**South Jersey Pain Consultants, LLC**

Date: _____

Thank you for scheduling a consultation with us. It is our pleasure to welcome you to South Jersey Pain Consultants, LLC in advance of your first visit.

The office is located at the corner of Evesham Ave and Route 73 South, across Evesham Road from the Bradley Funeral Home.

***GPS*** *- If using a GPS, you need to enter* ***NEW JERSEY 73*** *and not Route 73 South.*

Your appointment information is:

**DATE: _____ TIME: _____**

**LOCATION: Marlton ~ Woodbury ~ Cherry Hill at Dr. _____ office**

Enclosed you will find patient information forms that will help expedite your consultation. We have sent the following forms to be completed **prior** to your appointment. We would prefer you arrive 15-20 minutes early to ensure everything is complete.

It is imperative that the doctor have the **written MRI and/or EMG reports, the referring doctors last three office notes and the referral slip with the reason you are being sent to us** at the time of your consultation. You may have them faxed or you may bring them with you on the day of your appointment. We also prefer you bring the actual MRI film(s) and/or CD in addition to the written report for the doctor to review.

If you choose to have your reports or records faxed, please call the office to confirm they were received. If the reports are not received ***prior to*** your scheduled time or your paperwork has not been completed, your appointment will have to be rescheduled.

Please bring one form of identification, your insurance card and the billing information if your injuries are related to an accident.

Thank you for choosing South Jersey Pain Consultants, LLC for your medical care. We will work hard to serve your needs.

Sincerely,

South Jersey Pain Consultants, LLC
Vincent M. Padula, DO
Steven H. Ressler, MD

**Under no circumstances will prescription medication be given on the first visit.**
**Please note: 24 hour notice is required for cancellations to avoid a $45.00 charge.**

Evesham Commons ~ 525 New Jersey 73 South ~ Suite 103 ~ Marlton NJ 08053
Phone (856) 797-5777 ~ Fax (856) 797-5771
www.sjpainconsultants.net

**South Jersey Pain Consultants, LLC**

COMPREHENSIVE PAIN MANAGEMENT INTAKE FORM

PHYSICIAN: _____DATE: _____

| Last Name: | First Name: | Middle: |
|---|---|---|
| DOB: | Age: | Sex: |

| Name of Referring Physician: | Phone: | Fax: | |
|---|---|---|---|
| Address: | City: | State: | Zip: |

| Name of Family Physician: | Phone: | Fax: | |
|---|---|---|---|
| Address: | City: | State: | Zip: |

**DRUG ALLERGIES?** _____

A. **When did your pain start?**

_____

_____

B. **What caused your pain?**

□ Accident (Date of Accident: _____) □ Cancer □ Other Disease
□ Surgery (specify) _____
□ No obvious cause

C. **Describe in your own words the pain problem(s) that you would like help with:**

_____

_____

_____

_____

_____

D. **How often does your pain occur?**

□ Continuous
□ Several times a day
□ Once a day
□ Several times a week
□ Once a week

**E. How long does your pain last?**

□ Continuous
□ Weeks
□ Days
□ Hours
□ Minutes

**South Jersey Pain Consultants, LLC**

□ Less than once a week
□ Never
□ Seconds
□ None

F. **Below is list of words that might describe your pain. Check all that apply:**

□ Throbbing
□ Shooting
□ Stabbing
□ Sharp
□ Cramping
□ Gnawing
□ Sickening
□ Punishing-Cruel
□ Hot-Burning
□ Aching
□ Heavy
□ Tender
□ Splitting
□ Tiring-Exhausting
□ Fearful
□ Other:_____

**G. Circle the number below to indicate your *highest* pain intensity over the past week:**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| None | | Mild | | | Moderate | | | Severe | | Most |

**H. Circle the number below to indicate your *lowest* pain intensity over the past week**:

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| None | | Mild | | | Moderate | | | Severe | | Most |

I. **Circle the number below to indicate your *usual* pain intensity over the past week**:

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| None | | Mild | | | Moderate | | | Severe | | Most |

J. **Circle the number below to indicate how much your pain interfered with your activities this week**:

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| None | | Mild | | | Moderate | | | Severe | | Completely |

K. **What makes your pain better?**

□ Sitting
□ Standing
□ Walking
□ Bending
□ Lying Down
□ Driving
□ Coughing/Sneezing

