



Toll Free: (888) 985 - 2727 · Fax: (609) 567 - 8832

## Our Commitment to You

- We will provide you with the most appropriate care in the most time efficient fashion.
- We will treat you with respect and professionalism.
- We will always do our best to keep your scheduled appointment and to minimize any wait time you may incur; however, due to circumstances beyond our control, there may be times that we must re-schedule your appointment with short notice.
- In order to give you as much notice as possible we request a phone contact so that we can reach you in person during the day, such as a business number or cell phone.
- We will do our best to move your appointment to an earlier time or date if we have a cancellation in our office schedule.

If you have any questions regarding this information, please do not hesitate to ask us. We are here to help you.

## General Information

- Our office hours are very limited. It is very important that you keep your appointment.
- If you have an emergency and cannot keep your appointment, you must contact our office **no later than 48 hours** prior to your scheduled appointment date.
- We may charge a **NO SHOW FEE** if your appointment is not kept or cancelled 48 hours prior to your scheduled time.
- In order to treat you effectively and efficiently and within HIPAA guidelines, we require a Registration Form and several other forms be completed by you.
- We are sorry, but due to high fax volume, we are NOT able to accept any of the following documents via fax. Without the completed documents, films, tests, and referral, if appropriate, you will NOT be seen by the doctor and your appointment will be RESCHEDULED.
  1. Referral; if required by the insurance
  2. Active valid insurance card
  3. Case number or Claim number for Auto insurance or Worker's Comp
  4. Photo ID
  5. MRI films & Reports, CT Scan films & Reports, Bone scan reports
  6. EMG reports
  7. Primary doctor's notes, other specialists' notes (Orthopedic surgeon, neurologist, psychiatrist, rheumatologist, etc.)
  8. List of current medications
  9. Auto Insurance policy Declaration Page (PIP Coverage)

## Medication Policy

- It is important to your health that you follow the directions carefully on all medications that we prescribe.
- In addition, we must be informed of all other medications, prescription and over-the-counter.
- We WILL **NOT** refill controlled medications in advance of their refill date.
- We WILL **NOT** mail prescriptions.
- We WILL **NOT** prescribe any opioid (narcotic) medications at the first visit.
- They must be given **IN PERSON** to you at the time of your appointment.
- If there is an unavoidable reason that you cannot make an appointment, we require a 3-day notice for a medication refill.

## Financial Policy

- We are committed to providing you with the best possible care.
- We expect that you have an understanding of your responsibilities under your insurance contract in respect to referral and pre-authorization requirements, and your deductible, co-pay, and coverage limits.

- In order to achieve your maximum allowable benefits, we need your assistance and your understanding of our payment policy.
- Payment is due in full at time of service, unless you have made payment arrangements in advance with our business office.
- If you have insurance coverage with one of the plans we participate with, we will bill your insurance company along the guidelines of our contract; however, we require that **ALL COPAYS OR DEDUCTIBLES be paid at the time of service.**
- If you have an insurance with which we do not participate, we ask that payment be made at the time services are rendered and your insurance company will reimburse any amount due to you directly.
- Returned checks will be subject to **an additional \$35.00 service fee.**
- We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Please realize; however, that your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
- While filing of insurance claims is a courtesy we extend to our patients, all charges are the responsibility of the patient from the date the services are rendered.
- You will be required to show a copy of your insurance card at the time of service.
- If you do not have your insurance information or we are unable to verify your coverage, you will be required to pay for the services rendered to you that day.
- If your insurance coverage terminates or changes, you are responsible for notifying us of this change immediately so that we can assist you in receiving your maximum reimbursement.

**Missed Appointments**

- Please help us serve you better by keeping scheduled appointments.
- **Unless cancelled at least 48 hours in advance,** our policy is to charge a **NO SHOW FEE** for missed office appointments.
- **Missed appointments for procedures performed at surgery centers will incur a fee of \$100. This includes not following instructions; stopping of medications, food/drink restrictions and having a driver.**

**I HAVE READ the Financial Policy. I UNDERSTAND and AGREE to this Financial Policy. I GUARANTEE payment of all charges incurred for the account. I hereby assign benefits to RELIEVUS for all claims submitted to my insurance on my behalf. I further agree to pay any attorney’s fee, court cost and related collection fees incurred.**

Patient Print Name	Patient Signature	Date
Responsible Party Print Name (if not patient)	Responsible Party Signature (if not patient)	Date



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### Important Note Regarding After Hours/Weekend Services

**Relievus** provides care for chronic problems. As such, our patients are not expected to require urgent care or immediate contact with this practice after hours. If you have an urgent medical problem after regular business hours (8AM to 5PM Monday through Friday) or over the weekend, please do one of the following:

- Contact your primary care physician
- Go to an urgent care center
- Go to the emergency department of the nearest hospital

It is permissible that you obtain medications from these physicians for any acute pain or new injury that you have.

It is your responsibility to contact us within the next two business days to inform us of any changes, additions, or deletions made to your narcotic regimen. All non-narcotic changes should be reported at your next office visit.

Thank you in advance.

