Multi-Specialty Pain Management, PC

3713 East Tremont Avenue Lower Level Bronx, NY 10465
Tel. (718) 597-4878 Fax (718) 597-4877

Demographics

Name:_____ **DOB:**__/__/_____
Address: _____

_____
SSN: _____ - ____ - _____ **Gender:** ☐ M ☐ F **Marital Status:** ☐ S ☐ M ☐ D ☐ W
Primary Language: ☐ English ☐ Spanish ☐ Indian ☐ Russian ☐ Other ☐ Declined
Home #: _____ **Cell #:** _____ **Work #:** _____
Email: _____

Occupation:_____
Employer: _____ **Employer Address:**_____
Referring MD: _____ **Primary MD:** _____
Emergency Contact:_____ **Phone #:**_____
Relationship:_____

Pharmacy Name: _____ **Pharmacy Address:** _____
Pharmacy Phone: _____ **Pharmacy Fax:** _____
How did you hear about our office? _____

Private Insurance

Health Insurance: _____ **Effective Date:** __/__/_____
Health Ins. Address: _____
Member ID #: _____ **Group #:** _____
Policyholder's Name: _____ **Referral required: Y N**
Policyholder's DOB: __/__/_____ **SSN#:** _____ - ____ - _____ **Deductible $**_____
Co-Pay $_____ **Relation to Insured:** _____
Policyholder's Employer: _____

Health Insurance: _____ **Effective Date:** __/__/_____
Health Ins. Address: _____
Member ID #: _____ **Group #:** _____
Policyholder's Name: _____ **Referral required: Y N**
Policyholder's DOB: __/__/_____ **SSN#:** _____ - ____ - _____ **Deductible $**_____
Co-Pay $_____ **Relation to Insured:** _____
Policyholder's Employer: _____

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Patient: _____
Employer: _____
Claim/Group: _____
Social Security/ID number: _____

I hereby instruct and direct _____ Insurance Company to pay services rendered by the provider and have check made out and mailed to:

Multi Specialty Pain Management, PC
3713 East Tremont Avenue 2nd Floor
Bronx, New York 10465

OR

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to *make out the check to me and mailed* it as follows, or bring in the check and sign it over to:

Multi Specialty Pain Management, PC
3713 East Tremont Avenue 2nd Floor
Bronx, New York 10465

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above-mentioned assignee. A photocopy of this assignment shall be considered as effective and valid as the original, adjuster, or attorney involved in this case.

Dated at Multi-Specialty Pain Management, PC on _____.
(date)

_____ Signature of Policyholder

_____ Signature of Witness

Multi-Specialty Pain Management, PC
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Brian Haftel, MD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____,
(insert patient's name) Acknowledge receipt this day from MULTI-SPECIALTY PAIN MANAGEMENT, PC of a copy of the NOTICE OF PRIVACY PRACTICES of MULTI-SPECIALTY PAIN MANAGEMENT, PC.

DATE: _____ _____
(Patient's Signature)

Received By:

_____
(Print Name Of Staff Member)

_____
(Signature of Staff Member)

Multi-Specialty Pain Management, PC

3713 East Tremont Avenue Lower Level Bronx, NY 10465
Tel. (718) 597-4878 Fax (718) 597-4877

Name: _____
Account: _____

Notification Policy:

It is our policy not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. When returning calls and an answering machine picks up, we do not leave a message unless it is an appointment reminder. Information also will not be left with an authorized person who may answer the phone.

If you would like to have information released to someone other than yourself, please complete the following:

I authorize the staff of Multi Specialty Pain Management to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information chanes:

____ Yes ____ No **Home Telephone:**_____

____ Yes ____ No **Home Answering Machine:**_____

____ Yes ____ No **Home Fax:** _____

____ Yes ____ No **Work Telephone:**_____

____ Yes ____ No **Work Fax:**_____

____ Yes ____ No **Cell Phone and Voice Mail:**_____

____ Yes ____ No **Pager** :_____

Please list names of authorized people we may leave message with (i.e. spouse, boyfriend, girlfriend, parent, grandparent, etc).