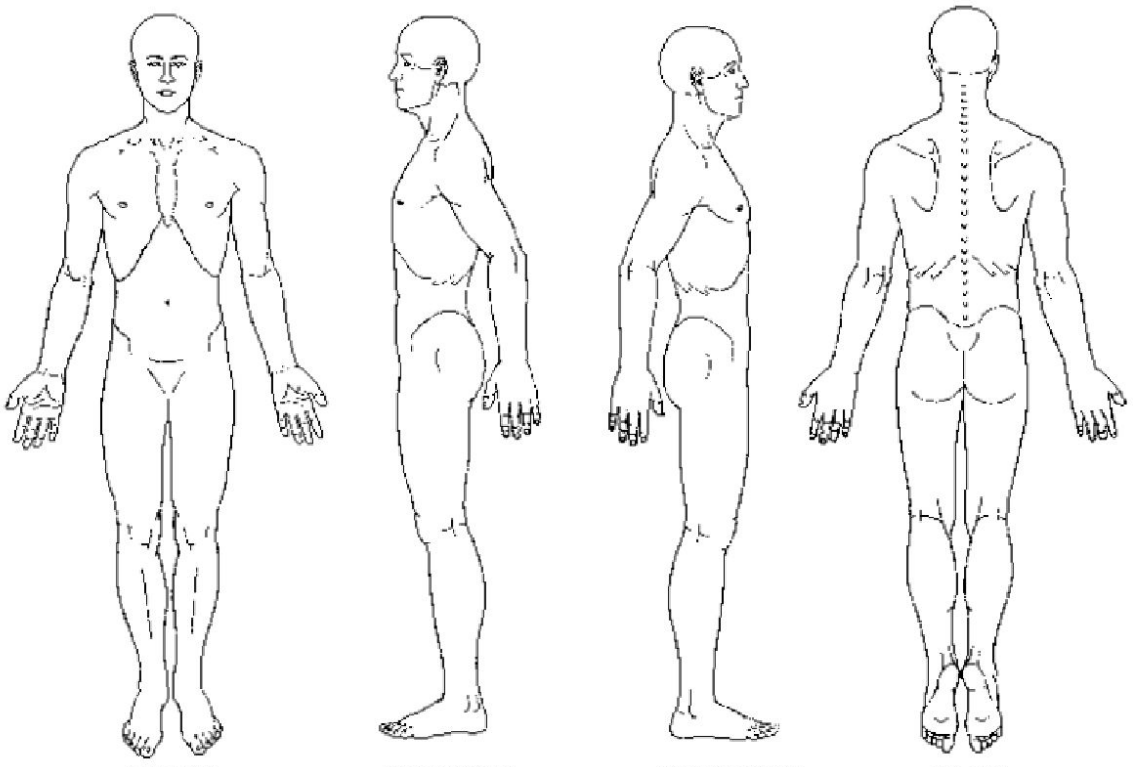
L. **What makes your pain worse?**

□ Sitting
□ Standing
□ Walking

**South Jersey Pain Consultants, LLC**

□ Bending □ Lying Down □ Driving
□ Coughing/Sneezing

M. **Please indicate where you have pain by marking the areas on your body.**




N. **Have you had any of the following tests to evaluate your pain? (please provide details)**

□ X-Rays _____
□ MRI _____
□ CT Scan _____
□ Myelogram _____
□ EMG _____
□ Blood Tests _____
□ Bone Scan _____
□ Discogram _____

O. **Do you have any of the following conditions associated with your pain? (indicate all that apply):**

□ Bowel/Bladder Incontinence □ Muscle Weakness □ Numbness/Tingling/Pins/Needles

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P. **Please indicate any previous treatments you have tried for your pain and whether they helped your pain:**

| | Yes | No |
|---|---|---|
| □ Acupuncture | | |
| □ Chiropractor | | |
| □ Biofeedback | | |
| □ Traction | | |
| □ TENS Unit | | |
| □ Physical Therapy | | □ |
| □ Massage | | |
| □ Psychologist | | |
| □ Psychiatrist | | |
| □ Alternative Medicine | | □ |
| □ Surgery | | |
| □ Medications | | |
| □ Epidurals | | |

