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?
_____

Motor Vehicle No-Fault Insurance

Date of Accident: ____/____/_____

<u>Is your visit related to a slip and fall or lien case if yes skip down to attorney information</u>

Motor Vehicle Insurance Name: _____
Motor Vehicle Insurance Address: _____

Policy#:_____ **Claim#:**_____

Adjuster/Case Mgr Name: _____
Phone #: _____ **Ext.**_____

Body part(s) injured established: _____

Attorney Name: _____
Address: _____
Phone #: _____ **Fax#:**_____

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____, ("Assignor") hereby assign to MULTI-SECIALTY PAIN MANAGEMENT, PC, "(Assignee")
(Print patient's name) (Print hospital or health care provider name)
all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____, not withstanding any other agreement to the contrary.
(Print accident date)

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO,AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICTS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____ _____
(Print name of Patient) **(Signature of Patient)**

_____ _____
(Date of signature)

_____
(Address of Patient)

_____ _____
(Print name of Provider) **(Signature of Provider)**

MULTI-SPECIALTY PAIN MANAGEMENT,PC _____
(Date of signature)

3713 EAST TREMONT AVENUE

BRONX, NEW YORK 10465

_____
(Address of Provider)

NYS FORM NF-AOB (Rev 1/2004)

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

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:** _____

NEW YORK MOTOR VEHICLE NO-FAUL T INSURANCE LAW
APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS

ADJUSTER NAME: ***TELEPHONE:***

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER NEW YORK NO-FAULT LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

IMPORTANT
1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST ALSO SIGN ANY ATTACHED AUTHORIZATIONS.
3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

YOUR NAME: ***YOUR ADDRESS:***

1. YOUR NAME	1. PHONE NOS. HOME	BUSINESS
3. YOUR ADDRESS (NO., STREET, CITY OR TOWN, STATE, AND ZIP CODE)	4. DATE OF BIRTH	5. SOCIAL SECURITY NO.
6. DATE AND TIME OF ACCIDENT A.M. P.M.	7. PLACE OF ACCIDENT (STREET) CITY OR TOWN, AND STATE	

8. BRIEF DESCRIPTION OF ACCIDENT

9. DESCRIBE YOUR INJURY

10. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF THE ACCIDENT:

OWNER'S NAME MAKE YEAR

THIS VEHICLE WAS ☐ A BUS OR SCHOOL BUS ☐ A TRUCK ☐ AN AUTOMOBILE, ☐ OR A MOTORCYCLE

	YES	NO
11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE?	☐	☐
WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	☐	☐
WERE YOU A PEDESTRIAN?	☐	☐
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD?	☐	☐
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE?	☐	☐

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE TWO

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES?
YES ☐ NO ☐

IF YES, NAME AND ADDRESS OF SUCH DOCTOR(S) OR PERSONS:

13. IF YOUR WERE TREATED AT A HOSPITAL(S), WERE YOU AN

OUT-PATIENT? ☐ IN-PATIENT? ☐

DATE OF ADMISSION: _____

HOSPITAL'S NAME AND ADDRESS: _____

14. AMOUNT OF HEALTH BILLS TO DATE:	15. WILL YOU HAVE MORE HEALTH TREATMENT(S)? YES ☐ NO ☐	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES ☐ NO ☐
$ _____		

17. DID YOU LOSE TIME FROM WORK? YES ☐ NO ☐	DATE ABSENCE FROM WORK BEGAN:	HAVE YOU RETURNED TO WORK? YES ☐ NO ☐

IF YES, DATE RETURNED TO WORK: _____ AMOUNT OF TIME LOST FROM WORK: _____

18. WHAT ARE YOUR GROSS AVERAGE WEEKLY EARNINGS?	NUMBER OF DAYS YOU WORK PER WEEK:	NUMBER OF HOURS YOU WORK PER DAY:

19. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT?
YES ☐ NO ☐

20. LIST NAMES AND ADDRESSES OF YOUR EMPLOYER ANDOTHER EMPLOYERS FOR ONEYEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

21. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?
YES ☐ NO ☐

IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.

22. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY OF THE FOLLOWING:

	YES	NO
NEW YORK STATE DISABILITY?	☐	☐
WORKERS' COMPENSATION?	☐	☐

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE THREE

THE APPLICANT AUTHORIZES THE INSURER TO SUBMIT ANY AND ALL OF THESE FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY PROVIDED FOR UNDER THE NO-FAULT LAW.

THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE APPLICANT AS TRUE UNDER THE PENALTIES OF PERJURY.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

SIGNATURE _____ DATE _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF WORK AND OTHER LOSS INFORMATION

THIS AUTHORIZATION, OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES, SALARY, OR OTHER LOSS WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____ SOCIAL SECURITY NO. _____

SIGNATURE _____ DATE _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

THIS AUTHORIZATION, OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT INCLUDING THE HISTORY OBTAINED, X-RAYS AND PHYSICAL FINDINGS, DIAGNOSIS, AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____

SIGNATURE* _____ DATE _____

(IF THE APPLICANT IS A MINOR, PARENT OR GUARDIAN SHALL SIGN AND INDICATE CAPACITY AND RELATIONSHIP).

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

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

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 or 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