Valley Pain Specialists, P.C.

Please fill out all information that applies, if it does not apply, please put N/A

Name	Home Phone#	Work Phone#
Address	Cell Phone #	
	DOB	
SS#	Gender: ☐ Male ☐ Female	Spouse's DOB
Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Emergency Contact or Spouse	Phone:	

Referring Physician:	Phone & Address:
PCP/Family Physician:	Phone & Address:
Pharmacy:	Phone & Address:

Primary Insurance Personal Coverage	**Secondary Insurance Personal Coverage**
Company Name	Company Name
Policy #/ID / Group#	Policy #/ID / Group#
Name of subscriber	Name of Subscriber
Subscriber SS# Subscriber DOB	Subscriber SS# Subscriber DOB

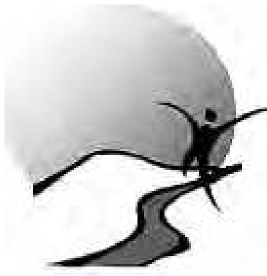
Fill out this block if your medical expenses will be covered by Worker's Compensation or Auto Insurance	
Insurance Company	**Claim/Policy #**
Phone #	Address:
Date/Area of Injury:	Case Manager
Employers Name	**Employers Telephone**
Attorneys Name	**Attorney's telephone**

I hereby acknowledge and accept final responsibility for payment of charges for medical services rendered. I hereby consent treatment for myself, my child, or the above mentioned minor, for whom I accept responsibility. The release of medical information to any insurance carrier and direct payment to Valley Pain Specialists, P.C. for treatment or examination rendered is authorized.

Please Sign ____
Signature of Patient or Guardian Date

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Valley Pain Specialists, P.C., for any services furnished me by the physician or supplier. 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 for related services.

Please Sign ____
Signature of Patient or Guardian Date



VALLEY PAIN SPECIALISTS, PC
Steven Mortazavi, M.D.
Christopher Lee, M.D.
Marissa Marion, PA-C
Ashley Zimmerman, PA-C
4250 Fritch Drive
Bethlehem, PA 18020
Telephone: (610) 954-9040
Fax: (610) 954-9093

CONTROLLED SUBSTANCE AGREEMENT

This agreement relates to my use of controlled substances for chronic pain prescribed by a provider at Valley Pain Specialists, P.C. I have been informed and understand the policies regarding the use of controlled substances that are followed by the staff at Valley Pain Specialists. I understand that I will be provided controlled substances while actively participating in this program only if I adhere to the following conditions:
1.) I will use the substances only as directed by Valley Pain Specialists.
2.) I will not receive replacement medications that I have lost or have been stolen.
a) I understand that I am responsible for the medication and prescriptions used in my treatment. I must be discreet about my possession of narcotics and I will keep my medications and prescriptions in inaccessible places so that they are not lost or stolen.
3.) I will receive controlled substances only from Valley Pain Specialists staff.
4.) I will not expect to receive additional medications prior to the time of my next scheduled refill, even if my prescription runs out.
a.) Running out of medications prior to your next scheduled refill may result in discharge.
5.) If it appears to the physician that there are is no clear benefits to your daily function or quality of life from the controlled substance, the provider will gradually taper my medication as directed by the prescribing physician.
6.) I agree to sumit to urine and blood screens to detect the use of non-prescribed medications (including "street" drugs) at any time.
7.) I recognize that my chronic pain represents a complex problem, which may benefit from interventional treatments, physical therapy, psychotherapy and behavioral medicine strategies. I also recognize that my active participation in the management of my pain is extremely important. I agree to actively participate in all aspects of the Pain Management Program to maximize function and improve coping with my condition.
8.) I agree to schedule and keep scheduled follow-up appointments with my Valley Pain provider at the recommended intervals. I understand that failure to do so may lead to discontinuation of treatment and/or discharge from the practice.
9.) I am responsible for keeping track of the amount of medication I have left and to plan ahead for arranging the refill of my prescriptions in a timely manner so I will not run out. I realize that this may affect travel plans, etc...
10.) I agree to use one pharmacy for filling all my prescriptions except in case of emergency.
11.) If the violation involves obtaining controlled substances or any prescription for my pain condition from another individual, or if I engage in any illegal activity such as altering a

prescription, I understand that the incident may be reported to my Valley Pain provider, to other physicians caring for me, local medical facilities, pharmacies, and other authorities such as the local police department, DEA, etc. as deemed appropriate for the situation.
12.) **Agree not to seek pain medication after office hours, on the weekend, or on holidays.**
13.) Understand that attempting to obtain pain medication after office hours, on the weekend, on holidays, or from other physicians may result in discontinuing pain medications and/or discharge from the Practice.
14.) I understand that I have been given informed consent about the risks of opioid addiction and readdiction. **I realize that I must take my pain medications exactly as prescribed and that not doing so may result in overdose or death. I also understand that taking legal or illegal drugs with my pain medications without my doctors knowledge may result in overdose or death.**
15.) If I violate any of the above conditions, my obtaining prescriptions and/or treatment at Valley Pain Specialists, PC may be terminated.
MEDICATION REFILL INFORMATION:
a.) Refill requests should not be made prior to (72) hours before you are due for a refill.
b.) Requests for scheduled refills must be telephoned to our prescription refill line (610)-954-9040. Refills will not be made at night, on holidays or weekends.
c.) Most controlled substances cannot be telephoned into a pharmacy. You must make arrangements to pick up your prescriptions during regular business hours. Prescriptions will not be mailed.
d.) Prescriptions refills will not be able to be picked up more than 48 hours before your scheduled due date.