Q. **Past Medical History**

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Arrythmia | □ | □ | Liver Disease | | |
| High Blood Pressure | | | Hepatitis | □ | □ |
| Angina/Heart Disease | | | Kidney Disease | □ | |
| Heart Attack | □ | | Ulcers | | |
| Heart Failure | □ | | Acid Reflux | | □ |
| Emphysema/Asthma | | | Other GI Illness | □ | |
| COPD | □ | □ | Bleeding Disorder | | □ |
| Stroke | □ | □ | Taking Blood thinners | | □ |
| Seizures | □ | □ | Thyroid Disease | | □ |
| Cancer | □ | □ | HIV | | |
| Arthritis | □ | □ | Irritable Bowel Disease | □ | □ |
| Diabetes | □ | □ | Skin Condition | | □ |
| Migraine Headaches | | | Depression | □ | □ |
| Psychiatric Illness | □ | | Other: | | |

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R. **Past Surgical History (please indicate type of surgery, date and physician's name)**

Surgery Date Surgeon

_____

_____

_____

_____

S. **Current Medications:**

Name Dose How Many Times a Day

_____

_____

_____

_____

_____

_____

T. **What is your mood like now?**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Worst | | Poor | | | Fair | | | Good | | Best |

U. **Do you have problems with any of the following? (check all that apply)**

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Sleep | | | Concentration | □ | |
| Mood | | | Anxiety | □ | |
| Depression | | | Suicidal thoughts | □ | |
| Self-worth | | | Homicidal thoughts | □ | |
| | | | | | |

□ □

V. **Family History**

Mother: Living/Deceased Cause: _____

**South Jersey Pain Consultants, LLC**

Father: Living/Deceased Cause: _____
Siblings: Living/Deceased Cause: _____
Siblings: Living/Deceased Cause: _____

W. **Social History**

Relationship Status

□ Married □ Single
□ Divorced □ Separated
□ Widowed □ Domestic Partnership

**With whom do you live?**

□ Self □ Spouse □ Children □ Parents □ Friends □ Other:_____

**What is your current employment status?**

□ Employed full-time □ Employed part-time
□ Self-employed □ Retired
□ Homemaker □ Unemployed due to pain
□ Unemployed due to other reason.

**Are you on disability?** □ Yes □ No

**Do you have an attorney or legal action pending related to this pain or any other health problems?** □ Yes □ No

If so, please list attorney's name: _____
_____
_____

**Do you drink alcohol?** □ Yes □ No If so, specify_____
**Do you smoke?** □ Yes □ No If so, specify_____
**Do you currently or have you ever abused recreational drugs?**
□ Yes □ No If so, specify:
_____
_____

X. **Do you experience any of the following?**

Review of Symptoms (please indicate all that apply):

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Fever | □ | □ | Weight Loss | | |
| Night Sweats | □ | | Swelling | | |

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| | | | | | |
|---|---|---|---|---|---|
| Rash | □ | □ | Cough | □ | |
| Sputum Production | | | Shortness of Breath | | |
| Wheezing | □ | □ | Chest Pain | | |
| Chest Pain | □ | □ | Palpitations | | |
| Abdominal Pain | □ | | Constipation | | |
| Diarrhea | □ | □ | Black bowel movement | | |
| Blood in stool | □ | | Nausea | | |
| Headache | □ | □ | Lightheadness | | |
| Dizziness | □ | □ | Vision Changes | | |
| Easy Bruising | □ | | Urinary Frequency | | |
| Difficulty Urinating | | | Pregnancy | | |
| Bowel or Bladder Incontinence | | | | | |
| Weakness/Paralysis of the arms and legs | | | □ | | |

□

********PHYSICIAN ONLY******  ******PHYSICIAN ONLY********

**Physical** **BP:** **HR:** **RR:** **Temp:** **Ht:** **Wt:**

**General**:

**HEENT**: □ NC/AT **Neck**: □ Supple **Lungs**: □ Clear

**CV**: □ RR **Abd**: □ Soft, NT/ND **GU**: □ Deferred

**Skin**: □ Clear **Extremites**: □ WNL **Pulses**: □ +2 Radial/DP

**Neuro**: □ CN II-XII grossly intact

**Sensory**:
UE: R □ LT/PP L □ LT/PP

LE: R □ LT/PP L □ LT/PP

| **Motor**: | C5 | C6 | C7 | C8 | T1 |
|---|---|---|---|---|---|
| RUE | /5 | /5 | /5 | /5 | /5 |
| LUE | /5 | /5 | /5 | /5 | /5 |
| | L2 | L3 | L4 | L5 | S1 |
| RLE | /5 | /5 | /5 | /5 | /5 |