By signing below, you agree that you have read the above notice regarding after hours/weekend services and that you understand your responsibilities.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



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### Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Sex:  M  F

If patient is a minor, name of parent or guardian accompanying patient: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Phone # (if different): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ 2<sup>nd</sup> Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_  Married  Single  Divorced  Widowed

Referred by: \_\_\_\_\_ Phone: \_\_\_\_\_ Location: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_ Location: \_\_\_\_\_

### INSURANCE

**Date of Accident (if applicable):** \_\_\_\_\_ **Type of Accident:** \_\_\_\_\_

Please briefly describe the accident. If necessary, you may use the back of this page. Please also note whether you were in the course of employment at this time: \_\_\_\_\_

**Primary Insurance Name:** \_\_\_\_\_  Auto  Health  Workers Comp

Phone #: \_\_\_\_\_ Adjuster: \_\_\_\_\_ Ext: \_\_\_\_\_

Claim or ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Relationship: \_\_\_\_\_

Subscriber Date of Birth: \_\_\_\_\_ Subscriber SS #: \_\_\_\_\_

**Secondary Insurance Name:** \_\_\_\_\_  Auto  Health  Workers Comp

Phone #: \_\_\_\_\_ Adjuster: \_\_\_\_\_ Ext: \_\_\_\_\_

Claim or ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Relationship: \_\_\_\_\_

Subscriber Date of Birth: \_\_\_\_\_ Subscriber SS #: \_\_\_\_\_

**Tertiary Insurance Name:** \_\_\_\_\_  Auto  Health  Workers Comp

Phone #: \_\_\_\_\_ Adjuster: \_\_\_\_\_ Ext: \_\_\_\_\_

Claim or ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Relationship: \_\_\_\_\_

Subscriber Date of Birth: \_\_\_\_\_ Subscriber SS #: \_\_\_\_\_

**Attorney Name:** \_\_\_\_\_ Firm: \_\_\_\_\_

Location: \_\_\_\_\_ Phone: \_\_\_\_\_

**Employer Name:** \_\_\_\_\_ Phone: \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Are we authorized to release your medical information to the listed Emergency Contact?**  Yes  No

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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### Accident & Injury Questionnaire

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Right hand dominant     Left hand dominant    Sex:  Male  Female

#### Describe your accident

Date of Accident: \_\_\_\_\_

#### Type of Accident:

Front/Head-on Collision     Rear-ended     "T-boned" – Driver Side     "T-boned" – passenger side

You were a driver     You were a front passenger     You were a back-seat passenger     Other \_\_\_\_\_

Loss of Consciousness?  Yes  No  Brief Moment  Unknown

Was the airbag deployed?  Yes  No                      Did you wear a seatbelt?  Yes  No

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**Impacted** Body Parts at the **TIME OF ACCIDENT:**  Head  Face  Neck  Midback  Lower Back

**Arm** ( RT  LT  Both)                      **Leg** ( RT  LT  Both)                      **Shoulder** ( RT  LT  Both)

**Knee** ( RT  LT  Both)                      **Hip** ( RT  LT  Both)

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**Immediately** started to experience pain on:  Head  Face  Neck  Midback  Lower Back

**Arm** ( RT  LT  Both)                      **Leg** ( RT  LT  Both)                      **Shoulder** ( RT  LT  Both)

**Knee** ( RT  LT  Both)                      **Hip** ( RT  LT  Both)

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Did you go to the Hospital?  Yes  No    If Yes, Hospital: \_\_\_\_\_

If Yes, who brought you?     Friend     Family Member     Spouse     Ambulance

When?     Immediately after accident     Later that day     The next day     Few days later     Few weeks later

X-Ray:     Yes  No    Hospitalization?     Yes  No    Released from ER same Day?     Yes  No

Released with Meds?     Yes  No

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Have you had treatments since the accident with any of the following?