THIS AGREEMENT WILL SUPERSEDE ALL OTHER AGREEMENTS!
BY SIGNING BELOW, I INDICATE THAT I UNDERSTAND AND AGREE TO ALL THE TERMS OF THE AGREEMENT. I RESERVE THE RIGHT TO REQUEST A COPY OF THIS AGREEMENT.

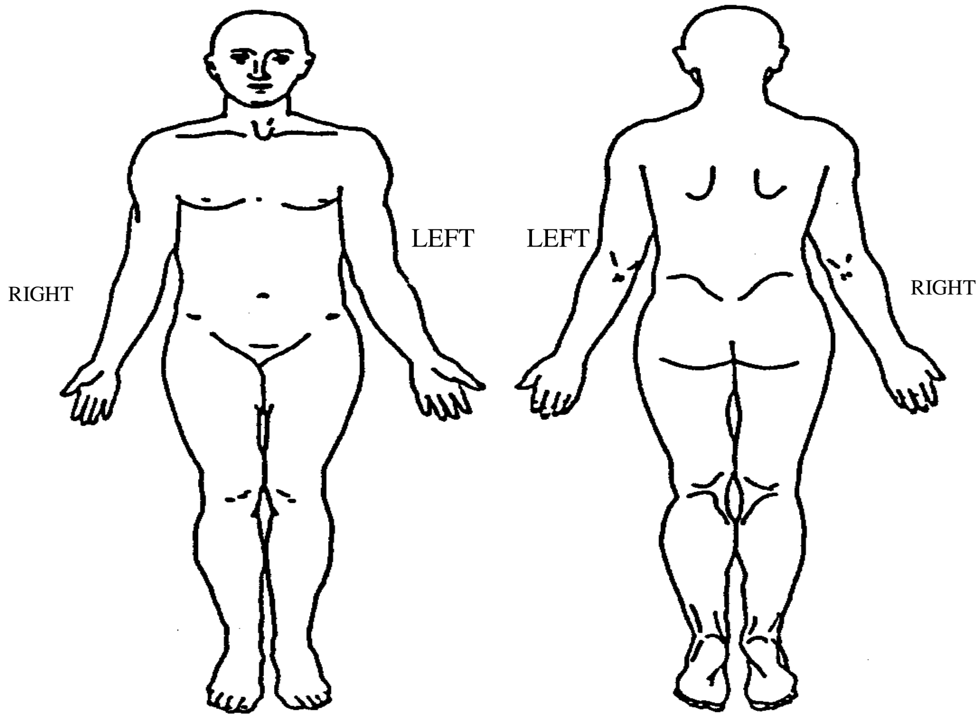
____
Signature Date

Name___________________________ Date____________

Valley Pain Specialists: Patient Questionnaire

Please complete **before** your appointment

1. Where is your pain located? Shade in area on diagram.



2. **When** did your pain begin? ___________________
3. **How** did your pain begin? (injury, workman's compensation, auto accident?)

____
____
____
____
____

4. How do you **describe your pain**? (Circle all that apply)

Sharp Stabbing Gnawing Dull Burning Heavy Shooting
Exhausting Throbbing Cramping Sickening Numbing Aching

5. Is your pain constant or on and off? ____

6. What kind of things help relieve your pain? (heat, ice, medicine, sitting…)

____

____

7. What kind of things make your pain worse? (stairs, walking…)

____

____

8. On a scale of 0-10 circle your average pain over the last month with 10 being the worst:

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain

9. What treatments have you had for your pain? (Circle all that apply)

Physical therapy Biofeedback TENS therapy Accupuncture
Chiropractic care Medications Counseling Hypnosis
Injections (list type and dates)

____

____

Other (list)

____

____

10. What tests have you had to evaluate your pain?

Test	Date	Location	Results
MRI			
CT-Scan			
X-Rays			
Myelogram			
EMG			
Other			

11. What **medications** do you take?

12. Do you have **allergies** to medications? No Yes (list) ____________________
____

13. Have you ever been exposed to or diagnosed with MRSA? No Yes (date) ____________________

14. Do you have an Advance Directive? No Yes

15. What **medical problems** do you have?

____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________

16. What **surgeries** have you had? Date

____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________
____________________ ____________________

17. Do you take blood thinning medications (Example- **Coumadin**)? No Yes (list) ____________________
____

18. Does anyone in your family have a history of spinal problems? No Yes (list) ____________________
____

19. Does anyone in your family have medical problems?

	Medical Problems
Father	
Mother	
Brothers	
Sisters	

20. List your present occupation:

____

21. Are you involved in workers compensation? No Yes (list date of injury)

____

22. Are you involved in litigation (circle one)? No Yes (name of attorney)

____

23. Are you (Circle one):

Single *Married* *Widowed* *Divorced* *Separated*

24. Do you have children? No Yes (number) ____________________

25. Do you smoke? No Yes (amount) ____________________

26. Do you drink alcohol? No Yes (amount) ____________________

27. Do you have any of the following?

	No	Yes	Explain
Chest pains			
Shortness of breath			
Leg swelling			
Depression			
Constipation			
Cancer			
leeding problems			

