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

This packet is for patients who have an active claim for MVA, Slip & Fall Injury and/or NJ Workers Compensation

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 $25.00 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.**

Communication

- You authorize Relievus and our subcontractors including our debt collection agency to contact you via email and/or text regarding your account. If you do not wish for us to contact you in this manner, you will notify our office in writing.

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:_____2nd 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

---

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)

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)

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

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

☐ Physical Therapist: _____ ☐ Chiropractor: _____

☐ Trigger Point Injections: _____ ☐ PENS: _____

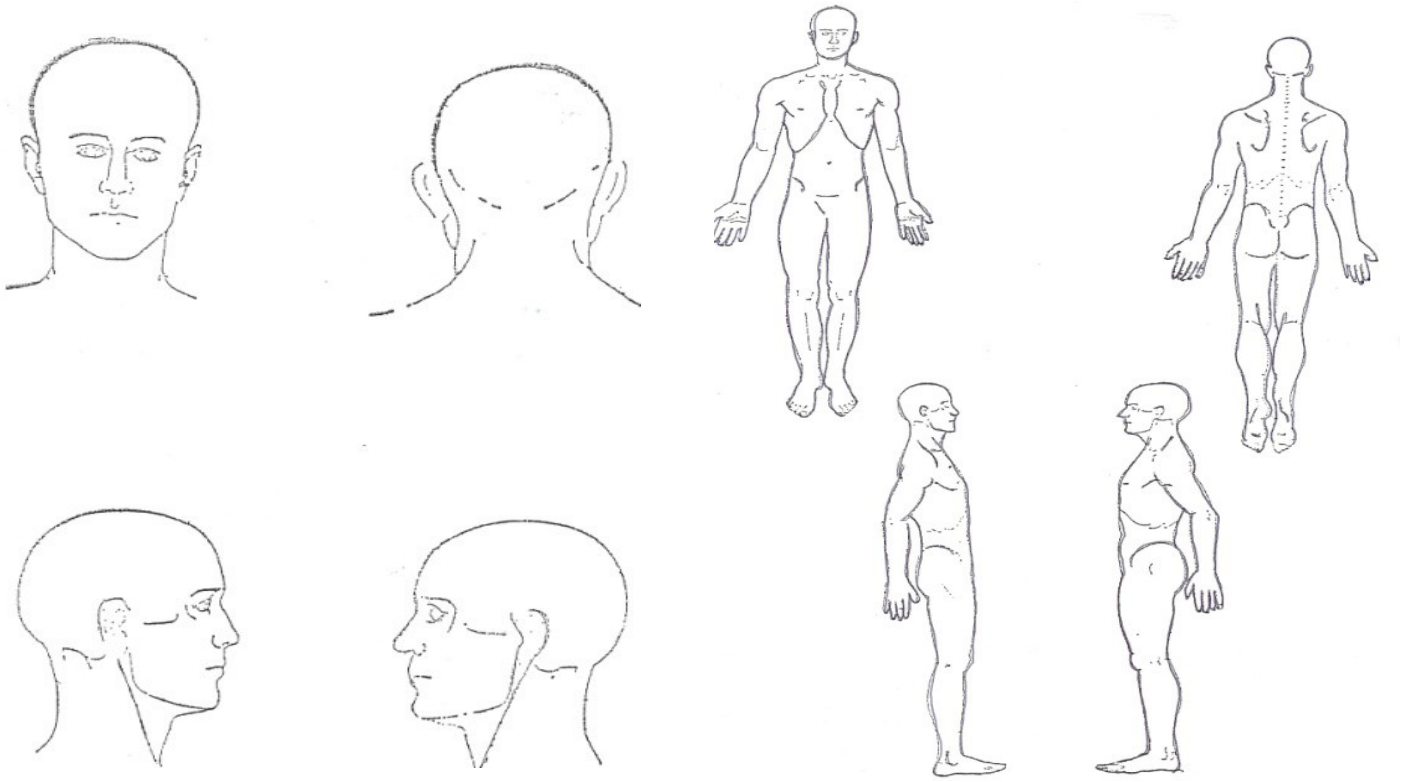
☐ Acupuncture: _____ ☐ Joint Injections: _____

☐ 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: _____

_____

_____

_____

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

_____

_____

- 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

	Date	Number of Injection(s)	Doctor's Name
☐ Epidural			
☐ Facet			
☐ Trigger Point			
☐ PENS			
☐ Acupuncture			
☐ Joints			
☐ Other _____			

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.

Patient's Name / Signature _____ Date _____

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To All Patients of Relievus,

If urine toxicology results read **positive for alcohol** while you are taking opioid pain medications, our practice will **discontinue opioid pain medications** and continue any other services you may receive at our clinic or you will be **promptly discharged** from our practice due to the potential serious side effects from drinking alcohol beverages while taking **Opioid pain medication.**

Due to the drug-drug interaction and potential serious side effects from **taking both Opioid pain medications and Benzodiazepines**, our medical providers at Relievus will not prescribe any opioid pain medications if you are on any of the following benzodiazepines:

- Valium (Diazepam)
- Ativan (Lorazepam)
- Xanax (Alprazolam)
- Klonopin (Clonazepam)
- Restoril (Temazepam)
- Prosom (Estazolam)

1. If you want to continue taking benzodiazepines, **opioid pain medication must be discontinued.**
2. Until the benzodiazepines are **completely weaned off**, any opioid pain medication will be avoided due to the serious drug-drug interaction.
3. If urine toxicology results read positive for any benzodiazepines while you are taking opioid pain medications, you will be promptly discharged from our practice.
4. If you want to continue Benzodiazepines with opioid pain medications, you will have to find another pain management practice for continuation of those medications together.
5. Please note, we frequently monitor the PDMP (Prescription Drug Monitoring Program) and know when you fill opioid pain medications and benzodiazepines.

I HAVE READ THIS FORM OR HAVE HAD IT 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.

Print Patient Name: _____ Date _____

Patient 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 Relievus. 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 Relievus 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 Relievus 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 Relievus. 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.

Patient Print Name	Patient Signature	Date

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

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 Print Name:_____Date:_____
Attorney Signature:_____Date:_____
Note: Attorney, kindly sign, print 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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Irrevocable Assignment of Benefits – NJ Workers' Compensation Only

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 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 any 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 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 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.

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 present at all legal proceedings including but not limited to Examinations Under Oath (EOU), depositions, whether there is pending litigation or not.

Patient's Name:_____**Date:** _____

Patient's Signature:_____**Date**: _____

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Assignment of Benefits – MVA Only

I,_____, the insured and/or beneficiary of the policy or policies of _____ Insurance proving 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.

Claim No.: _____ Date of Accident: _____

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

Patient Print Name _____ Patient Signature _____ 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

Relievus™

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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: ______________