_____ Yes ____ No ___
Name relationship

_____ Yes ____ No ___
Name relationship

_____ Yes ____ No ___
Name relationship

_____ Yes ____ No ___
Name relationship

Who may we discuss your financial situation with:

_____ Yes ____ No ___
Name relationship

_____ Yes ____ No ___
Name relationship

Signature: _____ **Date:** _____

MULTI-SPECIALTY PAIN MANAGEMENT
DOCTOR'S LIEN

TO: Attorney/Insurance Carrier

_____
_____
_____

RE: Patient records and Doctor's lien

I do hereby authorize the above doctor's office to furnish you, my attorney/insurance carrier, with a full report of his case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident/illness, which occurred/began on

_____

I hereby give a lien to said doctor on any settlement, claim, judgment, or verdict as a result of said accident/illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to said doctor such sums as may be due and owing him for service rendered me, and to withhold such sums from such settlement, claim, judgment, or verdict as may he necessary to protect said doctor adequately.
OUTSTANDING AMOUNT TO DATE: $_____

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered me, and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.
I fully understand that I am responsible to notify the above doctor's office if I change attorneys or if my case is dropped. My attorney also is to notify the above doctor's office if the patient changes attorneys or if the patient's case is dropped.

DATED: _____ **Patient's signature**: _____

The undersigned, being attorney of record or authorized representative of insurance Carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately said above named doctor.

DATED: _____ **Attorney Signature:** _____

NOTICE: Please date, sign, and return one copy to doctor's office at once.

MULTI-SPECIALTY PAIN MANAGEMENT, P.C.

BRIAN S. HAFTEL M.D., DIRECTOR

INFORMATION SHEET AND INFORMED CONSENT

At Multi-Specialty pain management P.C. we firmly believe that "every human being has the right to determine what shall be done with his own body". During the course of your treatment and evaluation here, you may be subjected to a number of different types of tests and treatments. It is our responsibility to explain the nature and purpose of these as well as known risks, benefits and alternatives. Listed below is a summary.

MRI (magnetic resonance imaging) is an imaging technique that uses electromagnetic forces, not potentially harmful radiation. It is generally safe but should not be performed in individuals who have a *pacemaker* or *metal* in their body from a previous surgery or injury. MRI WITH CONTRAST is performed with intravenous administration of a contrast agent. Allergic reaction or mild side effects are possible. If you have any *known allergies*, please inform your doctor of them. *Claustrophobic* individuals should discuss the possibility of sedation or other alternatives to MRI with the doctor prior to scheduling this test.

PHYSICAL THERAPY is a treatment program that is individually designed to relieve pain, rehabilitate injured tissue, and restore functional ability. Various modalities may be utilized including massage, electrical stimulation, ultrasound, traction, etc. The physical therapist will further explain the treatment plan to you. Physical therapy may result in increased soreness and discomfort initially since injured tissue is being rehabilitated. This should improve as the healing process occurs. If you are experiencing significant or ongoing pain, please bring this to the attention of your therapist and doctor.

SSEP (somatosensory evoked potential) is an electrodiagnostic test that measures the conduction of impulses from the arms and/or legs, through the spinal cord, to the brain. It requires a small electrical current but is not painful. NCV (nerve conduction velocity) is an electrodiagnostic test that measures the conduction of impulses in the peripheral nerves of the arms and/or legs. It requires a slightly stronger electrical impulse than the SSEP but both the NCV and SSEP are generally safe and well tolerated.

BAER (brainstem auditory evoked response) is an electrodiagnostic test that evaluates the auditory and vestibular system. It is performed by delivering a series of "clicks" in each ear. VER (visual evoked response) is an electrodiagnostic test that evaluates the visual system. It is performed by delivering a series of light flashes. EEG (electroencephalogram) is an electrodiagnostic test that records the brain's electrical activity. The machine delivers no electrical current. This test can be performed either with paste or small needle electrodes.

EMG (electromyography) is an electrodiagnostic test which detects muscle and nerve damage. It requires placement of a thin needle in various muscles. In general, it is a safe and well-tolerated procedure although there is a small risk of bleeding, infection, and damage to adjacent structures. If you have a *bleeding disorder* or take *anticoagulants like coumadin*, please bring this to the attention of the doctor.

MEDICATIONS may be prescribed. All drugs have potential side effects and interactions. Your doctor will discuss these with you when and if medications are prescribed.

INJECTION THERAPY consists of administration of local anesthetics (such as lidocaine) and/or steroids (such as cortisone). These medications are injected into the appropriate location (such as a joint, trigger point, nerve, or epidural space) to relieve pain and inflammation and promote healing. In general, these procedures are safe and well tolerated although associated risks include but are not limited to bleeding, infection, and damage to adjacent structures. There is a risk of headaches associated with the epidural injection. Furthermore, potential side effects of local anesthetics include but are not limited to dizziness, drowsiness, allergic reaction, low blood pressure, and slow heart rate. Potential side effects of steroids include but are not limited to fluid retention, ulcers, and increased blood sugar. These side effects usually occur with long-term administration or over-dosage. Injection therapy is effective since the medication is delivered directly to the injured tissue, lower doses are required, and there are fewer, if any, side effects.

