



Julien Vaisman, MD
Joe Ordia, MD
Karen Little, NP
Jane Sammarco, NP

NAME: _____ DATE OF APPOINTMENT: _____ TIME: _____

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

Enclosed is our Patient Registration packet and directions. Please complete all forms and bring with you to your appointment.

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

- Medical records from Primary Care Provider, Orthopedic Surgeon, Neurologist etc. **(IF OUTSIDE OF THE PARTNERS NETWORK)**
- MRI and/or XRAY films, CDs, and reports **(IF OUTSIDE OF THE PARTNERS NETWORK)**
- Picture ID (license, passport, etc)
- Insurance card(s)
- Insurance referral (if required)
- Insurance co-pay (Cash, checks, credit/debit cards, or money orders are accepted methods of Payment)
- Prescription bottles of any pain medicine you are currently taking showing the last time the Prescription was filled, the quantity, and the dosage. **PLEASE DO NOT TRANSFER YOUR PRESCRIPTIONS TO OUR FACILITY UNTIL AFTER YOUR EVALUATION AND ONLY IF APPROVED BY ONE OF OUR PROVIDERS.**
- Completed Pain Questionnaire

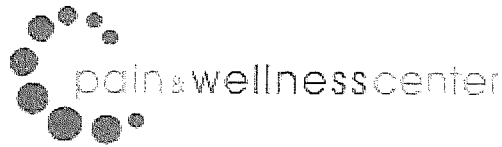
During your first visit, and at follow-up visits, you will see one of our medical professionals at the Pain and Wellness Center including Dr Julien Vaisman, Dr Joe Ordia, and Nurse Practitioners Karen Little and Jane Sammarco. For those unfamiliar with Nurse Practitioners (NPs), NPs are registered nurses 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. For more information about our practice, please visit our website at www.painandwellnesscenter.com

Please give 24-hour notice by calling 978-826-7230 if you need to cancel or reschedule your appointment. A \$25.00 fee will be billed for ALL NO-SHOW appointments.

Our office hours are Monday-Friday, 8:30AM to 4:30PM.

Sincerely Yours,

Julien Vaisman, MD



PATIENT REGISTRATION

First name _____ Middle Initial _____ Last name _____

Sex M ___ F ___ DOB: ____/____/____ Social Security #: _____ Marital Status: ___

Street address: _____ City: _____

State _____ Zip _____ Occupation _____

Telephone (H): _____ (W) _____ (C) _____

E-Mail address: _____

In case of emergency, please notify: _____ Phone: _____

Referred by: _____ Telephone: _____

Referring Physician's Address: _____

Primary Care Physician: _____ Telephone: _____

Address: _____

PRIMARY INSURANCE INFORMATION

Insurance carrier: _____ ID #: _____ Group #: _____

Subscriber's name: _____ Date of Birth: _____

Relationship to patient: _____ Telephone: _____

SECONDARY INSURANCE INFORMATION (if applicable)

Insurance carrier: _____ ID# _____ Group #: _____

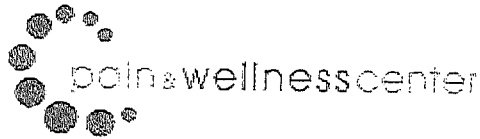
Subscriber's name: _____ Date of Birth: _____

