date: _____

Please do not write below line. Thank you.

For Internal Use Only:

Please forward the following circled requested information regarding the above patient to Gershon Pain Specialists at **(757) 689-4357** OR **(757) 963-0141**:

- Entire chart
- Most recent **3 (three)** office notes
- Diagnostic testing (x-ray, MRI, CT, labs, etc.)
- Procedure notes
- Medication list
- EMG testing

☐ Check box for **STAT REQUEST** (patient currently in the office)

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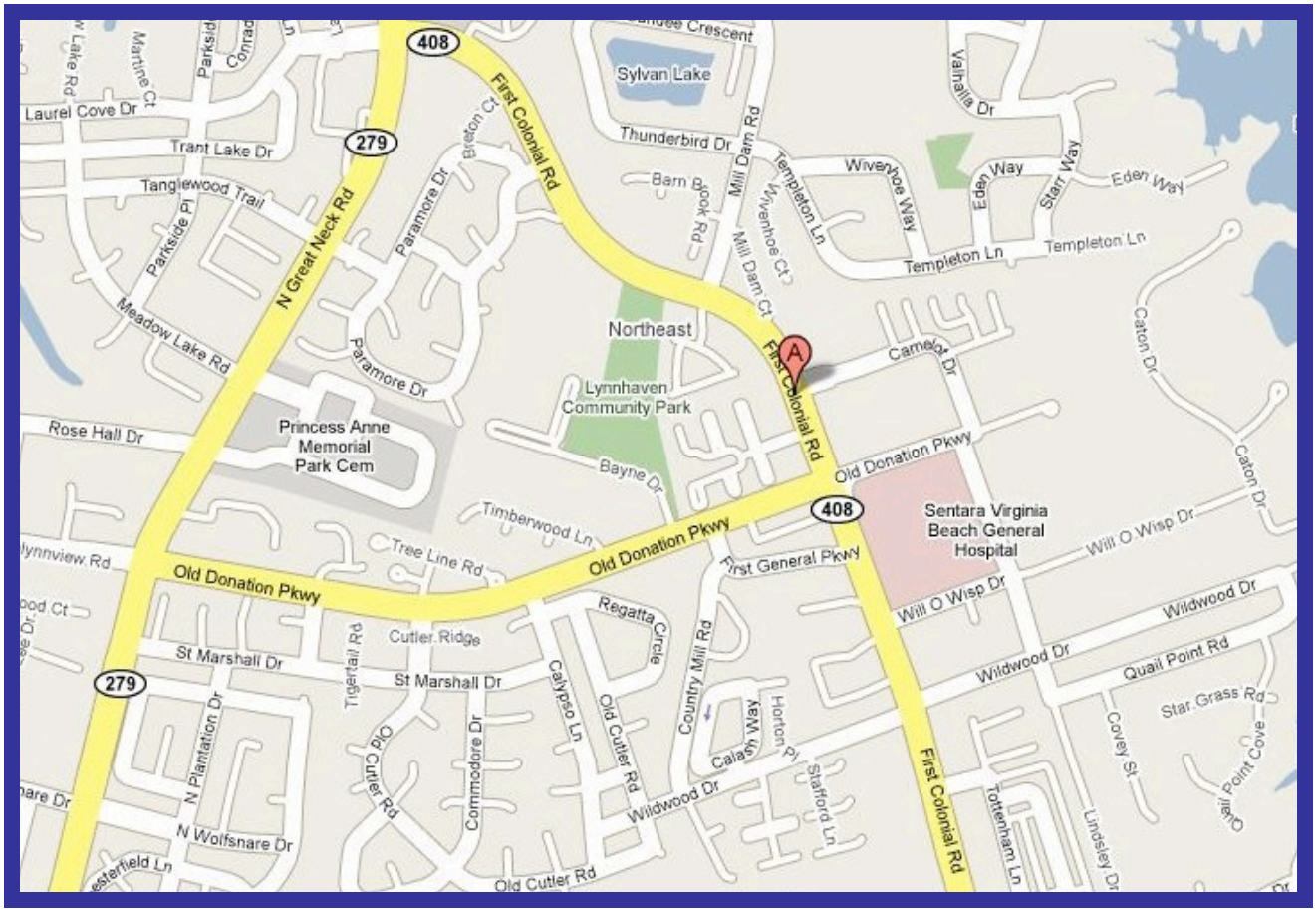

Gershon Pain Specialists is located at 1133 First Colonial Road.

From Interstate 264:

1. Take the First Colonial Road North Exit, 21B.
2. Continue on First Colonial Road past Sentara Virginia Beach General Hospital.
3. We are located in a 1-story L-shaped, brick building on the left side of the street, just past the light at Old Donation Parkway.
4. You will pass the building, then make a u-turn on First Colonial Road; turn into parking lot on right.

From Great Neck Road:

1. Turn onto First Colonial Road.
2. Go through the light at Mill Dam Road.
3. We are located in a 1-story L-shaped, brick building on the right side of the street, past Mill Dam Road.