



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

This Packet is ONLY for Nerve Pain Treatment Program with the ENR (Electro Nerve Regeneration)

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 reschedule 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 you don't show up for your appointment or if you cancel within 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 the 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. Photo ID
 2. MRI films and reports, CT scan films and reports, bone scan reports
 3. EMG reports
 4. Primary doctor's notes, other specialists' notes (orthopedic surgeon, neurologist, psychiatrist, rheumatologist, oncologists, infectious disease physicians, etc.)
 5. List of current medications

Financial Policy

- We are committed to providing you with the best possible care.
- 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 the time of service, unless you have made payment arrangements in advance with our business office.
- Returned checks will be subject to **an additional \$25 service fee.**

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: _____ Cell Phone: _____

Email: _____

Date of Birth: _____ SS#: _____

(Circle one) Married Single Divorced Widowed Other

Referred by: _____ Phone: _____ Location: _____

Family Doctor: _____ Phone: _____ Location: _____

INSURANCE

Primary Insurance Name: _____

ID #: _____ Group #: _____

Subscriber: _____ Relationship: _____

Subscriber Date of Birth: _____ Subscriber Social Security #: _____

Secondary Insurance Name: _____

ID #: _____ Group #: _____

Subscriber: _____ Relationship: _____

Subscriber Date of Birth: _____ Subscriber Social Security #: _____

Emergency Contact: _____ Phone: _____

Are we authorized to release your medical information to the listed emergency contact? Yes or No

SIGNATURE: _____ DATE: _____



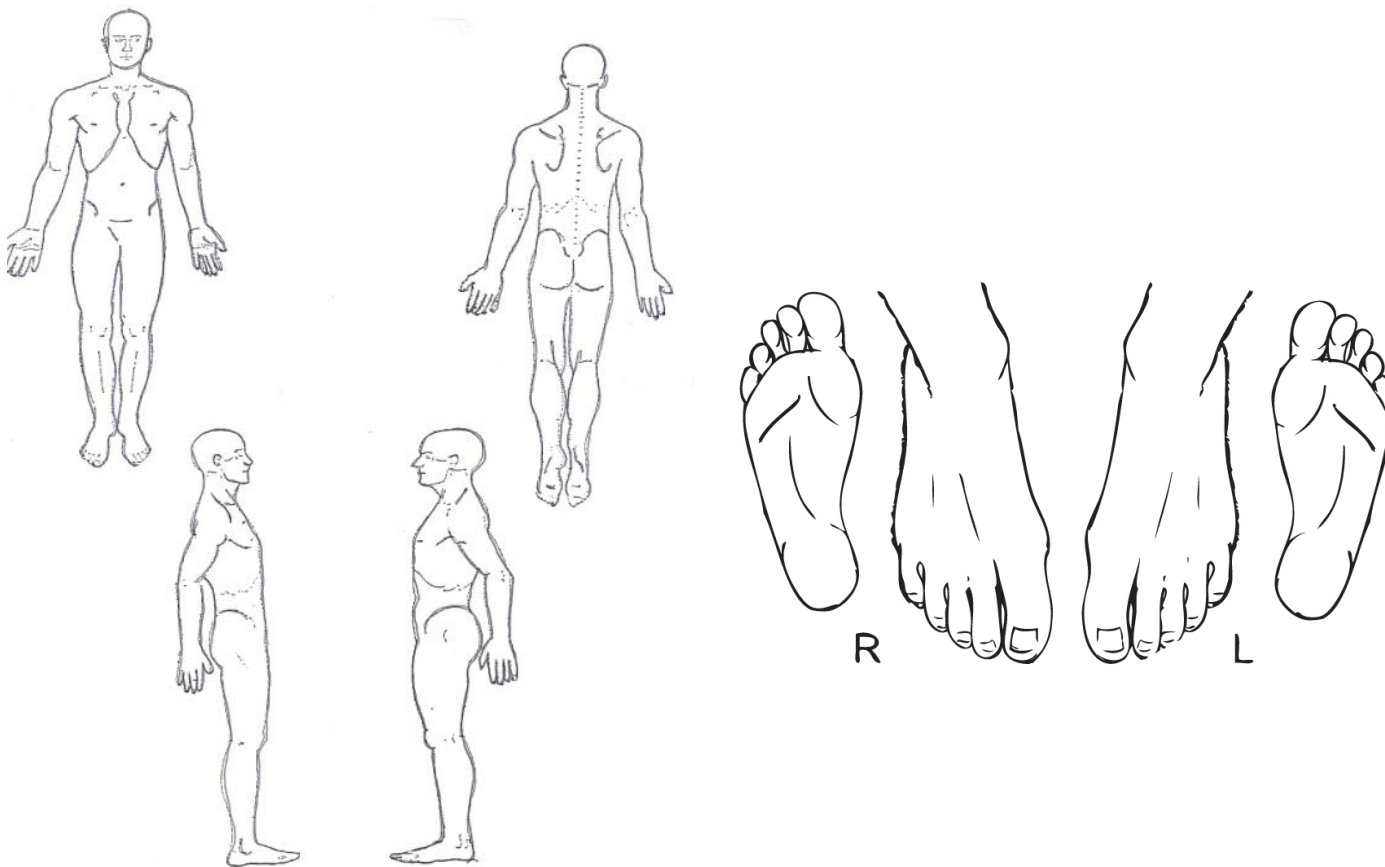
• Today's date: _____ • Name : _____

• Age _____ • Date of Birth _____ • Height _____ • Weight _____

Right hand dominant Left hand dominant • Sex : Male Female

Referral Physician: _____ **Primary Care Physician:** _____

Chief Complaints;



• Current Pain Level (0 ~ 10) 0 1 2 3 4 5 6 7 8 9 10

• Average Pain Level (0 ~ 10) 0 1 2 3 4 5 6 7 8 9 10

• Location _____

• Does the pain radiate (“shooting down” or “shooting up”)? If so, where does the pain radiate?

