

PAIN AND WELLNESS CENTER

Julien Vaisman, M.D.

Joe Ordia, M.D.

Dear Patient:

Thank you for scheduling an appointment at **Pain and Wellness Center**, 10 Centennial Drive, East Entrance, Peabody, MA 01960.

Once you have downloaded your Patient Registration packet, please fill out the forms completely and bring with you to your appointment.

To ensure that your appointment is not delayed in any way, also bring with you:

- **Medical records from your primary care physician, orthopedic surgeon, neurologist, etc.**
- **MRI and/or X-ray films and reports.**
- **Insurance card(s)**
- **Insurance Referral (if required)**
- **Insurance co-pay (there will be a \$10 service fee if co-pay is not paid at the time of the visit). Cash, credit/debit card or money orders are accepted methods of payment. NO PERSONAL CHECKS.**
- **Prescription bottles for any pain medicine you are currently taking showing the last time the prescription was filled, the quantity and the dose.**
- **Completed Pain Questionnaire**

During your first visit (and at follow-up visits), you will see one of our medical professionals at **Pain and Wellness Center**, including Dr. Julien Vaisman, Dr. Joe Ordia and Nurse Practitioners, Leslie Levitan and Karen Little. For those unfamiliar with nurse practitioners (NPs), NPs are registered nurses with advanced training and education. They conduct physical exams and can prescribe medications. Each NP is board certified in the state of Massachusetts. The NPs on staff consult with Dr. Vaisman and/or Dr. Ordia to design an appropriate treatment plan for the management of your pain.

Please give 24-hour notice if you need to cancel or reschedule your appointment. Our office hours are Monday-Friday, 8:30 AM – 4:30 PM. A \$75.00 fee will be billed for all **NO SHOW** appointments.

Sincerely,

Julien Vaisman, MD

PATIENT REGISTRATION

Patient Name: _____

Address: _____ (Last) _____ (First) _____ (Middle Initial) _____
City _____ State _____ Zip _____

Telephone: Home () _____ Work () _____ Cell () _____

Email address: _____

Date of Birth: ___/___/___ Age: ___ Sex: ___ SSN: _____ Marital Status: _____

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____

Telephone: () _____ Work: () _____

PRIMARY INSURANCE: _____ Subscriber: _____

IF SUBSCRIBER IS NOT THE PATIENT - Subscriber DOB: _____ Subscriber SSN: _____

Certificate Number: _____ Group Number: _____ Co-pay \$ _____

SECONDARY INSURANCE: _____ Subscriber: _____

IF SUBSCRIBER IS NOT THE PATIENT - Subscriber DOB: _____ Subscriber SSN: _____

Certificate Number: _____ Group Number: _____ Co-pay \$ _____

Primary Care Physician: _____ Phone: () _____

Address: _____

Referred By: _____ Phone: () _____

Address: _____

WORKMAN'S COMPENSATION – Is this a work related injury? [] Yes [] No

****IF YOU HAVE AN OPEN CLAIM, YOU MUST FILL OUT AND SIGN THE WORKERS' COMPENSATION FORM****

CHARGES CAN NOT BE BILLED TO YOUR HEALTH INSURANCE CARRIER.

IF WORKERS' COMPENSATION INFORMATION IS NOT PROVIDED, YOU WILL BE RESPONSIBLE FOR ANY CHARGES INCURRED.

Signature of Patient or Authorized Individual: *I authorize release of medical or other information necessary to process all Government, commercial and workers' compensation insurance claims. I authorize the payment of medical benefits to the attending physician or supplier for services rendered. I understand that I am financially responsible for all charges not paid by my insurance and/or workers' compensation carrier.*

Signature: _____ Date: _____

PAIN AND WELLNESS CENTER

Patient Pain Questionnaire

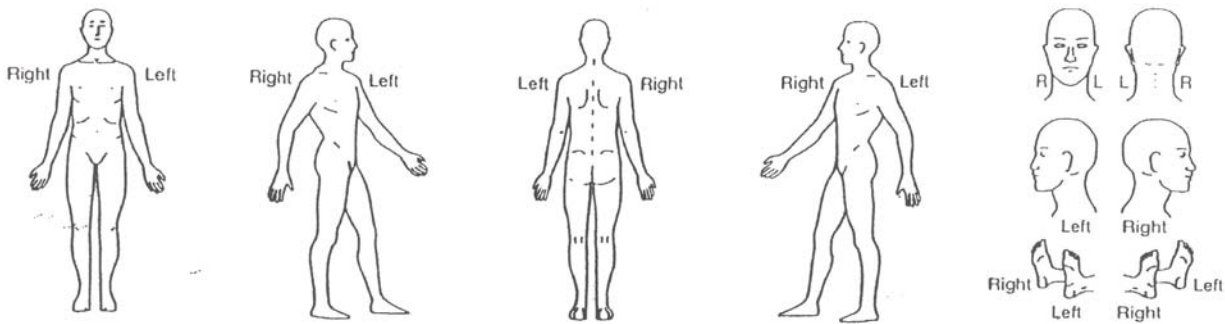
PLEASE COMPLETE PRIOR TO INITIAL APPOINTMENT

Name: _____ Age: _____ Sex: ___M___F

Referring Physician: _____ Primary Care Physician _____

1. Where is your major source of pain? _____

Please indicate, on the diagram below, where your pain is located.