Physical Therapist: \_\_\_\_\_                       Chiropractor: \_\_\_\_\_

Trigger Point Injections: \_\_\_\_\_                       PENS: \_\_\_\_\_

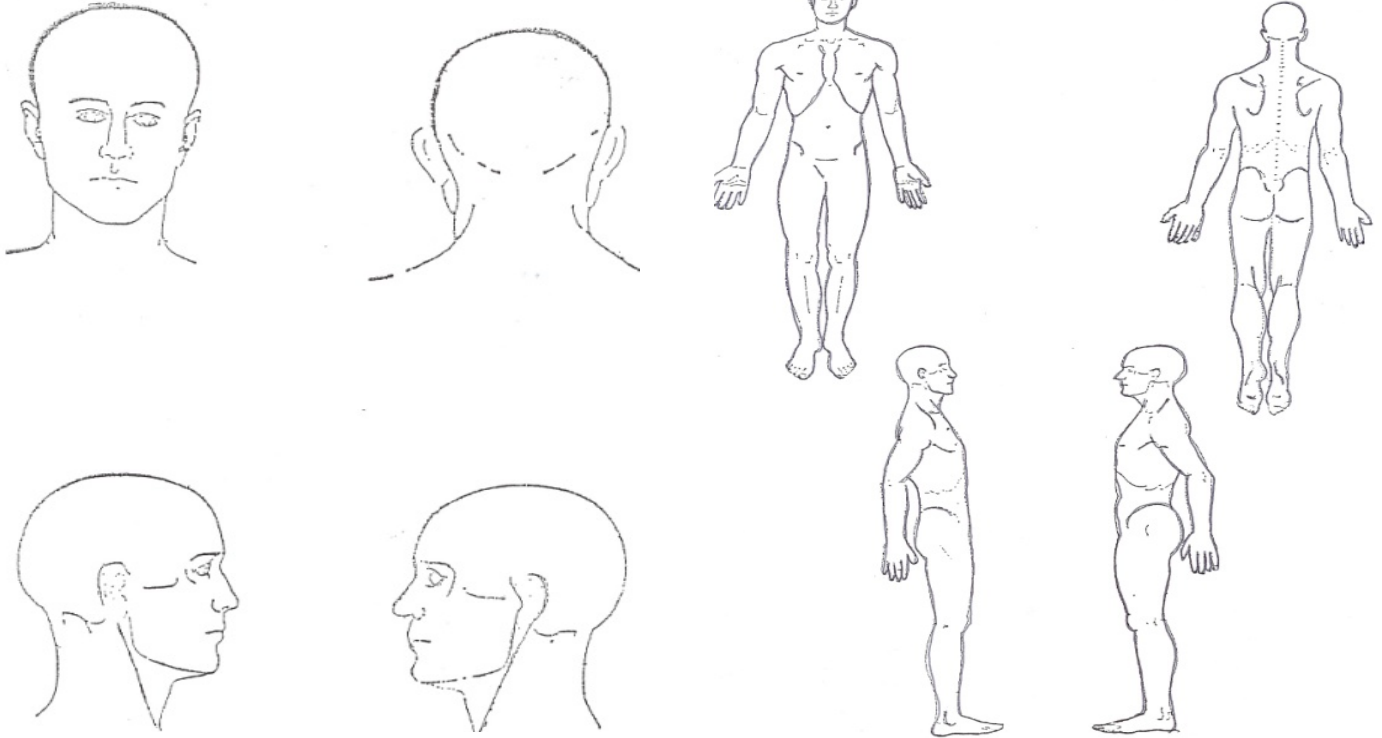
Acupuncture: \_\_\_\_\_                       Joint Injections: \_\_\_\_\_

Neurologist: \_\_\_\_\_                       Orthopedic Surgeon: \_\_\_\_\_

Surgery: \_\_\_\_\_

Meds (Muscle Relaxants, NSAIDS, Tylenol, Paid Meds): \_\_\_\_\_

**Current Pain? Please circle areas of current pain**



**Circle Pain Level**

- NECK: Pain Level (0 ~ 10)    0   1   2   3   4   5   6   7   8   9   10
- MIDBACK: Pain Level (0 ~ 10)    0   1   2   3   4   5   6   7   8   9   10
- LOWER BACK: Pain Level (0 ~ 10)    0   1   2   3   4   5   6   7   8   9   10
- HEADACHE: Pain Level (0 ~ 10)    0   1   2   3   4   5   6   7   8   9   10
- Other Location: \_\_\_\_\_    0   1   2   3   4   5   6   7   8   9   10
- Other Location: \_\_\_\_\_    0   1   2   3   4   5   6   7   8   9   10
- Location: \_\_\_\_\_

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- Does the pain radiate anywhere? (“shooting down the left or right arm” or “shooting up to the head”):

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- When did the pain start? \_\_\_\_\_

- Describe your pain:  Dull  Aching  Sharp  Shooting  Stabbing  Throbbing  Numbness  Burning
- How often is your pain present?  Occasionally     Frequently     Constantly
- Worst time of the day?  Morning     Afternoon     Evening     Night     All the time

- Any color change or temperature change? \_\_\_\_\_
- Numbness anywhere? \_\_\_\_\_
- "Pins and needles" or tingling sensation anywhere? \_\_\_\_\_
- Weakness? (Right leg, right arm, both legs...) \_\_\_\_\_
- Swelling? \_\_\_\_\_
- What makes symptoms worse/exacerbate? \_\_\_\_\_
- Walking  Standing  Lying Down  Sitting  Bending Forward  Bending Backward  Driving
- Coughing  Bowel Movement  Cold Weather  Hot Weather  Rainy Day  Lifting Objects
- What makes symptoms better? \_\_\_\_\_
- Resting  Massage  Exercise  Sitting  Lying Down  TENS Unit  Physical Therapy  Chiropractic
- Injections  Sleeping  Medications (Names): \_\_\_\_\_  Other: \_\_\_\_\_
- Sleeping:  Well  "OK"  Terrible Sleeping How long?  2 hrs  4 hrs  6 hrs  8 hrs  >10 hrs
- How often do you wake up due to pain?  0  1  2  3  4  >5 times
- Physical Therapy Location: \_\_\_\_\_ Date of Last Appt: \_\_\_\_\_ Duration: \_\_\_\_\_
- Chiropractic Treatment Location: \_\_\_\_\_ Date of Last Appt: \_\_\_\_\_ Duration: \_\_\_\_\_
- TENS Unit:  Never Used  I have a Unit  Used at home daily  Used at home as needed  Used during PT