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LLE /5 /5 /5 /5 /5

**Gait**:

**Musculoskeletal:**

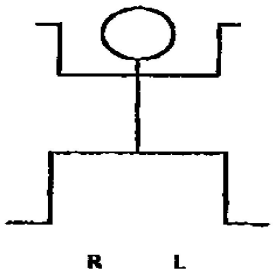
□ SLR □ Slump □ Spurling
□ FABER/Patrick □ Ganselen

□ Other: _____

**Palpation:**

□ TTP
□ MTrP:_____

**Reflexes:**

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********PHYSICIAN ONLY****** ******PHYSICIAN ONLY********

---

**RADIOGRAPHIC DATA:**

---

**IMPRESSION:**

**1.**
**2.**
**3.**
**4.**
**5.**
**6.**
**7.**

---

**PLAN:**

**1.**
**2.**

**South Jersey Pain Consultants, LLC**

**3.**
**4.**
**5.**
**6.**
**7.**

---

**SIGNATURE:**

---

**DATE:**

---

# Disclosure of Financial Interest and Out of Network Election

---

"In addition to such other information as the board determines necessary, the disclosure shall inform the patient whether any services or facility fees associated with the referral will be considered to be, and reimbursed at, an "out-of-network" level by the patient's insurance carrier or other third party payer (cf: P.L. 1989, c.19, s. 3)."

"disclosure of the referring practitioner's significant beneficial interest in the practice or facility is made to the patient in writing, at or prior to the time that the referral is made, consistent with the provisions of section 3 of P.L.1989, c.19 (C.45:9-22.6)."

Public law of the State of New Jersey and rules of the board of Medical Examiners mandates that a physician, podiatrist and all other licensees of the Board of Medical Examiners inform patients of any significant beneficial interest held in a health care service.

Accordingly, take notice that practitioners in the office of **South Jersey Pain Consultants, LLC** do have a significant beneficial interest in the following health care service(s) to which patients are referred:

**The Surgical Center of South Jersey and the Gloucester County Surgery Center**

Vincent M Padula, DO NPI: 1558397083

Steven H Ressler, MD NPI: 1932135464

This basically means that the doctor is an owner/partner in the surgery center you are being referred to, and you may, of course, seek treatment at a health care service provider of your own choice. A listing of alternative health care service providers can be found in the classified section of your telephone directory under the appropriate heading.

I have discussed with my physician or his/her representative the health care service that he or she will provide to me in connection with my treatment and I understand that services or facility fees associated with my referral to the above named facility will be considered to be, and reimbursed at an "out of network" level by my insurance carrier or other third party payer (cf: P.L. 1989, c.19, s. 3).

**Additional CMS (Medicare) Requirements- effective 5/18/2009**

We are proud to announce the ownership interest of the above physicians in the Surgical Center.
I hereby acknowledge that I have been informed of my "Patient Rights", "Advance Directives", and "Ownership Disclosure" prior to today which is the day of my surgery

Date: _____ _____

Patient Signature

_____ _____

Print Patient Name Patient/Guardian Signature

**Exception Statement:**

I have determined that it is medically necessary to provide treatment to this patient the same day as seen in my office, and that the ASC is an appropriate care setting for this patient.
All the above requirements have been met prior to the procedure.

Date: _____ _____

Physician Signature

# FINANCIAL POLICY

**We would like to inform you of our financial policy in order to avoid possible misunderstandings or difficulties at a later date.**

- If you have no verifiable insurance coverage, payment in full is expected at the time of service unless prior arrangements have been made with our billing department.

- Your insurance co-pay, if any, is due in full at the time of service. If you are unprepared to pay it in full, your appointment may be rescheduled and you may be responsible for a late cancellation fee. If we agree to see you without it being paid in full, there will be a $10.00 processing fee.

- When your account is not paid in full within 45 days after the status changes from the insurance responsibility to the patient's, we will charge an interest charge of 1 ½% per month (18% APR) on the outstanding balance.

- Unpaid accounts more than 60 days old may be referred to a collection agency. If this occurs, an additional fee of $50.00 may be added along with any interest charges accumulated.

- If there are unresolved balance issues, we will not be able to continue to schedule you as a patient which may hinder your treatment.

*rance: Insurance is a contract between you and your insurance company. We are party to this contract. We will bill your insurance carrier; however your nce company makes the final determination of your eligibility and the amount ill pay. You agree to pay any portion of the charges not paid for by insurance ntractual adjustments, if any. If your insurance requires a referral you are ble for obtaining it. The balance of your account is ultimately your ility whether your insurance company pays or not.*

Your signature signifies you agree to all of the terms and conditions contained herein and this agreement will be in force and effect.

