

WELCOME TO ADVANCED SPINE AND PAIN, LLC

Toll Free: (888)985-2727

Fax: (609) 567-8832

Our Commitment to You

- We will provide you with the most appropriate care in the most time efficient fashion.
- We will treat you with respect and professionalism.
- We will always do our best to keep your scheduled appointment and to minimize any wait time you may incur. However, due to circumstances beyond our control, there may be times that we must re-schedule your appointment with short notice.
- In order to give you as much notice as possible, we request a phone contact so that we can reach you in person during the day, such as a business number or cell phone.
- We will do our best to move your appointment to an earlier time or date if we have a cancellation in our office schedule. If you have any questions regarding this information, please do not hesitate to ask us. We are here to help you.

General Information

- Our office hours are very limited. It is very important that you keep your appointment.
- If you have an emergency and cannot keep your appointment, you must contact our office **no later than 48 hours** prior to your scheduled appointment date.
- We may charge a **NO SHOW FEE** if your appointment is not kept or cancelled 48 hours prior to your scheduled time.
- In order to treat you effectively and efficiently and within HIPAA guidelines, we require 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. Recent Blood work reports
 8. Primary doctor's notes, other specialties' notes (Orthopedic surgeon, neurologist, psychiatrist, rheumatologist, etc)
 9. List of current medications

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.

Patient Registration Form

Personal Information			
Name		Date of Birth	
Home Address		Age	
		Sex	
		SS#	
Home phone #		Driver's license #	
Mobile #		Marital status	
Referred by		Pharmacy Name	
Primary physician		Pharmacy phone #	
Employment information			
Employed by		Occupation	
Address		Phone #	
Spouse Information / Guardian's Information if Under Age 18			
Spouse's name		Spouse's occupation	
Spouse's phone #		Spouse employed by	
Emergency contact			
Name		Phone #	
Address		Relationship	
Primary Insurance			
Name of Insurance		Primary Holder	
Address		Policy #	
Subscriber's Birthdate		Group name or #	
Secondary Insurance			
Name of Insurance co		Primary Holder	
Address		Policy #	
Subscriber's Birthdate		Group name or #	
Auto Insurance / Worker's Comp			
Name of insurance co		Primary Holder	
Address		Claim #	
Adjuster's Name		Pre-Cert #	
Phone #			
Date of injury			

ADVANCED SPINE AND PAIN, LLC

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• Today's date: _____ • Name : _____

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

Right hand dominant Left hand dominant • Sex : Male Female

Describe your accident

DATE OF THE ACCIDENT: _____

FRONT/Head-on collision Rear-ended "T-boned" on the driver's side "T-Boned" on the passenger's side

You were a driver You were a front passenger You were a back-seat passenger other

LOSS OF CONSCIOUSNESS ? No Yes Brief moment Unknown

WAS THE AIRBAG DEPLOYED? Yes No

DID YOU WEAR 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)

HOSPITAL? Y / N HOSPITAL: _____ BY AMBULANCE? Y / N

BROUGHT TO THE HOSPITAL BY Friend Family member Spouse

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

XRAY: Y / N HOSPITALIZATION: Y / N RELEASED from the ER same day: Y / N with MEDS Y / N

TREATMENTS SINCE THE ACCIDENT: PT _____ CHIROPRACTOR _____

Trigger Point Injections by _____ PENS by _____

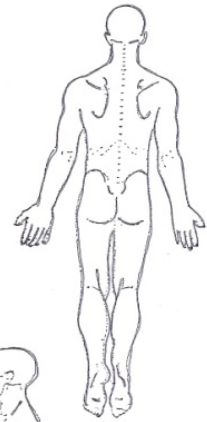
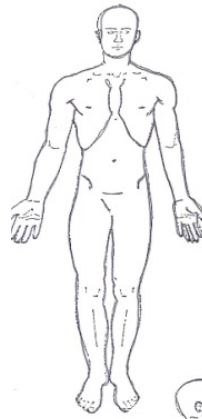
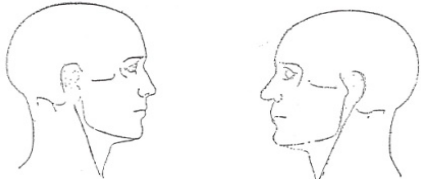
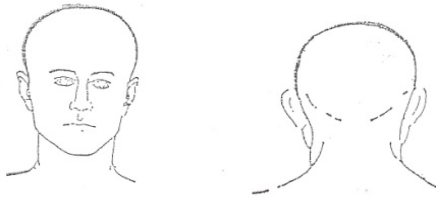
Acupuncture by _____ Joint Injections by _____

Neurologist _____ Orthopedic Surgeon _____

Surgery _____

MEDS (MUSCLE RELAXANTS, NSIADS, TYLENOL, PAIN MEDS) _____

CURRENT PAIN ?