**Previous "Injections" Treatments**

<input type="checkbox"/> Epidural	_____	_____	_____
	<b>Date</b>	<b>Number of Injection(s)</b>	<b>Doctor's Name</b>
<input type="checkbox"/> Facet	_____	_____	_____
	<b>Date</b>	<b>Number of Injection(s)</b>	<b>Doctor's Name</b>
<input type="checkbox"/> Trigger Point	_____	_____	_____
	<b>Date</b>	<b>Number of Injection(s)</b>	<b>Doctor's Name</b>
<input type="checkbox"/> PENS	_____	_____	_____
	<b>Date</b>	<b>Number of Injection(s)</b>	<b>Doctor's Name</b>
<input type="checkbox"/> Acupuncture	_____	_____	_____
	<b>Date</b>	<b>Number of Injection(s)</b>	<b>Doctor's Name</b>
<input type="checkbox"/> Joints	_____	_____	_____
	<b>Date</b>	<b>Number of Injection(s)</b>	<b>Doctor's Name</b>
<input type="checkbox"/> Other	_____	_____	_____
	<b>Date</b>	<b>Number of Injection(s)</b>	<b>Doctor's Name</b>

**Previous Injury/Accident History**

Did you have an MVA or work-related injury prior to this accident?  Yes  No

If Yes,

- What kind of injury / accident? \_\_\_\_\_
- When? \_\_\_\_\_
- Symptoms? \_\_\_\_\_

**Previous Injury/Accident History (Continued from Previous Page)**

- Treatments? \_\_\_\_\_

- Last Treatment (ex. 2 years prior to this accident) \_\_\_\_\_

**Review of System**

- General:**             Weight loss  Weight Gain  Fever  Fatigue  Loss of Appetite  Nausea  Vomiting
- Skin:**                 Skin Problem  Rash  Psoriasis  Slow healing  Easy bruising  Itching
- Neuro:**               Lightheaded/dizziness  Fainting  Weakness  Stroke  Tremor  Seizure  Memory Loss
- Eyes:**                 Vision Problem  Glaucoma  Blurred Vision  Double Vision
- ENT:**                  Ear pain  Hearing loss  Ear noises  Nose bleed  Sore throat  Hoarseness  Dental Problems
- Cardiovascular:**    Chest pain  Chest Pressure  Shortness of breath  Irregular heart beat  Murmurs
- Respiratory:**         Coughing  Difficulty breathing  Asthma/Wheezing  Coughing up blood
- Gastrointestinal:**    Constipation  Diarrhea  Heartburn  Bloody stool  Pain in stomach  Ulcers  Hepatitis
- Genitourinary:**      Painful urination  Frequent Urination  Bloody Urine  Kidney stone  Incontinence  Loss of libido  
 Sexual difficulty  Infection
- Endocrine:**          Hypothyroidism  Hyperthyroidism  Diabetes  Parathyroid problems
- Hematology:**         Anemia  Bleeding disorder  Easy bleeding  Lymphoma/Leukemia  Sickle cell disease
- Immunologic:**       Catch cold easily  HIV/AIDS  Fever  Hay Fever  Frequent Sinus Problems  Allergies
- Musculoskeletal:**    Arthritis  Rheumatoid Arthritis  Osteoarthritis  Compression Fracture  Head Injury  Neck Injury  
 Lower back injury  Spina trauma  Birth trauma  Birth defect  Lupus  Spina bifida  Gout  
 Osteoporosis  Muscular Dystrophy  Muscle pain  Scoliosis
- \*Women Only:**       Irregular periods  Premenstrual depression  Hot flashes  Menstrual Cramps  Vaginal discharge  
 Hysterectomy  Breast surgery  Nipple discharge  Breast lumps  Last mammogram \_\_\_\_\_
- \*Men Only:**          Burning on urination  Dripping after urination  Prostate problems  Difficulty starting urination
- Psychiatric:**         Depression  Anxiety  Panic attacks  OCD  Manic  Bipolar  Suicidal attempts  
 Suicidal ideation  Homicidal  Hallucination  Psychosis  Other: \_\_\_\_\_

**Past Medical History**

- Heart:**                 Coronary artery disease  Hypertension  Murmurs  Valvular disease  Aneurysm  
 High Cholesterol
- Lungs:**               Asthma  COPD  Emphysema  Bronchitis  TB  Pneumonia  Lung Cancer  
 Other: \_\_\_\_\_
- Gastrointestinal:**    Ulcer  Reflux  Gastritis  Hepatitis  Cancer  Bleeding  Diverticulosis  Other: \_\_\_\_\_
- Kidney:**              Failure  Stones  Dialysis (When): \_\_\_\_\_  Other: \_\_\_\_\_
- Endocrine:**          Diabetes  Hypothyroidism  Hyperthyroidism  Other: \_\_\_\_\_
- Neuro:**                 Stroke  Aneurysm  Brain cancer  Nerve injury  Spinal cord injury  Alzheimer's  Dementia  
 Seizures  Parkinson's  Other: \_\_\_\_\_
- Psychiatric:**         Depression  Bipolar  Anxiety  Panic disorder  Psychosis  Schizophrenia  Other: \_\_\_\_\_
- Bone/Muscular:**     Arthritis  Rheumatoid arthritis  Osteoarthritis  Gout  Osteoporosis  Scoliosis
- Cancer:**             \_\_\_\_\_
- Other:**                \_\_\_\_\_

