PREMIER
MED GROUP

WELCOME TO OUR OFFICE

Dear Patient:

Enclosed please find an information packet consisting of a welcome registration form, health history questionnaires, notice of our privacy practices, privacy practice acknowledgement form, authorization form to leave messages, and financial agreements. Please review and complete these forms. Please bring this packet with you to your initial evaluation appointment. Bringing these forms will allow you to save time on your appointment day.

There are a few things to remember when coming to your appointment. Please bring your insurance card(s), driver's license (or any photo identification), a script from your referring physician, tests or x-rays / reports that you have in your possession, and a list of your current medications.

A special note to patients, it is the policy of Premier Med Group that acceptance of a patient for an initial evaluation does not in any way constitute an obligation to continue any previously prescribed treatments meant for the treatment of pain. If you are concerned about this, please make sure that your current physician discusses your case ahead of time with Dr. Das.

We appreciate your time in completing these forms. If possible return these forms prior to your appointment date. It will cut down the waiting time the day of your appointment. If not please bring them with you the day of your initial appointment. We look forward to seeing you.

Your appointment is scheduled for _____ at _____ AM / PM. If you cannot make this appointment, please contact the office at least 24 hours in advance. Please review the Cancellation Policy. Directions are included in this package.

With kind regards,

The Staff at Premier Med Group
Office# (908) 904-1900
Fax# (908) 904-1908

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PATIENT INFORMATION

Last Name_____, First Name_____ MI_____

DOB ____/____/_____ SSC # _____-____-_____ Sex: M / F Marital Status: _____

Address _____ City _____ State ___ Zip _____

Home# (____)-____-_____ Cell # (____)-____-_____ Work# (____)-____-_____

Employer _____

Please indicate the number you prefer to be reached at: Home / Cell / Work

Referring Doctor _____ Phone# (_____)-_____-_____

Primary Doctor _____ Phone# (_____)-_____-_____

Pharmacy _____ Phone# (_____)-_____-_____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____ Phone#_____

MEDICAL INSURANCE INFORMATION

Primary Insurance _____ ID# _____ Group# _____

Name of Subscriber _____ DOB ___/___/_____ SSC# ____-___-_____

Secondary Insurance _____ ID# _____ Group# _____

Name of Subscriber _____ DOB ___/___/_____ SSC# ____-___-_____

Is this a work related injury? Yes / No Motor Vehicle Accident? Yes / No

Other Insurance (Workers Comp / Auto) _____ Adjustor _____

Date of Accident ____/____/_____ Claim# _____ Phone# (_____)-_____-_____

I GIVE PERMISSION TO VIVEK T. DAS, MD OF PREMIER MED GROUP TO PROVIDE MEDICAL CARE TO ME.

I hereby direct the above insurance companies to pay Premier Med Group all benefits for covered care services provided by said companies. **I understand that I will remain financially responsible to Premier Med Group to the extent that benefits that are not covered or paid by the above insurance companies or if I do not provide any insurance information.**

_____ _____

Signature of Patient / Guardian Date

PREMIER MED GROUP

FINANCIAL POLICY

Thank you for choosing us as your Pain Management provider. We are committed to providing you with quality and affordable healthcare. Because some of our patients may have questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have and sign in the space provided. A copy of this policy can be provided to you upon request.

1. **Insurance Plans.** We are participating providers with Medicare, Qualcare, First Health, Great West, Local 825 Operating Engineers and Medicaid. If you are not insured by a plan we do business with, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions that you may have regarding your coverage.
2. **Co-payments**. All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Please help us in upholding your agreement by paying your co-payment at each visit.
3. **Non-covered Services**. Please be aware that some of the services you receive may be non-covered or not considered necessary by your insurance, even though your physician feels that it is essential to your care. If they decide not to pay for a service, then we ask that you submit payment for that item.
4. **Claims Submission.** If we participate with your insurance carrier, we will submit your claim and assist you in any way to help get your claims paid.