- 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 to the left or right arm” or “shooting up to the head”)

- When was the pain started? _____
- Please, 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
- Any color change or temperature change? _____
- Numbness in anywhere? _____
- “Pins and needles” or tingling sensation in 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 the symptoms better ? _____
 Resting Massage Exercise Sitting Lying down TENS unit Physical therapy Chiropractic treatment
 “Injections” Sleeping Medication (Names) _____ Other _____
- Sleeping : Well “OK” Terrible 2 hrs 4 hrs 6 hrs 8 hrs >10 hrs
- How often do you wake up at night due to pain? 0 1 2 3 4 >5 times
- Physical therapy Location _____ Date of Last PT _____ Duration _____
- Chiropractic treatment Location _____ Date of Last treatment _____ Duration _____
- 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

Previous “injections” treatments

<input type="checkbox"/> Epidural	_____	_____	_____
	Date	Number of injection	Doctor's name
<input type="checkbox"/> Facet	_____	_____	_____
	Date	Number of injection	Doctor's name
<input type="checkbox"/> Trigger point	_____	_____	_____
	Date	Number of injection	Doctor's name
<input type="checkbox"/> PENS	_____	_____	_____
	Date	Number of injection	Doctor's name
<input type="checkbox"/> Acupuncture	_____	_____	_____
	Date	Number of injection	Doctor's name
<input type="checkbox"/> Joints	_____	_____	_____
	Date	Number of injection	Doctor's name
<input type="checkbox"/> Others	_____	_____	_____
	Date	Number of injection	Doctor's name

Previous Injury / Accident History

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

If Yes,

- What kind of injury / accident ? _____
- When? _____
- Symptoms ? _____
- Treatments ? _____
- Last treatment (ex. 2 years prior to this accident) _____

Review of System

- Gen 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 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 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 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
 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 _____
- Cancer _____
- Other _____

Past Surgery History

Allergies

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

• Allergic to any medication(s) ? Not that I know of _____

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) _____ Reason _____

This form is completed by

Patient X _____ Date _____

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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.

• Your health information is contained in a medical record maintained by ADVANCED SPINE AND PAIN, LLC which medical record is the physical property of ADVANCED SPINE AND PAIN, LLC uses and/or discloses your health information to carry out your treatment, to obtain payment for such treatment, for health care operations and for other purposes either permitted or required by law. This Notice of Privacy describes how we may use and/or disclose your health information in connection with providing you with medical treatment or services and describes your rights to obtain access to your health information.

HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

- **For Treatment** – We will use and/or disclose your health information to provide you with medical treatment and related services, including coordination or management of your care with a third party that is also involved in your treatment. For example, we may disclose your health information to another health care provider, such as a specialist to whom you are referred by your physician, or to a laboratory performing tests related to your medical care.
- **For Payment** – We will use and/or disclose your health information to others, as necessary, to obtain payment for the treatment or services you receive. For example, a bill, containing information that both identifies you and your diagnosis or treatment, may be sent to you or directly to your insurance company, health plan or other third party payer. We may also use your health information for the purpose of determining your eligibility or coverage under a certain health plan.
- **Emergencies** – We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.
- **Judicial and Administrative Proceedings** – We may disclose your health information in the course of any administrative or judicial proceeding.
- **Law Enforcement** – We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing in person, complying with a court order or subpoena, and other law enforcement purposes.
- **Deceased Persons** – We may disclose you health information to coroners or medical examiners.
- **Organ Donation** – We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.
- **Specialized Government Agencies** – We may disclose your health information for military, national security, prisoner, and government benefits purposes.
- **Marketing** – We may contact you for marketing purposes or fundraising purposes as described below: (Example) “As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.”

“It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, postcard, invitation or call your home to invite you to participate in the charitable activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Pan Management of Tinton Falls, PA sponsored fundraising events.”