• When did the pain start? _____

• How did the pain start? _____

• Describe your pain

Dull Aching Sharp Shooting Stabbing Throbbing Numbness Burning

• How often is your pain present? Occasional Frequent Constant

• Worst time of day? Morning Afternoon Evening Night All the time

• Is there any color change or temperature change to the skin? _____

• Numbness anywhere? If so, where? _____

• “Pins and needles”? If so, where? _____

• Weakness? If so, where (example: right leg, right arm, both legs....) _____

• Do you have swelling? If so, where _____

• Do any of the following make symptoms worse? _____

Walking Standing Lying down Sitting Bending forward Bending backward Driving
 Coughing Bowel movement Cold weather Hot weather Rainy day Lifting objects

• Do any of the following make symptoms better? _____

Resting Massage Exercise Sitting Lying down TENS unit Physical therapy
 Injections Sleeping Medication (Names) _____ Other _____

• Sleeping: Good Fair Poor

• How many hours do you typically sleep? 2 hrs 4 hrs 6 hrs 8 hrs >10 hrs

• How often do you wake up at night? 0 1 2 3 4 >5 times

• Are you awoken due to pain? If yes, how often _____

Previous Treatments

Physical therapy Location _____ Date of Last PT _____ Duration _____

Acupuncture _____ Psychotherapy _____

Chiropractor _____ Other (Biofeedback, Meditation, Yoga, Swimming)

TENS Unit Never used I have a unit I don't have one Used at home daily Used at home as needed Used during PT

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 Light headed/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 issues
- 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
 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 Spinal 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 urinating
- 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
 Pacemaker Deliberator Heart failure Angina Other _____
- 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 Other _____
- Cancer _____
- Other _____

Past Surgery History

Allergies

• Latex No Yes Reaction _____ • Contrast (Dye) No Yes Reaction _____

• Allergic to any medication(s)? _____

Previous Medications (Tried previously but failed to relieve the symptoms & pain)

Current Medications

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

- Father side _____
- Mother 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: No Yes (Type) _____

This form is completed by

Patient _____ Date _____

Authorization for Release of Information

Name of Patient _____ Date of Birth _____

Relievis 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 Description of information to be released

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

- Voice Mail
 - 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 authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient

X _____ Date _____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)



Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purpose that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, which may identify you and that, related to your past, present or future physical or mental health or condition and related health care service. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy practices by accessing our web site www.relievus.com, calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and other outside of our office that are involved in your care and treatment of the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice. Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosure that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when have the necessary permission from you to disclose your protected health information. For example, your protected health information is provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time to time to another physician or health care provider (e.g. a specialist or laboratory) who, at the request of your physician, becomes involved in your case by providing assistance with your health care diagnosis or treatment to your physician.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization: Other uses and Disclosure of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made with Your Authorization or Opportunity to Object: We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use of disclosure of the protected health information, then your physician may, using professorial judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member or your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on out professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your

protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or

Opportunity to Object: We may use or disclose your protected health information in the following situation without your authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirement of the law. You will be notified, as required by law, of any such or disclosures.

Public Health: We may disclose your protected health information for public health activities and purpose to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency got activities authorized by law, such as audits, investigations, and inspection. Oversight agencies seeking this information include government agencies that oversee the health care systems, government benefit program, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been victim of abuse, neglect or domestic violence to the government entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirement of applicable federal and state law.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic products deviation, tract products; to enable product recalls; to make repairs replacements, or to conduct post marketing surveillance as required.

Legal Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized) in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These laws enforcement purpose include (1) legal processes and otherwise required by law, (2) limited information request for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises or the practice, and (6) medical emergency (not on practice's premises) and it's likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donations: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to reasonable anticipation of death. Protected health information may be used and disclose for cadaveric organ, eye or tissue donation purpose.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state law, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health protected information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected information to authorized federal official for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Required Uses and Disclosure: Under the law, we must make disclosure to you and when required by the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. Seq.

Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A “designated record set” contains medical and billing records and any other records that your physician and the practice use for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have the decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record. **You have the right to request a restriction of your protected health information.** This means you may ask us not to disclose any part of your protected health information for the purpose of treatment, payment or health operation. You may also request that any part of your protected health information not be disclose to family members or friends who may be involved in your case or for notification purpose as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclose your protected health information, your protected health information will not be restricted. If your physician does agree to the request restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss and restriction you wish to request with your physician. You may request a restriction by **(describe how patient may obtain a restriction.)**

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, as a result of an authorization signed by you or for notification purpose. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. The right to receive this information is subject to certain; restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name _____

Address: _____

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

Signature _____ Date _____