**Past Surgery History**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**Allergies**

Latex:  Yes  No Reaction: \_\_\_\_\_ Contrast (Dye):  Yes  No Reaction: \_\_\_\_\_

Allergies to any medication(s)  Yes, please list below  Not that I know of

\_\_\_\_\_  
\_\_\_\_\_

**Current Medications** (Please list current medications)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Significant Family History** (Cancer, hypertension, diabetes, depression, back pain...)

Father's side: \_\_\_\_\_

Mother's side: \_\_\_\_\_

Siblings: \_\_\_\_\_

**Social History**

**Tobacco:**  Never  Quit in \_\_\_\_\_  Currently \_\_\_\_\_ pack per day

**Alcohol:**  Never  Rarely  Moderate  Daily \_\_\_\_\_

**Use of drugs:**  Never  Occasionally  Frequently, Type/frequency: \_\_\_\_\_

**Marital status:**  Single  Married  Separated  Divorced  Widowed

**Family Status:** Living with: \_\_\_\_\_

**Occupation:** \_\_\_\_\_

**Disability:**  Yes  No If yes, please list reason/type: \_\_\_\_\_

This form was completed by: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_



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## Opioid (Narcotic) Treatment Agreement

I understand that in order to receive care for the treatment of pain in Relievus, I **MUST** comply with the following rules:

1. I **UNDERSTAND** that narcotic and controlled drug prescriptions are **MY RESPONSIBILITY** once they are placed in my hand. I **UNDERSTAND** that if anything happens to this prescription (i.e. it is lost, stolen, flushed down the toilet, etc.), I am personally responsible, and physicians, physician's assistants and/or nurse practitioners **WILL NOT** rewrite the prescription until the designated time is given.
2. Your narcotic and controlled drug prescription **WILL NEVER** be refilled after hours or on the weekends.
3. All controlled substances should be obtained at the **SAME PHARMACY**. Should the need arise to change pharmacies our office must be informed.
4. I **WILL** take medications at the dose and frequency prescribed. Any changes in the dose or frequency will be discussed with my physician, physician's assistant and/or nurse practitioner at Relievus. If my medications are prescribed on an every eight-hour basis, I **WILL** take these medications every eight hours. I **UNDERSTAND** that if I use more than the allowed amount or use up my medication before my appointment date, **NO MORE PILLS WILL BE GIVEN**.
5. I **UNDERSTAND** that narcotics and controlled drug prescriptions **WILL NOT** be phoned into the pharmacy. I **MUST** appear for my given appointment time.
6. I **UNDERSTAND** that if I come in at an earlier date for an appointment, my medication **WILL NOT** be given until the date of the original appointment.
7. I **WILL** receive prescriptions at the interval determined by physician, physician's assistant and/or nurse practitioner in Relievus.
8. I **WILL NOT** receive controlled substances for the treatment of pain from any source other physician, physician's assistant and/or nurse practitioner in Relievus.
9. I **WILL** communicate with my primary physician that I am treated at Relievus for the controlled prescribing of pain medications. I understand that Relievus has the permission to discuss all diagnostic and treatment details with the dispensing pharmacist or other professionals who provide my health care.
10. I **WILL** consent to random drug testing. I will **NOT** drink any alcohol beverages with pain medications. I will **NOT** use any illegal substances (cocaine, heroin, crystal methamphetamine, PCP, ecstasy, ketamine, etc.) or use any controlled substances which are not prescribed in our practice while being treated with controlled substances at Relievus. Refusal of such testing or positive results will result in prompt termination of care from Relievus.
11. I **WILL** safeguard my prescribed medications. I understand that these medications may be lethal or hazardous to a person that is not tolerant to its affects, especially a child.
12. I **WILL** comply with my scheduled appointments.
13. I **UNDERSTAND** that there is a possibility of impairment of thought processes, especially if this narcotic is combined with a sedative, a sleeping pill, tranquilizer or alcohol.
14. I **UNDERSTAND** the possible adverse effects and dependencies associated with these medications. Overdose of medication may result in injury or possible death. Other side effects may include, but are not limited to constipation, difficulty in urination, fatigue, drowsiness, nausea, itching, loss of appetite, confusion, sweating, flushing, sexual dysfunction, and or depressed respiration.
15. I **UNDERSTAND** that if I plan to become pregnant or become pregnant, I have to inform the physician, physician's assistant and/or nurse practitioner in Relievus immediately. I **UNDERSTAND** that if I become pregnant, a child **WILL** likely be physically dependent at birth if I continue narcotics.
16. You are expected to **INFORM OUR OFFICE** of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.
17. I **UNDERSTAND** that changing date, quantity or strength of medication or altering a prescription in any way, shape or form is against the law. Forged signatures are also against the law. If there is a violation this will be reported to the patient's pharmacy, local authorities and DEA.
18. I realize that it is **MY RESPONSIBILITY** to keep others and myself from harm, including safety of driving and the operation of machinery.
19. I **UNDERSTAND** that if I violate this contract, all medications from Relievus **WILL** thereafter CEASE.
20. I **UNDERSTAND** this mode of treatment will be stopped if any of the following occurs:
  - a) I giveaway, sell, or misuse the drugs or use other people's drugs or illegal substances;
  - b) I am noncompliant with any of the terms of this agreement;
  - c) I disrespect or harass any Relievus personnel;
  - d) I do not follow up regularly or as requested by my physician, physician's assistant and/or nurse practitioner.