- **For Health Care Operations** – We may also use and / or disclose your health information as necessary to run our business operations and to support the core functions of treatment and payment. These activities include: quality assessment and improvement activities; employee evaluation activities; conducting medical review; legal and auditing services; business planning and development activities; and business management and general administrative activities. We will share your health information, as necessary, with certain “business associates” that provide certain services on our behalf, such as billing or transcription services. Whenever we have an arrangement with a “business associate” involving your health information, we will have that party execute a written contract containing terms that will protect the privacy of your health information.
- **As Required by Law** - We may use and /or disclose your health information as and to the extent required to comply with applicable law. ADVANCED SPINE AND PAIN, LLC may, for example, disclose information in the course of a judicial or administrative proceeding in response to a court order, subpoena or other lawful process, or may be required in certain instances to report certain information to law enforcement officials or other governmental authorities.
- **Public Health Activities** – We may use and / or disclose your health information for public health activity purposes to a public health agency that is permitted to collect such information for the purpose of controlling disease, injury, disability or other health oversight activities.
- **Disclosure to Coroners, Funeral Directors and for Organ Donations** – We may disclose your health information to a coroner or medical examiner for identification purposes, to ascertain the cause of death or to carry out other purposes authorized by law. ADVANCED SPINE AND PAIN, LLC may also disclose health information to a funeral director, as authorized by law, to permit the funeral director to perform his/her duties. Further, protected information may be used for cadaveric organ, eye or tissue donation purposes.
- **Research** – We may disclose your health information to researchers when the institutional review board that has reviewed the research proposal has established protocols to ensure the privacy of your health information.
- **Workers Compensation** – We may use and / or disclose your health information in order to comply with applicable laws and regulations related to Workers Compensation.
- **Appointment Reminders and Miscellaneous Other Uses** – ADVANCED SPINE AND PAIN, LLC may also use your health information to provide appointment reminders, or to send you materials with respect to treatment alternatives or other health-related information that may be of interest to you.

YOUR HEALTH INFORMATION RIGHTS

- *You have the right to inspect and copy your health record.* (However, federal and/or state laws may prohibit inspection of certain records, such as psychotherapy notes.)
- *You have the right to request a restriction on certain uses and disclosures of your information.* However, ADVANCED SPINE AND PAIN, LLC is not obliged to agree to the requested restriction.
- *You have the right to request communications of your health information by alternative means or at alternative locations.* (We will accommodate reasonable requests made, in writing, to our Privacy Officer.)
- *You may have the right to have your physician amend your health information.* (You may request an amendment, and in certain cases we may deny your request, in which event, you may file a statement of disagreement and we may opt to prepare a rebuttal thereto, in which case, we will provide you with a copy of such rebuttal.)
- *You have a right to revoke your authorization to use or disclose your health information, except to the extent that action has already been taken.*
- *You have the right to receive an accounting of certain disclosures of protected health information we have made.* (This right pertains to disclosures made after April 14, 2003 and does not include disclosures made for treatment, payment or operation purposes or as covered by other restrictions, exceptions or limitations set forth in federal regulations at 45 CFR Section 164.58.)
- *You have the right to obtain a paper copy of this Notice from us upon request.*

COMPLAINTS

- You may complain to ADVANCED SPINE AND PAIN, LLC and/or to the Department of Health and Human Services if you believe we have violated your privacy rights. We will not retaliate against you for filing a complaint. You may file a complaint with us by notifying our office;

2 Eighth Street, Hammonton, NJ 08037 (888) 985-2727

- You may also contact our office manager if you have any questions concerning our policies or your health information.
- If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
 200 Independence Avenue, S.W.
 Room 509F HHH Building
 Washington, D.C. 20201

OUR RESPONSIBILITIES

ADVANCED SPINE AND PAIN, LLC is responsible to:

- Protect the privacy of your health information
- Provide you with this Notice of its duties and practices
- Comply with the terms of this Notice
- Obtain your written authorization to use and / or disclose your information for reasons other than those listed above or permitted by law.

MODIFICATION OF PRIVACY NOTICE

ADVANCED SPINE AND PAIN, LLC reserves the right to change its information practices and make new provisions effective for all protected health information it maintains. Any modification shall have prospective application, but will apply to health records made both before and after the effective date of the policy modification. Revised Notices will be made available to all then current patients and posted in a prominent location within our office. We will also mail copies to any current or former patient who has advised us, in writing, that they want us to mail them copies.

HIPPA PRIVACY PRACTICE ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of the Offices of ADVANCED SPINE AND PAIN, LLC. Our Notice of Privacy Practices provides information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at (888) 985-2727

Name _____

Signature X _____ Date _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Name and Signature of Provider Representative:

_____ Date _____

ADVANCED SPINE AND PAIN, LLC

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AUTHORIZATION AND CONSENT

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to **ADVANCED SPINE AND PAIN, LLC** for any services furnished me by **ADVANCED SPINE AND PAIN, LLC**. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to myself or to the party who accepts assignment.

I request that payment of authorized Medigap Benefits be made on my behalf to **ADVANCED SPINE AND PAIN, LLC** for any services furnished me by **ADVANCED SPINE AND PAIN, LLC**. I authorize any holder of medical information about me to release to my insurance carrier any information needed to determine these benefits payable for related services.

AUTHORIZATION to release information and payment request. I certify that they service(s) covered by this claim has been received and I request that payment for these services be made on my behalf. I authorize any holder of medical or other information about me to release to the Division of Medical Assistance and Health Services or it's authorized agents any information needed for this or a related claim.