I hereby authorize Dr. Haftel and his associates to provide such medical care and to administer such treatment as deemed necessary advisable to me each time that I am present in the office. Such medical care and treatments may include but are not limited to administration and/or injection of pharmaceutical agents and medications. To the extent possible, I have been informed of risks and complications that may occur and alternatives that may be available.

Print name _____

Sign name X _____

_____

Brian S. Haftel, MD

MULTI-SPECIALTY PAIN MANAGEMENT P.C.

3713 East Tremont Avenue, Bronx, NY 10465
Telephone: 718-597-4877 Facsimile: 718-824-8026, 718-597-4877

AGREEMENT OF RELEASE AND WAIVER OF LIABILITY

I, _____, hereby agree to and initial the following:

1. That I am participating in a one on one exercise program offered by **MULTI-SPECIALTY PAIN MANAGEMENT P.C.**. (hereafter referred to as **MSPM**) during which I will receive information about health and fitness. I recognize that fitness programs require physical exertion which may be strenuous and may cause physical injury. I am fully aware of the risks and hazards with the access of the gym while performing the exercises and I am aware of the risk with ultrasound, bike equipments, electric stimulation, hot packs, cold packs, paraffin wax and any physical therapy equipments used for performing my treatment. ____ (initial)

2. I understand that it is my responsibility to consult with a physician prior to and regarding my participation in the one on one exercise program. I represent and warrant that I am physically fit and I have no medical condition which would prevent my full participation in the one on one exercise program. ____ (initial)

3. In consideration of being permitted to participate in the one on one exercise program, I agree to assume full responsibility for any risks, injuries, or damages, known or unknown, which I might incur as a result of participating in the program. If, however, I observe any unusual significant hazard during my participation, I will remove myself from participation and bring such to the attention of management. ____ (initial)

4. In further consideration of being permitted to participate in the one on one exercise program, I knowingly, voluntarily, and expressly waive any claim I may have against **MSPM** or _____ or any therapist, for injury or damages that I may sustain as a result of participating in the program. ____ (initial)

5. I, my heirs or legal representatives forever release, waive, discharge and convent not to sue **MSPM** or _____ or any therapist, for injury or death caused by their negligence or other acts. ____ (initial)

6. I,_____ understands that if I am being treated by MULTI-SPECIALTY PAIN MANAGMENT outpatient physical therapy, I will inform the therapist and the administration if I have already used or has a remaining therapy visits from my insurance. _____(initial)

7. **I also realize that I will be responsible for any payments MULTI-SPECIALTY PAIN MANAGMENT that I have not previously informed "Multi-Specialty Pain Management" of.** ____ (initial)
I have read the above release and waiver of liability and fully understand its contents. I voluntarily agree to the terms and conditions stated above. ____ (initial)

_____ Date ___/____/_____
PATIENT SIGNATURE

If participant is under 18:
AS LEGAL GUARDIAN OF (PRINT) _____, I CONSENT TO THE ABOVE TERMS AND CONDITIONS.

_____ Date ___/____/_____
PARENT OR GUARDIAN SIGNATURE

Multi-Specialty Pain Management P.C.
3612 East Tremont Avenue
Bronx, New York 10465

General Release

I understand that Multi-Specialty Pain Management, P.C., is a medical practice that has contracted with a third party to provide complimentary transportation for patients who, due to a lack of transportation, would otherwise be unable to receive medically necessary care.

In exchange for such transportation, I, on behalf of myself, my heirs, executors, administrators and assigns, do hereby:

(1) Assume full responsibility for utilizing the transportation services provided by any such third party.

(2) Forever release, discharge, indemnify, defend and hold harmless Multi-Specialty Pain Management, P.C., its successors and assigns, employees, officers, directors and agents and each of their heirs, executors and administrators, from any and all claims, demands, liability, fees, and costs of any kind whatsoever, including attorneys' fees, in law or in equity, that I may have or claim to have on account of or in any way related to, any and all personal injury, property damage or any other claims of whatever nature and however incurred arising from the actual transportation to and from Multi-Specialty Pain Management, P.C., the proposed transportation, the cancellation or delay of the transportation, and/or the failure to provide initial or return transportation.

(3) Acknowledge my understanding that Multi-Specialty Pain Management, P.C. is not responsible for any personal property left in any transport vehicle.

I understand that upon request to Multi-Specialty Pain Management, P.C. I may be given the direct contact information for any third party providing such transportation.

This General Release may only be changed in writing.

Dated: _____

_____
Patient Name

_____
Signature (Signature of Parent/Legal Guardian, if applicable)

_____
Name of Parent/Legal Guardian, if applicable