   If we do not participate with your insurance carrier, payment for your visit payment will be expected at the time services are rendered. As a courtesy to you we will submit your claims to your insurance carrier and you will be reimbursed directly. We will assist you in any way we reasonably can to help you get your claim paid.

5. **Coverage Changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. We will also need to have a copy of your new insurance card.
6. **Non-Payment.** If your account is over 30 days past due, you will received a letter from our billing department. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid **we will charge your credit card per the information you provided** and/or refer your account to collection.

Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of Patient or Responsible Party Date

PREMIER MED GROUP

ASSIGNMENT OF BENEFITS

MEDICARE
Name of Beneficiary: _____ Medicare Policy # _____

I request the payment of authorized Medicare insurance benefits to be made on my behalf to Premier Med Group I authorize Premier Med Group to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits payable.
I understand my signature requests that payment be made and authorizes the release of medical information necessary to pay the claims. Premier Med Group agrees to accept the charge determination of the CMS or its agents as the full charge. The patient is responsible for the deductible, co-insurance ad non-covered services. Co-insurance and deductible are based upon the charge determination of CMS or its agent.

_____ _____
Beneficiary Signature Date

MEDICARE SUPPLEMENTAL/COORDINATION OF BENFITS

Name of Beneficiary _____ Medicare Policy# _____

Insurance Company _____ Policy# _____

I request that payment of authorized Medicare Supplemental (Medigap) benefits to be paid to Premier Med Group. I authorize Premier Med Group to release medical information needed to determine these benefits payable to related services to the Medigap insurer indicated above.

_____ _____
Beneficiary Signature Date

INSURANCE

Name of Beneficiary _____

Insurance Company_____ Policy# _____

I request that payment of authorized insurance benefits be made on my behalf to Premier Med Group for any services furnished to me by Dr. Vivek T. Das. I authorize release of any medical information deemed necessary to determine these benefits payable.

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ASSIGNMENT OF BENEFITS – (Continued)

I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the claim form is completed, my signature authorizes releasing of the information to the same insurance company (ies) of its agents. Premier Med Group agrees to accept the contracted fee schedule with those insurance companies with Premier Med Group holds a current contract. The patient is responsible for all deductibles, co-insurance and non-covered services. If we do not participate with your insurance, the patient is responsible for all deductibles, co-insurance and non-covered services. It is the patients' responsibility to check with their insurance as to benefits and covered services. Insurance coverage is a contract between the insured (Patient) and the insurance company.

_____ _____

Beneficiary Signature Date

PREMIER MED GROUP

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 PREMIER MED GROUP, which medical record is the physical property of PREMIER MED GROUP.
PREMIER MED GROUP 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
Following Uses and Disclosures Do Not Require Your Authorization
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.
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, is 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. PREMIER MED GROUP 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. PREMIER MED GROUP 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 organ, eye or tissue donation and transplant 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 – PREMIER MED GROUP 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.

PATIENTS 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, PREMIER MED GROUP 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 many 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 PREMIER MED GROUP 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 management, whose number and address is set forth below: **Phone# (908)-704-9007**
Practice Name: PREMIER MED GROUP
Address: 501 OMNI DR. HILLSBOROUGH, NJ 08844
You may also contact us if you have any questions concerning our policies or your health information.

OUR RESPONSIBILITIES

PREMIER MED GROUP is legally 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

PREMIER MED GROUP 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 those copies.

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HIPPA PRIVACY PRACTICE ACKNOWLEDGEMENT

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of the Office of Dr. Vivek T. Das, PREMIER MED GROUP Our Notice of Privacy Practices provides information as to how we may use and disclose your protected health 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 908-704-8088. If you have any questions about our Notice of Privacy Practices of the Office of Dr. Vivek T. Das, PREMIER MED GROUP, please contact the office.