28. Has there been a change in any of the following?

	No	Yes	Explain
Sleep			
Weight			
Appetite			
Bowel/ Bladder patterns			
Hearing			
Vision			

Valley Pain Specialists, PC
4250 Fritch Drive
Bethlehem, PA 18020
610-954-9040 tel
610-954-9093 fax

COMBINED ACKNOWLEDGEMENT AND CONSENT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

This acknowledgement of notice and consent authorizes Valley Pain Specialists to use and disclose health information about you for treatment, payment, and healthcare operations purposes.

Notice of Privacy Practices: Valley Pain Specialists has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgment and consent.

Amendments: We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to contact our Privacy Officer

VALLEY PAIN SPECIALISTS, PC
4250 Fritch Drive
Bethlehem, PA 18020

Acknowledgement and Consent: I have received the Notice of Privacy Practices for Valley Pain Specialists, PC and authorize them to use and disclose health information about treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

____
Signature of patient (or patient's personal representative) Date

____
Name of personal representative Date

VALLEY PAIN SPECIALISTS, PC
Steven Mortazavi, M.D.
Allen Kao, M.D.
Marissa Marion, PA-C
Ashley Zimmerman, PA-C

4250 Fritch Drive
Bethlehem, PA 18020
Telephone: (610) 954-9040
Fax: (610) 954-9093

Dear Patient:

Welcome to Valley Pain Specialists, P.C. We would like to briefly state our office policies to you.

You are required to present your health insurance card at every appointment. If your health insurance requires a referral, this is your responsibility to get from your primary care physician. If you do not have a referral or your insurance cards, you have the option of paying in full up front for your visit or to reschedule your appointment. Copayments, deductibles, and co-insurance are collected at time of check in.

If you have a worker's compensation or automobile accident claim that we are submitting bills to, we require you to present your health insurance card also. If the worker's compensation or automobile claim closes or exhausts throughout your treatment time with Valley Pain Specialists, we will bill your private health insurance. If you do not present your insurance to us, or if you have no other health insurance coverage, the bill becomes your full responsibility. We do not accept claims in litigation.

Valley Pain Specialists does not tolerate consecutive cancellations or no-shows. If you cancel an appointment in less than 24 hours of the scheduled appointment time, this is considered a no-show. Patients with (3) or more no-shows will be discharged from the practice.

If you need a prescription refill, you must call (72) hours in advance and leave a message on our prescription hotline. We will notify you when the prescription is ready for pick up (we do not mail prescriptions), and they may only be picked up by someone listed on your consent sheet. There will be no medication changes made over the phone.

Please limit the amount of people you bring with you for your appointment. We have limited space in the waiting area and exam rooms. If you need to bring your children, please make sure they are accompanied by another adult at all times. Children will not be allowed in the exam rooms.

By signing below, you are giving your consent to Valley Pain Specialists to take your photo. This photo will be used soley for identification purposes.

If you have any questions, please contact our Practice Administrator at (610) 954-9040.

____

Patient Signature Date

Valley Pain Specialists, PC
4250 Fritch Drive
Bethlehem, PA 18020
610-954-9040 tel
610-954-9093 fax

Worker's Compensation (W/C), Motor Vehicle Accident (MVA), and Litigation Patients:

It is the policy of this office to request your health insurance information in addition to your Worker's Compensation, Motor Vehicle Accident, or other information you may have already provided to us.

Your health insurance will be billed ***only*** in the event your claim is denied.

It is also your responsibility to understand and follow the guidelines of your health insurance. If you are enrolled in a health maintenance organization (HMO) that requires referral forms from your primary care physician in order to be treated by a specialist, this office requires you follow through with obtaining the appropriate referrals. Again, your insurance will ***only*** be billed in the event your Worker's Compensation or Motor Vehicle Accident insurance is denied.

In the event that your Worker's Compensation or Motor Vehicle Accident claim is denied, and you have not followed the guidelines of your health insurance, or do not have primary health insurance, **you will be liable for all outstanding balances.** In addition, you may be responsible for copays, deductibles, and or coinsurance depending on your type of health insurance.

If your Worker's Compensation or Motor Vehicle Accident claim is in **litigation** or it goes into **litigation** throughout your treatment at Valley Pain Specialists, your treatment may become suspended pending insurance resolution.

It is our goal to have all your claims paid by your insurance carriers, therefore, we ask for your cooperation in this matter. If you have any questions on this matter, please contact a representative from the billing department.

Your signature is required to process your claim completely, otherwise, we reserve the right to postpone or reschedule your appointment.

____

Patient signature   Date