Signature: _____ Date: _____

Evesham Commons ~ 525 Route 73 South ~ Suite 103 ~ Marlton NJ 08053
Phone (856) 797-5777 ~ Fax (856) 797-5771
www.sjpainconsultants.net

## Acknowledgement of Receipt of Notice of Privacy Practices

"You may refuse to sign this acknowledgement"

I have reviewed a copy of this office's Notice of Privacy Practices.

_____
(Please print name)

_____
(Signature)

_____
(Date)

**For Office Use Only. Please do not write below this line.**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)

_____
_____
_____

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www.sjpainconsultants.net

**South Jersey Pain Consultants, LLC**

To maintain compliance with HIPAA, we must have written permission to leave a message on your voicemail and/or to speak with anyone other than yourself.

NAME: _____

**Check all that apply:**

_____ I give permission for a message to be left on my voicemail

_____ I give permission for my medical information to be disclosed to:

_____, relationship: _____
(please print)

_____ I give permission for my billing information to be disclosed to:

_____, relationship: _____
(please print)

**OR**

_____ I deny my information to be released to anyone other than myself.

SIGNATURE: _____ DATE: _____

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## INFORMED CONSENT WITH CONTROLLED SUBSTANCE PRESCRIPTIONS

I have discussed with my pain management provider the risks associated with the drugs prescribed that include, but are not limited to

(1) The risks of addiction and overdose associated with opioid drugs and the dangers of taking opioid drugs with alcohol, benzodiazepines and other central nervous system depressants;
(2) The reasons why the prescription is necessary;
(3) Alternative treatments that may be available; and
(4) Risks associated with the use of the drugs being prescribed, specifically that: opioids are highly addictive, even when taken as prescribed; there is a risk of developing a physical or psychological dependence on the controlled substance; and the risks of taking more opioids then prescribed, or mixing sedatives, benzodiazepines or alcohol with opioids, can result in fatal respiratory depression.

My pain management provider has answered my questions to my satisfaction. I am aware of the risks involved with the use of controlled substances including development of a physical or psychological dependence and alternative treatments that may be available.

I am aware that my pain management provider may periodically make reasonable efforts, unless clinically contraindicated, to either stop the use of the controlled substance, decrease the dosage, try other drugs or treatment modalities and effort to reduce the potential for abuse or the development of physical or psychological dependence and document with specificity the efforts undertaken.

I am aware that my pain management provider will review the prescription drug monitoring information provided by the state of New Jersey to monitor compliance with the pain management agreement. I am also aware that I may be referred to another provider if compliance is not met.

_____
Patient signature

_____
Patient 's printed name

_____
Date

**South Jersey Pain Consultants, LLC**

Date:

To:

From:

Re:

I authorize any licensed physician, medical practitioner, pharmacist, psychiatrist, psychologist or other mental health care provider, hospital, clinic or other medical or medically-related facility, insurance or reinsuring company, consumer reporting agency or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, to give any and all such information to South Jersey Pain Consultants, LLC.

_____ _____

(Signature of patient or authorized representative) (Date)

_____

(Printed name)

Evesham Commons ~ 525 Route 73 South ~ Suite 103 ~ Marlton NJ 08053
Phone (856) 797-5777 ~ Fax (856) 797-5771
www.sjpainconsultants.net

# ASSIGNMENT OF PERSONAL INJURY PROTECTION BENEFITS AND COLLECTION RIGHTS

I, _____ residing at _____
of full age hereby assign following:

1. On or about _____ I was involved in an automobile accident in New Jersey and sustained personal injuries.

2. At the time of my accident I was eligible for the Personal Injury Protection benefits under _____ automobile insurance with a policy number of _____.

3. As a result of the injuries I sustained in this accident I sought and obtained medical treatment from South Jersey Pain Consultants, LLC.

4. In consideration for the services rendered or to be rendered to me by Drs. Padula and/or Ressler, I hereby authorize the insurance company to pay all PIP medical benefits to which I may be entitled directly to Drs. Padula and/or Ressler.

5. In addition, I hereby assign directly to Drs. Padula and/or Ressler all PIP collection rights to which I may be entitled.

6. I have not been coerced in any way to give this assignment.

I have read the above statement and believe it to be true to the best of my knowledge.