**YOU ARE INFORMED** that you have the right and power to sign and be bound by this agreement, and that you have read, understand and accept all of its terms.

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Patient's Name / Signature

---

Date



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## Consent for Opioid Therapy

**Patient's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

I understand that the treatment with opioid pain medication is being carefully evaluated and recommended because my pain complaints are moderate to severe and other treatments have not sufficiently helped my pain. I understand that many medications can have interactions with opioids that can either increase or decrease their effect. Therefore, I have told the medical providers (physicians, nurse practitioners and/or physician assistants) at Relievus about all other medicines and treatments that I am receiving – and that I will promptly advise the medical provider at Relievus if I start to take any new medications or have new treatments. Likewise, I have told the medical providers at Relievus about my complete personal drug history and that of my family. I have been informed by the medical providers at Relievus that the initiation of a narcotic/opioid medication is a trial. Continuation of the medication is based on evidence of benefit to me from, associated side effects of, and compliance with instructions on, usage of the medication. I have also been informed by the medical providers at Relievus that continuation and any changes in dosage of the medication will be determined by pain relief, functional improvement, side effects, and adherence to usage restrictions.

**It has been explained to me that taking narcotic/opioid medication has certain risks associated with it. These include, but are not limited to, the following:**

- Allergic reactions
- Slowing of breathing rate, slowing of reflexes or reaction time, sleepiness, drowsiness, dizziness, and/or confusion
- Impaired judgment and inability to operate machines or drive motor vehicles
- Nausea, vomiting, and/or constipation, itching
- **Overdose** (which could result in harm or even death)
- **Addiction**
- **Physical dependence or tolerance** to the pain relieving properties of the medication (This means that if my medication is stopped, reduced in dose, or rendered less effective by other medications I may be taking, I may experience runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body, and a flu-like feeling. These can be very painful but are generally not life-threatening.)
- Failure to provide pain relief
- Changes in sexual function (This is generally caused by reduced testosterone levels. Such reduced levels may affect mood, stamina, sexual desire and physical and sexual performance.)
- Changes in hormonal levels
- Use of these medications poses **special risks to women who are pregnant or may become pregnant**. If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetrician and this office to inform them. I have been advised that, should I carry a baby to delivery while taking this medication, the baby will be physically dependent upon opioids. I also understand that birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid. Furthermore, I recognize that the long-term consequence on a child's development who was exposed to opioids is not understood.

**It has been explained to me that there are other treatments that do not involve use of narcotic/opioid medications. Having been informed of these risks and potential benefits both of such medications and possible alternative treatments, I have freely consented to taking the narcotic/opioid medication.**

I would note that I have been given the opportunity of ask any questions that I may have – and that any questions that I have raised have been discussed to my satisfaction. I will take this/these medication(s) only as prescribed and I will not change the amount or dosing frequency without authorization from the medical providers at Relievis. I understand that unauthorized changes may result in my running out of medications early, and early refills may not be allowed. I also understand that if I do not take the medication correctly, I may have withdrawal reactions that may include stomach pain, sweating, anxiety, nausea, vomiting and general discomfort. I will obtain all opioids prescriptions from my physician or, during his or her absence, by the covering physician. I will not request medications outside of normal business hours. I will obtain all scheduled medications from one pharmacy. I will notify my physician if I change pharmacies.

I hereby authorize the physicians, nurse practitioners and physician assistants at Relievis to discuss all diagnostic and treatment details of my condition with the pharmacists at the dispensing pharmacy. I will submit to random urine and/or blood drug tests as requested by the medical providers at Relievis to monitor my treatment. I understand that the presence of any unauthorized substances in my urine or blood may prompt referral for assessment of addiction or chemical dependency and could result in discontinuation of further opioid prescriptions. I also understand that failure to follow these rules may lead to my no longer being treated by the medical providers at Relievis. I will not share, sell or otherwise permit others to have access to these medications.