_____ _____

Signature of Patient / Guardian 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:

_____ _____

Signature of Patient / Guardian Date

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Date: _____

MEDICAL HISTORY

_____, _____ _____
Last Name First Name Middle

Age: ___ Height: _____ Weight: _____ lbs Handedness: __Right __Left Sex: M / F

Marital Status: __Single __Married __Divorced __Widowed __Separated

With whom do you live: [ ] Alone [ ] Spouse [ ] Child/ren [ ] Parent/s [ ] Other: _____

Present or Most Recent Occupation: _____ [ ] Full Time Parent

If not working date last worked: _____

Current Employment Status: [ ] Full-time [ ] Part-time [ ] Retired [ ] Disabled

[ ] Unemployed

Litigation History: Is there any litigation in progress regarding your pain condition? Yes / No

ALLERGIES (list all the substances you are allergic to)

[ ] Medications _____
[ ] Food _____
[ ] Environmental _____
[ ] None

Last Menstrual Period: _____ [ ] N/A

Smoking Habits: [ ] Smoker Packs/Day _____ [ ] Ex-Smoker Year Quit _____ [ ] Never

Alcoholic Beverages: How Often? _____ How Much? _____

Current Description of Pain

Location –

Quality –

Intensity –

Aggravating Factors –

Alleviating Factors –

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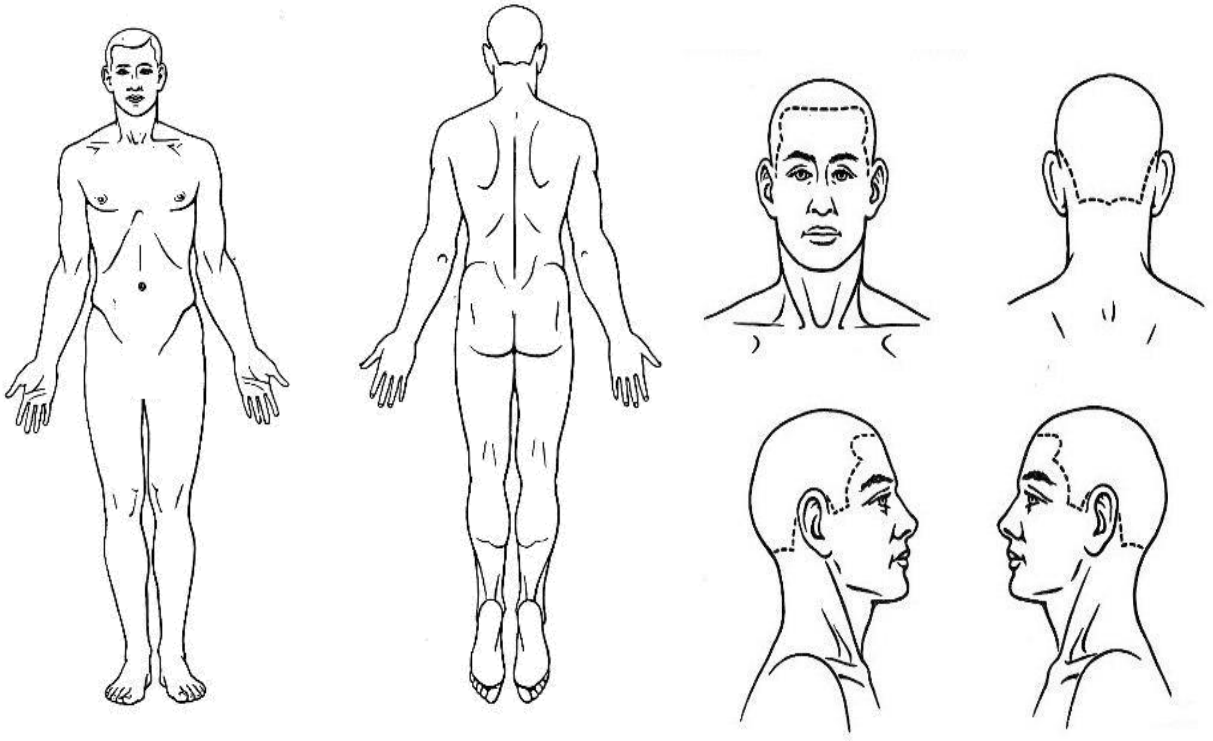
Shade the painful area in the diagram below. (Please circle the one most painful area)