2. How did your pain begin? (i.e. lifting injury, motor vehicle accident, etc.) _____

3. What do you believe is causing the pain? _____

4. Have you had surgery related to your pain (i.e. discectomy, fusion, laminectomy)?
 Yes No

If yes, please complete the following:

Procedure	Date	Surgeon	Hospital	Outcome

5. Is your pain constant? Yes No

6. Which best describes your pain currently: sharp dull burning aching
 throbbing stabbing other _____

NAME: _____

Please rate your pain on the scale below:

	<u>No Pain</u>	<u>Mild</u>	<u>Discomforting</u>		<u>Distressing</u>		<u>Horrible</u>		<u>Excruciating</u>		
At Present	0	1	2	3	4	5	6	7	8	9	10
Worst Pain	0	1	2	3	4	5	6	7	8	9	10

7. What makes the pain worse?

- Coughing/Sneezing
- Lifting over 15 lbs.
- Lying Down
- Walking
- Hot/Cold Weather
- Bowel Movement
- Exercise
- Sitting
- Damp/Dry Weather
- Sexual Activity
- Standing
- Other _____

8. Which of the following helps the pain?

- Bed Rest
- Physical Therapy
- Exercise Program
- Psychotherapy
- Drinking Alcohol
- TENS (Transcutaneous Electrical Nerve Stimulation)
- Brace/Cast
- Counseling
- Acupuncture
- Biofeedback
- Trigger Point Injections
- Chiropractor
- Relaxation Training
- Massage Therapy
- Hypnosis

List all Medication(s):

Drug	Dose	How many times per day?	Comments

9. Do you have weakness in your extremities? Yes No

10. Is the pain better at certain times of the day or night? _____

11. Please describe the effects of your pain:

- Accompanying symptoms: (e.g. nausea, headaches) _____
- Sleep _____
- Appetite _____
- Physical Activity _____
- Relationship with others (e.g. irritability) _____
- Emotions (e.g. anger, suicidal thoughts, crying) _____
- Concentration _____
- Other _____

NAME: _____

12. Have you undergone Nerve Blocks/Pain Procedures?

Date	Procedure	Physician	Hospital	Outcome

13. Have you ever had any of the following to diagnose your problem?

- X-rays CT Scan MRI Myelogram EMG Bone Scan
 Other, please specify: _____

PAST MEDICAL HISTORY:

Please indicate all surgeries that you have had below:

Date	Procedure	Surgeon	Hospital	Outcome

Please circle the following conditions that you currently or have previously experienced:

Epilepsy/seizure disorder, migraine headaches, cluster headaches, strokes, hyperthyroidism, hypothyroidism, heart disease/heart attack, high cholesterol, high blood pressure, anemia, tuberculosis, asthma, emphysema, chronic bronchitis, gastric reflux, peptic ulcer, kidney disease, arthritis, diabetes, mental illness, alcoholism, drug addiction, cancer (specify) _____
Other: _____

SOCIAL HISTORY:

1. Do you smoke? Yes No
If yes, how many packs per day? _____ How many years? _____
2. Do you drink alcohol? Yes No
If yes, how much and how often? _____
3. Do you use illicit drugs? Yes No
If yes, please specify: _____
4. Marital Status: Married Divorced Widowed Single
5. How many children do you have? _____
6. Are you currently working? Yes No
If yes, what is your occupation? _____

NAME: _____

14. Do you have any of these symptoms?

- a. **General:** fever, sweats, chills, skin rashes, headaches.
- b. **Head:** head injuries
- c. **Eyes:** decreased vision, double vision, visual spots/flashing lights, sensitivity to bright lights, cataracts, glaucoma.
- d. **Ears:** decreased hearing, ringing of the ears, dizziness, infection.
- e. **Nose:** nasal congestion, sneezing, hay fever, nose bleeds.
- f. **Mouth/Throat:** sore tongue, sore throat, hoarseness, bleeding gums, neck masses, stiff neck.
- g. **Breast:** breast mass, breast pain, breast discoloration.
- h. **Respiratory:** cough, coughing up blood, shortness of breath, wheezing, asthma, bronchitis, emphysema, pneumonia, tuberculosis.
- i. **Cardiovascular:** chest pain, palpitations, shortness of breath with lying down, shortness of breath at night time, leg edema, leg cramps with walking, heart failure, high blood pressure, rheumatic fever, heart murmurs, abnormal EKG.
- j. **Gastrointestinal:** heartburn, nausea, vomiting, vomiting of blood, rectal bleeding, black tarry stools, hemorrhoids, constipation, diarrhea, abdominal pain, jaundice, liver or gall bladder trouble, hepatitis.
- k. **Urinary:** frequent urination, burning or pain upon urination, blood in your urine, reduced force of urinary stream, urinary hesitancy, incontinence, urinary infections, stones.
- l. **Musculoskeletal:** muscle or joint pain, stiffness, arthritis, gout, joint redness, joint swelling, weakness, limitation of joint motion.
- m. **Neurologic:** fainting, seizures, weakness, paralysis, numbness, tingling, tremor.
- n. **Hematologic:** anemia, easy bruising or bleeding, prior blood transfusions.
- o. **Endocrine:** Heat or cold intolerance, excessive sweating, excessive thirst or hunger, frequent urination, hyperthyroidism, hypothyroidism, diabetes.
- p. **Psychiatric:** nervousness, tension, suicidal thoughts, suicide attempts, depression, schizophrenia, manic-depressive.