ASSIGNMENT OF INSURANCE BENEFITS: I irrevocably assign all payments to **ADVANCED SPINE AND PAIN, LLC** for medical insurance benefits including any Major Medical Benefits otherwise payable to me under the terms of my policy but not to exceed the balance due to **ADVANCED SPINE AND PAIN, LLC** for services performed during this period of treatment. In making this assignment, I understand and agree that I am financially responsible to the above party for charges not paid under this insurance policy. I permit a copy of this authorization to be used in place of the original.

RELEASE OF INFORMATION: **ADVANCED SPINE AND PAIN, LLC** may disclose any or all parts of the clinical record to me (our) insurance company(s) or employer(s) for purposes of satisfying charges billed by **ADVANCED SPINE AND PAIN, LLC**. I further understand that it may be necessary for **ADVANCED SPINE AND PAIN, LLC** to contact my (our) past or present employer(s) in regards to this claim. This authorization does not cover 3rd party liability claims.

GUARANTEE OF ACCOUNT: **ADVANCED SPINE AND PAIN, LLC** For and in consideration of services rendered by ASAP to the below named patient, the undersigned (jointly and severally, if more than one) guarantees payment of all charges incurred for said patient in accordance with the policy of payment of such bills. There will also be added 35% collection and reasonable attorney fee if your account goes to a collection agency.

THE UNDERSIGNED CERTIFIES THAT EACH HAS READ AND UNDERSTANDS THE ABOVE TERMS AND CONDITIONS.

_____ X _____
Patient's Name Patient's Signature Date

ADVANCED SPINE AND PAIN, LLC

Opioid (Narcotic) Contract

I understand that in order to receive care for the treatment of pain in ADVANCED SPINE AND PAIN, LLC, 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 the physician or/and the 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 must be obtained at the SAME PHARMACY. Should the need arise to change pharmacies our office must be informed.
4. I WILL take medications as a dose and frequency prescribed. Any changes in the dose or frequency will be discussed with my Physician and nurse practitioners in ADVANCED SPINE AND PAIN, LLC. If my medications are prescribed 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 be given the date of the original appointment.
7. I WILL receive prescriptions at the interval determined by the physician and nurse practitioners in ADVANCED SPINE AND PAIN, LLC.
8. I WILL NOT receive controlled substances for the treatment of pain from any source other than the physician and nurse practitioners in ADVANCED SPINE AND PAIN, LLC.
9. I WILL communicate with my primary physician that I am on contract with ADVANCED SPINE AND PAIN, LLC for the controlled prescribing of pain medications. I understand ADVANCED SPINE AND PAIN, LLC has the permission to discuss all diagnostic and treatment details with the dispensing pharmacist or other professionals who provide your health care.
10. I WILL consent to random drug testing. I will NOT use any illegal substances (cocaine, heroin, marijuana, crystal methamphetamine, ecstasy, ketamine, etc.) while being treated with controlled substances. Refusal of such testing or positive results will result in prompt termination of care from ADVANCED SPINE AND PAIN, LLC.
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 schedule appointments. 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 and nurse practitioners. 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 ADVANCED SPINE AND PAIN, LLC 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 of ADVANCED SPINE AND PAIN, LLC personnel.
 - d) I do not follow up regularly or as requested by my physician.

21. 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.

_____ X _____
Patient's Name Patient's Signature Date

Advanced Spine and Pain, LLC

2 Eighth Street, Hammonton, NJ 08037

Young J. Lee, MD

Milind D. Patharkar, MD

Telephone: (888)985-2727

Facsimile: (609)567-8832

Assignment of Benefits & LTD. Power of Attorney

Patient's Name: _____

Date of Accident: _____

I irrevocably assign to you, my medical provider, all of my rights and benefits under my insurance contract for payment for services rendered to me. I authorize you to file insurance claims on my behalf for services rendered to me as a result of this automobile accident and this specifically includes filing arbitration/litigation on your name on my behalf against the PIP carrier/health care carrier. I irrevocably authorize you to retain an attorney of your choice on my behalf for collection of your bills. I direct that all reimbursable medical payments go directly to you, my medical provider. I authorize you to act on my behalf. I consent to your acting on my behalf in this regard and in regard to my general health insurance coverage pursuant to the "benefit denial appeal process" set forth in the NJ Administrative Code.

In the event the insurance carrier responsible for making medical payment in this matter does not accept my assignment, or my assignment is deemed invalid, I execute this limited power of attorney and appoint your collection attorney as my agent to collect payment for your medical services directly against the carrier in this case including filing and arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in your name as a medical provider rendering services to me.

I authorize you and or your assigned to obtain medical information regarding my physical condition from any health care provider, including hospitals, diagnostic centers, etc., and I specifically authorize such health care provider to release all such information to you about me, including medical reports, x-ray reports, narrative reports, and any other report or information regarding my physical condition.

Date: _____

Patient's Signature

Parent/Legal Guardian