Check appropriate boxes that describe your pain. (Shade only one circle within each category)

	None	Mild	Moderate	Severe
Throbbing	○	○	○	○
Shooting	○	○	○	○
Stabbing	○	○	○	○
Sharp	○	○	○	○
Cramping	○	○	○	○
Gnawing	○	○	○	○
Hot-burning	○	○	○	○
Aching	○	○	○	○
Heavy	○	○	○	○
Tender	○	○	○	○
Splitting	○	○	○	○
Tiring-exhausting	○	○	○	○
Sickening	○	○	○	○
Fearful	○	○	○	○
Punishing-Cruel	○	○	○	○

Present Pain Intensity	
	(Circle one)
0	No Pain
1	Mild
2	Discomforting
3	Distressing
4	Horrible
5	Excruciating

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Please make a slash mark on the scale from 0 – 10 to indicate how you feel

1. What is the average level of pain you have every day on a scale of 0-10 with "0" being No PAIN and "10" the WORST IT CAN GET?----------
2. How much is pain interfering with your activities on a scale of 0-10 "0" being NOT AT ALL "10"
3. COMPLETELY? ----------
4. What is the worst consequence of your pain? (Withdrawal from people, lose temper, overeat, etc.)
   Specify in detail –

Previous Medications (Shade appropriate circle below if you have used these type of medications for your current pain condition)

O Narcotics (i.e. Demorol, Morphine, Dilaudid, MS Contin, Methadone, Percocet, Percodan, Talwin, Vicodin, Codeine, Tylenol 3, Tylox, Fentanyl Patch) Other _____

O NSAIDS (i.e. Aspirin, Motrin, Ibuprofen, Dolobid, Toradol, Advil, Naprosyn, Relafen, Orudis) Other____

O Sedatives / Relaxants (i.e. Ativan, Xanax, Valium, Librium, Flexeril, Parafon Forte) Other _____

O Sleep medicines (i.e. Halcion, Ambien, Restoril, Benadryl) Other_____

O Antidepressants (i.e. Elavil, Pamelor, Desipramine, Effexor, Desyrel, Prozac, Zoloft, Paxil, Serzone, Remeron) Other_____

O Anticonvulsants (i.e. Neuronton, Klonopin, Tegretol, Dilantin) Other_____

O Neuropathic Pain Medications (i.e. baclofen, Mexitil, Hytrin, Phenoxybenzamine, Ultram, prazosin) Other_____

Previous Treatments (Circle all that apply)

Acupuncture	Traction	TENS Unit	Psychiatrist	Chiropractor	Warm Heat
Physical Therapy	Biofeedback	Massage	Psychologist	Other: _____	

Review of Systems (Circle all that apply)

Fever	Shortness of Breath	Black Bowel Movement	History of Easy Bruising
Weight Loss	Wheeze	Nausea	Urinary Frequency
Sweats	Chest Pain	Weakness/Paralysis of Arms & Legs	Difficult to Urinate
Swelling	Palpitations	Bowel or Bladder Incontinence	Headache
Rash	Abdominal Pain	Lightheadedness	Pregnancy
Cough	Constipation	Dizziness	Sputum Production
Diarrhea	Vision Changes	Other: _____	

Sleep # ___ hours per night

☐ No Relevant Positive Systems

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PMH (Circle all that apply)

Arrythmia	Heart Attack	Angina / Coronary Artery Disease	Stroke
Heart Failure	High Blood Pressure	Liver Disease	Kidney Disease
Peptic Ulcer	Other GI illness	Bleeding Disorder	Taking Anticoagulants
Thyroid Disease	Cancer	Rheumatologic Disease	Migraine Headaches
Diabetes	Depression	Emphysema or Asthma	Skin Condition
Seizures	Other (Specify) : _____		

☐ No Relevant PMH

Past Surgical History (Please indicate date, type of surgery, and physician's name)

Date	Surgery	Surgeon

Medications (Include all OTC medications as well as vitamins, supplements, etc. currently being used)

Drug	Dose	How many times / day