15. Please list all allergies (including medicine): _____

PAIN AND WELLNESS CENTER

Financial Policy

The Pain and Wellness Center participates with most insurance plans including Workman's Compensation, with the exception of MassHealth/Medicaid and Blue Care 65. Motor Vehicle Accidents (MVA) and Liens are not acceptable forms of insurance. You must have active health insurance coverage as well.

All **past due balances** are to be paid in full prior to further treatment unless other arrangements have been made.

New "self-pay" patients must pay for the initial visit, in full, by either cash or credit card (Visa or MasterCard). No personal checks will be accepted.

We require 24-hour notice for cancelled appointments. Repeated cancellations or no shows could result in discharge from the practice.

- **CO-PAY AND DEDUCTIBLE PAYMENTS ARE DUE AT THE TIME OF SERVICE.**
- **A VALID REFERRAL MUST BE OBTAINED PRIOR TO YOUR VISIT. (Without a valid referral your appointment will be cancelled and/or rescheduled until the appropriate referral is obtained.)**
- **PAYMENT CAN BE IN THE FORM OF CASH, CREDIT/DEBIT CARD OR MONEY ORDERS. NO PERSONAL CHECKS.**

INSURANCE

Insurance is a contract between you and your insurance company. We are **NOT** a party to this contract. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, pre-existing conditions, etc, other than to supply factual information as necessary. **You are responsible for the timely payment of your account.**

PPO/HMO

Each time you make an appointment with any physician, it is your responsibility to make sure your physician is currently under contract with your plan and to obtain the appropriate referral or authorization for your visit. **Verification of your plan is required. Therefore, you must show your current card to our receptionist at each visit.**

MINORS ACCOMPANIED BY ADULT

PAIN AND WELLNESS CENTER

Financial Policy

The parents (or guardian) accompanying a minor are responsible for full payment at time of service.

Your signature below indicates that you have read and understand our **Financial Policy**. If you have any questions, or need any further information please let us know.

Patient Signature

Date

Print Name

PAIN AND WELLNESS CENTER

Julian Vaisman, MD

Joe Ordia, MD

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 (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes 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, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. 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 others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

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. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for our health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organization Donation, Research, Criminal Activity, Military Activity and National Security: Workers' Compensation, Inmates, Required Uses and Disclosure. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

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.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. 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.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes 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 physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. 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 alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

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.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Signature

Date

Print Name

Pain and Wellness Center - Contact Us - Maps/Driving Directions to Peabody Office

From Boston:

- Take Route 93 North to Route 95/128 North.
- Exit 45 (stay left onto Route 128) where 95 and 128 splits
- Take 128 North to Exit 28. Stay in the middle lane on the off ramp, which will veer to the right.
- Turn LEFT at the first light onto Centennial Drive (Technology Center).
- Take your first LEFT into 10 Centennial Drive.
- Turn LEFT into the complex and follow the sign that says "The Pain and Wellness Center", at the East Entrance
- Turn RIGHT into our parking lot.

From Southeastern New England:

- Take 95/128 North to Exit 45 (stay left onto Route 128) where 95 and 128 splits
- Take 128 North to Exit 28. Stay in the middle lane on the off ramp, which will veer to the right.
- Turn LEFT at the first light onto Centennial Drive.
- Take your first LEFT into 10 Centennial Drive (Technology Center).
- Turn LEFT into the complex and follow the sign that says "The Pain and Wellness Center", at the East Entrance
- Turn RIGHT into our parking lot.

From Northern New England:

- Take Route 95 South to Route 128 North
- Take 128 North to Exit 28. Stay in the middle lane on the off ramp, which will veer to the right.
- Turn LEFT at the first light onto Centennial Drive.
- Take your first LEFT into 10 Centennial Drive (Technology Center).
- Turn LEFT into the complex and follow the sign that says "The Pain and Wellness Center", at the East Entrance
- Turn RIGHT into our parking lot.

From 128 North:

- Exit 28. Continue STRAIGHT on the off ramp.
- Turn LEFT at the first light onto Centennial Drive.
- Take your first LEFT into 10 Centennial Drive (Technology Center).
- Turn LEFT into the complex and follow the sign that says "The Pain and Wellness Center", at the East Entrance
- Turn RIGHT into our parking lot.
- The Pain and Wellness Center is on Centennial Drive directly across from the North Shore Cancer