_____
(Patient's signature)

_____
(Date)

# Patient Information Sheet

| | |
|---|---|
| NAME | |
| BIRTH DATE | |
| ADDRESS | |
| CITY, STATE & ZIP | |
| PHONE NUMBER | (  )  -  CELL :(  )  - |
| MARITAL STATUS | MARRIED  SINGLE  WIDOWED  DIVORCED |
| SOCIAL SECURITY # | |
| RACE: | Afro American  Asian  Caucasian  Hispanic  Native American  Pacific Islander |
| ETHNICITY | Hipanic or Latino  Not Hispanic or Latino  Unknown |
| OCCUPATION | |
| EMPLOYER | |
| EMPLOYER PHONE # | (  )  - |

***(please use the back of this form to list additional insurance information)***

| | |
|---|---|
| INSURANCE NAME | |
| INS ADDRESS | |
| | |
| INS PHONE # | (  )  - |
| ADJUSTER/CONTACT PERSON'S NAME | |
| INS CLAIM/ID # | |
| SUBSCRIBER | |
| RELATION TO PATIENT | |
| SUBSCRIBER DOB | |
| SUBSCRIBER SS# | |
| SUBSCRIBER EMPLOYER | |

| | | |
|---|---|---|
| ACCIDENT DATE & TYPE | MVA - W/C - SLIP & FALL (CIRCLE ONE) | DATE: |
| ATTORNEY'S NAME | | |
| ATTORNEY'S ADDRESS | | |
| | | |
| ATTORNEY'S PHONE | (  )  - | |
| ATTORNEY'S FAX | (  )  - | |

| | | | |
|---|---|---|---|
| ALLERGIES | | | |
| HEIGHT | | WEIGHT | |
| DO YOU SMOKE? | YES OR NO….IF YES, HOW MUCH? | | |

| | |
|---|---|
| REFERRED BY | |
| ADDRESS | |
| PHONE # | (  )  - |

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage and I understand it is my responsibility to know, understand and follow the guidelines for my coverage.

_____ _____

(Patient's signature)  (Date)

# Patient Information Sheet

| | |
|---|---|
| FAX # | (  )  - |

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage and I understand it is my responsibility to know, understand and follow the guidelines for my coverage.

_____ _____

(Patient's signature) (Date)

# SOAPP Version 1.0 (revised SOAPP-R)

Name: _____ Date: _____

***The following are some questions given to patients who are on or being considered for opioids for their pain. Please answer as honestly as possible. Your answers alone will determine your treatment.***

Please answer the questions below using the following scale:

**0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often**

| | |
|---|---|
| 1. How often do you have mood swings? | 0 1 2 3 4 |
| 2. How often have you felt a need for higher doses of medication to treat your pain? | 0 1 2 3 4 |
| 3. How often have you felt impatient with your doctors? | 0 1 2 3 4 |
| 4. How often have you felt that things are just too overwhelming that you can't handle them? | 0 1 2 3 4 |
| 5. How often is there tension in the home? | 0 1 2 3 4 |
| 6. How often have you counted pain pills to see how many are remaining? | 0 1 2 3 4 |
| 7. How often have you been concerned that people will judge you for taking pain medication? | 0 1 2 3 4 |
| 8. How often do you feel bored? | 0 1 2 3 4 |
| 9. How often have you taken more pain medication than you were supposed to? | 0 1 2 3 4 |
| 10. How often have you worried about being left alone? | 0 1 2 3 4 |
| 11. How often have you felt a craving for medication? | 0 1 2 3 4 |
| 12. How often have others expressed concern over your use of medication? | 0 1 2 3 4 |
| 13. How often have any of your close friends had a problem with alcohol or drugs? | 0 1 2 3 4 |
| 14. How often have others told you that you had a bad temper? | 0 1 2 3 4 |
| 15. How often have you felt consumed by the need to get pain medication? | 0 1 2 3 4 |
| 16. How often have you run out of pain medication early? | 0 1 2 3 4 |
| 17. How often have others kept you from getting what you deserve? | 0 1 2 3 4 |
| 18. How often, in your lifetime, have you had legal problems or been arrested? | 0 1 2 3 4 |
| 19. How often have you attended an AA or NA meeting? | 0 1 2 3 4 |
| 20. How often have you been in an argument that was so out of control that someone got hurt? | 0 1 2 3 4 |
| 21. How often have you been sexually abused? | 0 1 2 3 4 |
| 22. How often have others suggested that you have a drug or alcohol problem? | 0 1 2 3 4 |
| 23. How often have you had to borrow pain medications from your family or friends? | 0 1 2 3 4 |
| 24. How often have you been treated for an alcohol or drug problem? | 0 1 2 3 4 |