**I HAVE READ THIS FORM (Page 1 and Page 2) OR HAVE HAD IT (Page 1 and Page 2) READ TO ME. I UNDERSTAND ALL OF IT. I HAVE HAD A CHANCE TO HAVE ALL OF MY QUESTIONS REGARDING THIS TREATMENT ANSWERED TO MY SATISFACTION. BY SIGNING THIS FORM VOLUNTARILY, I GIVE MY CONSENT FOR THE TREATMENT OF MY PAIN WITH OPIOID PAIN MEDICINES. I UNDERSTAND AND AGREE THAT FAILURE TO ADHERE TO THESE POLICIES WILL BE CONSIDERED NONCOMPLIANCE AND MAY RESULT IN CESSATION OF OPIOID PRESCRIBING AND POSSIBLE DISMISSAL FROM RELIEVUS.**

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Patient Print Name

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Patient Signature

---

Date



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<b>All PATIENTS! -- Mark each box that applies</b>	<b>Female</b>	<b>Male</b>
	(These boxes are for Doctors / PAs / NPs)	
<input type="checkbox"/> <b>Your current age is between 16 – 45 years old</b>	<b>1</b>	<b>1</b>
<input type="checkbox"/> <b>History of preadolescent sexual abuse</b>	<b>3</b>	<b>0</b>
<b>Family history of substance abuse</b>		
<input type="checkbox"/> <b>Family history of alcohol abuse</b>	<b>1</b>	<b>3</b>
<input type="checkbox"/> <b>Family history of illegal drug abuse</b>	<b>2</b>	<b>3</b>
<input type="checkbox"/> <b>Family history of prescribed drug abuse</b>	<b>4</b>	<b>4</b>
<b>Personal history of substance abuse</b>		
<input type="checkbox"/> <b>Personal history of alcohol abuse</b>	<b>3</b>	<b>3</b>
<input type="checkbox"/> <b>Personal history of illegal drug abuse</b>	<b>4</b>	<b>4</b>
<input type="checkbox"/> <b>Personal history of prescribed drug abuse</b>	<b>5</b>	<b>5</b>
<b>Psychological disease</b>		
<input type="checkbox"/> <b>Personal history of ADD, OCD, Bipolar, Schizophrenia</b>	<b>2</b>	<b>2</b>
<input type="checkbox"/> <b>Personal history of Depression</b>	<b>1</b>	<b>1</b>
<b>Total</b>		

\_\_\_\_\_  
Patient Print Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



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**Irrevocable Assignment of Benefits / Letter of Protection / Lien**

I, \_\_\_\_\_, the insured and/or beneficiary of the policy of \_\_\_\_\_ insurance providing medical benefits to me, do hereby authorize you, **Relievus**, medical benefits due to me under the terms of the applicable policy(s) issued by our company(s). Payment is authorized upon receipt of the itemized statement for services rendered. This insurance policy was in full force and effect at the time services were rendered. Payment, in whole or in part, shall be considered the same as if paid by your company directly to me, the insured. A photocopy of this assignment shall be valid as the original.

I authorize **Relievus** to obtain legal counsel by and through any law firm of their choosing and to enter into legal (PIP Arbitration) or other action to collect such sums due should sums not be paid within the legally prescribed time period. I do hereby promise full and complete cooperation with **Relievus'** legal counsel, including attending any type of medical examination (IME), deposition, arbitration, or court proceeding. I understand that should I fail to cooperate with the legal counsel, I may be held personally responsible to **Relievus** for any expense not covered by this assignment / letter of protection (hereinafter referred to as an "LOP") and/or expenses not recovered due to my failure to cooperate.

**Authorization to Release Medical Records**

The undersigned hereby consents and authorizes the release of any and all medical records, reports, films, etc. directly to **Relievus** and/or their designated legal counsel, directly from \_\_\_\_\_ or any and all hospitals, diagnostic facilities, or physicians that have rendered medical treatment, diagnostic testing, or any type of medical services to the undersigned as a patient.

**Authorization to Release Information**

\_\_\_\_\_ is hereby authorized to release to **Relievus** and /or their designated legal counsel all or any part of my medical record, billing information, insurance policy information, EOBs, and any information contained in my PIP file.

**Financial Responsibility**

I hereby agree and acknowledge that I may receive benefit checks directly from the insurance carrier for services rendered by **Relievus**. I hereby agree to immediately forward said check(s) to **Relievus** upon receipt of same. It is understood and agreed that should I receive benefit checks and fail to forward any benefit checks to **Relievus**, **Relievus** does maintain the right to request checks from me and initiate any and all collections efforts against me. If such action is taken by **Relievus**, I agree to be responsible for any and all benefit checks received plus any and all reasonable collection cost incurred including, but not limited to, attorney fees, interest, expert fees, and court costs.

**Letter of Protection / Attorney Directive / Irrevocable Assignment**

I hereby irrevocably authorize my attorney \_\_\_\_\_, Esquire to pay directly to **Relievus** sums as may be due and owing for services rendered by **Relievus**, and to withhold such sums from any bodily injury policies, disability, medical payment benefits, no-fault benefits, health and accident benefits, workers' compensation benefits, or any other insurance benefits obtained to reimburse the undersigned, or from any settlement, verdict or judgment which may be paid to me or my attorney as a result of the injury or illness for which I have received service from **Relievus**. I irrevocably assign to **Relievus** all rights and benefits under my insurance contracts for the payment of services rendered by **Relievus**. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by **Relievus** be released to **Relievus** and/or their legal counsel.