Relationship to patient: _____

Signature _____

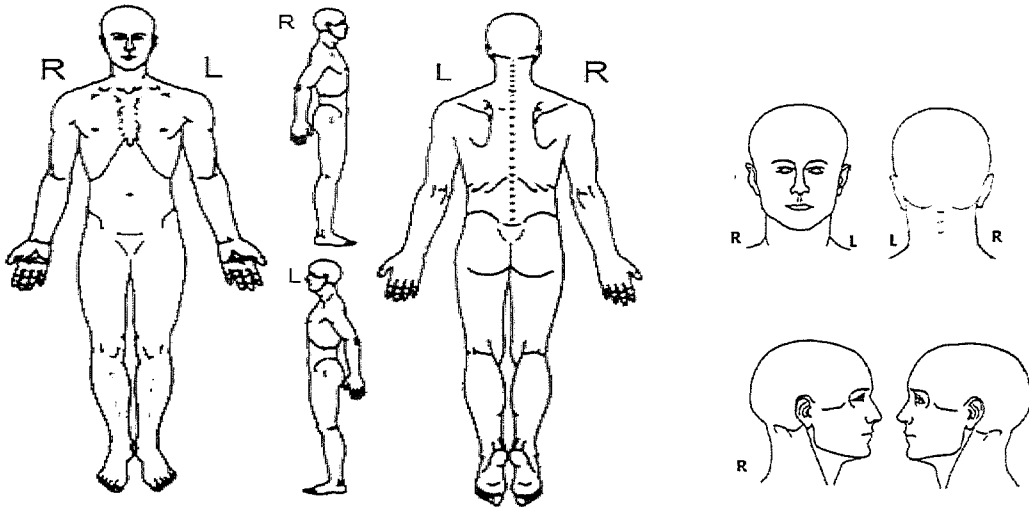
Date _____

Print Name _____



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.)

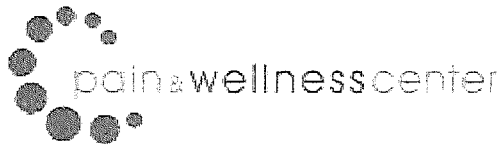
3. What do you believe is causing the pain? _____

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 _____

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
Worst Pain	6	7	8	9	10	

7. What makes the pain worse? Check all that apply
- Coughing/Sneezing Lifting over 15lbs. 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? Check all that apply
- Bed Rest Drinking Alcohol Trigger Point Injections Tens Unit
 Physical Therapy Brace/Cast Chiropractor Biofeedback
 Exercise Program Counseling Relaxation Training
 Psychotherapy Acupuncture Massage Therapy

LIST ALL MEDICATION(S):

DRUG	DOSE	HOW MANY TIMES PER DAY?	COMMENT

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

10. Do you have weakness in your extremities? Yes No
11. Is the pain better at certain times of the day or not? _____



12. 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 _____

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 _____

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: _____

Review of Systems:

Do you have any of the following?

General

- Fever Chills
- Weight Loss
- Weight Gain
- Recent infection
- Skin rash
- Headache

Head

- Head injuries

Eyes

- Decreased vision
- Double vision
- Visual spots/Flashing lights
- Sensitivity to bright lights
- Cataracts
- Glaucoma

Ears

- Hearing loss
- Ringing in the ears
- Ear pain
- Ear drainage
- Ear infection
- Dizziness/Vertigo

Nose

- Nasal congestion
- Hay fever
- Nose bleeds
- Sneezing
- Loss of sense of smell
- Sinusitis

Mouth/Throat

- Sores tongue
- Sore throat
- Hoarseness
- Bleeding gums
- Tooth infection
- Loss of taste
- Difficulty swallowing
- Bleeding gums
- Sore throat
- Hoarseness

Breast

- Breast mass
- Breast pain
- Breast discoloration

Hematologic

- Anemia
- Easy bruising or bleeding
- Prior blood transfusion
- Taking blood thinner

Respiratory

- Cough
- Coughing up blood
- Shortness of breath
- Wheezing
- Asthma
- Bronchitis
- Emphysema
- Pneumonia
- Tuberculosis
- Pulmonary embolus

Cardiovascular

- Chest pain
- Palpitations
- Shortness of breath lying down
- Shortness of breath at night
- Leg edema
- Leg cramps with walking
- High blood pressure
- Heart failure
- Rheumatic fever
- Heart murmur
- Atrial fibrillation
- Abnormal EKG

Gastrointestinal

- Abdominal pain
- Heartburn
- Nausea
- Vomiting
- Vomiting blood
- Rectal bleeding
- Black tarry stool
- Hemorrhoid
- Difficulty swallowing
- Diarrhea
- Constipation
- Jaundice
- Liver or gall bladder problem
- Hepatitis

Urinary

- Urinary infection
- Cloudy urine
- Frequent urination
- Urinary incontinence
- Pain or burning with urination
- Blood in urine
- Weak urinary stream
- Urinary hesitancy
- Urinary incontinence
- Kidney stone

Musculoskeletal

- Muscle or joint pain
- Stiffness
- Arthritis
- Gout
- Joint redness
- Joint swelling
- Weakness
- Limitation of joint movement
- Fractures

Neurologic

- Fainting
- Dizziness/Vertigo
- Seizures
- Weakness
- Paralysis
- Numbness
- Tingling
- Tremor
- Parkinson's Disease
- Multiple sclerosis

Endocrine

- Heat or cold intolerance
- Excessive sweating
- Excessive thirst or hunger
- Frequent urination
- Diabetes
- Hypothyroidism
- Hyperthyroidism

Psychiatric

- Anxiety
- Depression
- Tension or Stress
- PTSD
- Suicidal thoughts
- Suicide attempt
- Bipolar
- Schizophrenia
- Manic-depressive
- Addiction

Others

- _____
- _____
- _____
- _____



The 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, Network Health and Blue Care 65. Motor Vehical 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.

"SELF PAY" patients must pay cash or credit card for the initial visit and any subsequent visits, in full. 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,CHECK, CREDIT/DEBIT CARD OR MONEY ORDERS

INSURANCE

Insurance is a contract between you and your insurance company. We are NOT a party to this contract. 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 insurance plan is required. Therefore, you must provide current insurance information and/or inform our office if there have been any changes made to your insurance plan or benefits.

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



**10 Centennial Dr.
East Entrance
Peabody, MA 01960**

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.

Our practice is committed to educating our patients about healthcare issues that affect them. As a result, we are providing you with general information about the Privacy Rule, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) along with a brief overview of our Notice of Privacy. Our practice does comply with HIPAA regulations.

What is HIPAA and how does the Privacy Rule affect you? The Health Insurance Portability and Accountability Act of 1996 (HIPAA) gave the federal government the ability to mandate how healthcare plans, providers, and clearinghouses store and send a patient's personal information as it relates to healthcare. The Privacy Rule was created to protect your rights as a patient of our practice and we are required by law to comply with this regulation. Under the Privacy Rule, you are guaranteed access to your medical records, allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by following the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

What is Individually Identifiable Health Information? Any health information you provide to our practice, including your mailing address. Information that is created and retained by our practice or received from another healthcare provider that relates to your treatment, healthcare operations, payment and/or that identifies you as an individual.

What is the Notice of Privacy Practice? Our official Notice of Privacy Practice is posted in our reception area and informs our patients about their rights surrounding the protection of their Individually Identifiable Health Information and our obligations concerning the use and disclosure of such information. This notice applies to all records created, obtained or retained by our practice. We may update our Notice of Privacy Practices at any time. Our Notice of Privacy Practice will be posted in our reception area and you may ask for a copy at any time.

The following categories describe the circumstances in which we may use and disclose your Individually Identifiable Health Information: Treatment - Appointment Reminders - Payment - Health Care Operations - Treatment Options - Disclosures required by law - Health related benefits and services

The following categories describe unique situations in which we may disclose your Individually Identifiable Health Information: Public Health Risks - Health Oversight Committees - Lawsuits and Similar Activities - Deceased Patients - Organ and Tissue Donation Serious Threats to Health or Safety - Military - National Security - Inmates - Worker's Compensation - Law Enforcement - Research

What are your rights concerning your Individually Identifiable Health Information? You have rights regarding the Individually Identifiable Health Information that we maintain about you.

1. Confidential Communications
2. Requesting Restrictions
3. Inspection and Copies
4. Amendment
5. Accounting of Disclosures
6. Right to a Paper Copy of this Notice
7. Right to File a Complaint
8. Right to Provide an Authorization for Other Uses and Disclosures

If you have any questions regarding this notice or our Privacy Practices please contact:

Jenna Connolly,
Privacy Officer
10 Centennial Dr.
Peabody, MA 01960
Phone: 978-826-7230

I have read the short notice provided by Pain and Wellness Center and have been informed of how to obtain more information regarding the practice's Notice of Privacy.

Signature

Date

Print Name