I irrevocably authorize **Relievus** to file insurance claims on my behalf for service rendered to me. I irrevocably direct that all such payments go directly to **Relievus**. I irrevocably authorize the above medical provider, and/or their legal counsel, to be preset at all legal proceedings with regard to my Personal Injury Protection (PIP) benefit, including but not limited to Examinations Under Oath (EOU), depositions, whether there is pending litigation or not (e.g. Arbitrations or Court Proceedings).

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

The undersigned, being the attorney of record for the above patient, does hereby agree to observe all terms of the above and agree to withhold such sums from any settlement, verdict, or judgment as may be necessary to fully protect **Relievus'** rights to be compensated for services rendered and related to the above-captioned claim/case. This agreement is irrevocable.

**Attorney's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Note:** Attorney, kindly sign and date one copy and return as soon as possible to the address listed above as an acknowledgment of this document.



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### Assignment of Benefits

I, \_\_\_\_\_, the insured and/or beneficiary of the policy or policies of \_\_\_\_\_ Insurance providing medical benefits to me, do hereby authorize you to pay directly to **Relievus**, medical provider, benefits due me out of the indemnity under the terms of the applicable policy/policies issued by your company. Payment is authorized upon receipt of the itemized statement for services rendered. This policy was in full force and effect at the time services were rendered. I also authorize the above medical provider to obtain counsel and enter legal or other action on my behalf and/or in my name to collect such sums due, should sums not be paid within the legally prescribed, or within a reasonable period of time. I do hereby promise full and complete cooperation with any legal counsel obtained by the medical provider including attending of any type of Deposition, Arbitration, or Court proceeding. I irrevocably authorize the above medical provider, and/or their legal counsel, to be present at all legal proceedings with regard to my Personal Injury Protection (PIP) benefits, including but not limited to Examinations Under Oath (EOU), depositions, whether there is pending litigation or not (e.g. Arbitrations or Court proceedings). I understand that if I fail to cooperate with legal Counsel, I may be held personally responsible to the medical provider for any expenses not covered by this assignment. Payment, in whole or in part, shall be considered the same as if paid by your company directly to me. A photocopy of this assignment shall be valid as the original. Should any penalties be applied to the provider as per N.J.A.C. 11:3-4.9 the provider agrees to hold the patient harmless of payment of such penalties. I hereby agree and acknowledge that I may receive benefit checks directly from the insurance carrier for services rendered by the provider. I hereby agree to immediately forward said checks to the provider upon receipt of the same. It is understood and agreed that should I not forward any benefits to the provider; the provider does maintain the right to request checks from me and initiate any and all collections efforts. If such action is taken by the provider, I agree to be responsible for any and all benefit checks received, plus any and all collection costs incurred including attorney fees and Court costs. I irrevocably assign to above company or provider all rights and benefits under any insurance contracts for payment of services rendered to provider. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by provider to be released to provider. I irrevocably authorize provider to file insurance claims on my behalf for services rendered to me. I irrevocably direct that all such payments go directly to provider. I irrevocably authorize provider to act on my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities. This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

\_\_\_\_\_  
Patient/Claimant Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient/Claimant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Legal Guardian Signature (if patient is a minor, parent/guardian must sign)

\_\_\_\_\_  
Date



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### Authorization for Release of Information

**Name of Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relievus** is authorized to release protected health information about the above-named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

**Entity to Receive Information**

Check each person/entity below that you approve to receive information.

**Description of Information to be Release**

Check each item below that can be given to the person/entity as indicated on the left.

**Voicemail**

**Results of Lab tests/x-rays**

**Other:** \_\_\_\_\_

**Spouse (Provide Name & Phone Number)**

\_\_\_\_\_

**Financial**

**Medical as follows:** \_\_\_\_\_

**Parent (Provide Name & Phone Number)**

\_\_\_\_\_

**Financial**

**Medical as follows:** \_\_\_\_\_

**Other (Provide Name & Phone Number)**

\_\_\_\_\_

**Financial**

**Medical as follows:** \_\_\_\_\_

**Patient Information**

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.

I understand that information used or disclosed as a result of this arbitration may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

*I understand that I have the right to refuse this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.*

\_\_\_\_\_  
Patient/Legal Representative Name

\_\_\_\_\_  
Patient/Legal Representative Signature

\_\_\_\_\_  
Date





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**Notice of Privacy Practices  
Acknowledgement of Receipt**

**Patient Name & Address:** \_\_\_\_\_

\_\_\_\_\_

**I have received a copy of the Notice of Privacy Practices for the above-named practice.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\* You may review our Notice of Privacy Practices under "Notice of Privacy Practices" on our website at: <http://www.relievus.com/forms/> or you may request a copy from the front desk. \*\*\*



**For Office Use Only**

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because of the following:

- An emergency existed and a signature was not possible at that time.
- The individual refused to sign.
- A copy was mailed with a request for a signature by return mail.
- Unable to communicate with the patient for the following reason:

\_\_\_\_\_

Other:

\_\_\_\_\_

Prepared by: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_