# REGISTRATION FORM

## HealthCare Pain Centers, LLC

**(Please Print)**

**Patient Information**

Name ______________________________ Sex: M/F Soc. Security ______________

*Last Name* *First Name* *Initial*

Address: __________________________ City_____________ State ____Zip ______

Home Phone: _______________ Cell Phone _______________ Work Phone _____________

Marital Status _____ Your occupation __________ Date of birth _______________

Primary Physician ________________________ Phone_________ Referral doctor ______________

Emergency Contact: __________________ Phone __________Relationship__________

Email ________________

We are required by the federal Government to ask and collect information on race, ethnicity and employment status and language preferences. We appreciate you providing us with this information.

**Race**

__ American Indian/ Alaska Native

__ Asian

__Black/ African American

__Native Hawaiian or other Pacific Islander

__ White

**Work Status**: __ Full time __ Part time __ Disability

Employer: ______________________

Address: _______________________

**Ethnicity**: __ Hispanic / Latino __ Not Hispanic/ Latino

**PLEASE FILL OUT FOR BOTH ACCIDENT AND NON-ACCIDENTAL CASES**

Primary insurance: ______________________ Name of insured: ______________________

Address of insured: ______________________________ Date of birth __________

Secondary Insurance: ________________ Name of insured: __________________________

**AGRREMENT AND RELEASE**

I Understand and agree that (regardless of my insurance status), I am ultimately responsible for that balance of my account for any professional services rendered. I assign directly to Health Care Pain Centers/ Francisco Del Valle all insurance benefits. If any otherwise, payable to me for services. I understand that I am finically responsible for all charges weather or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions. I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf. I certify that this information is true and correct.

_____________________________________________________________Responsible

Party Signature Date

# Healthcare pain center llc

*Francisco DELVALLE m.d.*

Welcome to *HEALTHCARE PAIN CENTER, LLC* and thank you for selecting Dr. Francisco DelValle for your pain management needs.

Please be advised that we participate with most but not all insurance plans and will gladly file a claim to your insurance carrier on your behalf to seek reimbursement for services provided to you. A list of all par and non-par plans is available to you. It will be the duty of the office to obtain authorization from your plan for any procedures that may need to be performed, but it will be the patient's responsibility to obtain any referral from the primary care physician if they are required by your plan. You will have a financial responsibility applicable to health care services provided by an out-of-network professional and will be held responsible for all co-payments, deductibles and any co-insurance. The estimated amount that will be billed for our services is available upon request. We recommend that you contact your insurance carrier should you require further consultation on the cost that might be associated with the scheduled services. A list of Physicians and Facilities we work with is available to you, please use the contact information provided should you need to determine the health benefit plans in which these health providers participate.

Our billing department will send you a statement once your claim has been filed to keep you up to date of the status of your account. Any questions can be directed to the billing department at 201-342-1205. They are available to assist you Monday through Friday from 8:30AM until 5:00 PM.

ASSIGNMENT OF BENEFITS / RELEASE OF MEDICAL INFORMATION

I ______________________________ hereby authorize and direct my insurance ____________________ carrier(s), including Medicare, private insurance and any other health/medical plan to issue payment check(s) directly to *HEALTHCARE PAIN CENTER, LLC* for medical services furnished to me or my dependent regardless of my insurance benefits, if any. I understand that my insurance company may only cover a portion of the total bill. I further understand that I may be responsible for all charges not covered by this assignment. In addition, I authorize *HEALTHCARE PAIN CENTER, LLC* to disclose any and all written information from the above-named insurance company and/or its designated representatives, at the determination of to *HEALTHCARE PAIN CENTER, LLC*. Such disclosure shall be for reimbursement purposes for those services received. I hereby release to *HEALTHCARE PAIN CENTER, LLC*, its officers, agents, employees and any clinical staff associated with my case, from all liability that may arise as a result of disclosure of information to the above-named insurance company(s) or their designated representatives. By signing this assignment of benefits and release of information I acknowledge:

1. I am aware and understand that this authorization will not be used unless the above-named insurance company(s) or their designated representatives request records or information for reimbursement purposes; or seek to take action regarding payment for treatment/services. I am also aware and have been advised of the provisions of Federal and State Statues, rules and regulations that provide for my right to confidentiality of these records

2. I have been provided a list of facilities and physicians with contact information and have been informed as to how to determine the health benefit plans in which they participate and advised that I should contact my health carrier for any further consultation on costs associated should services be provided to me by these health care professionals.

3. *HEALTHCARE PAIN CENTER LLC* is appointed by me to act as my authorized representative and on my behalf in any proceeding that may be necessary to seek payment from my insurance carrier and is assigned the right to pursue all courses of action, including, but not limited to the right to pursue payment and all administrative appeals and litigation as necessary. This includes receiving a copy of my insurance plan's documents.

4. I authorize the use of this signature on all insurance submissions. Furthermore, I permit a copy of this authorization to be used in place of the original. I understand that this assignment and authorization will remain in effect until revoked by me in writing.

5. A firm contracted by to *HEALTHCARE PAIN CENTER, LLC* for billing and collection purposes may do billing.

I acknowledge receipt of a completed and signed copy of this assignment and release

______________________________________________

Patient/Responsible Party Signature: Date

______________________________________________

Staff/Witness: Date:

Diplomate
American Board of
Physical Medicine & Rehabilitation

Diplomate
American Board of
Pain Medicine

# HEALTHCARE PAIN CENTERS, LLC

FRANCISCO DELVALLE, M D
Ph: 201 342 1205 Fax: 201 342 1259

## CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATION

I hereby acknowledge receipt of written notice of my privacy rights and I consent to HEALTHCARE PAIN CENTERS, LLC using and disclosing my protected health information to carry out treatment, payment, or health care operations.

I understand and have been provided with a Notice of Privacy Practices, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent.

I understand that HEALTHCARE PAIN CENTERS, LLC reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by written request address to FRANCISCO DELVALLE, c/o HEALTHCARE PAIN CENTERS, LLC 300 PERRINE RD, OLD BRIDGE, NJ 08857.

I understand that I have the right to restrict how HEALTHCARE PAIN CENTERS LLC uses or discloses my protected health information to carry out treatment, payment or health care operations; that HEALTHCARE PAIN CENTERS LLC is not required to agree to the restrictions and that HEALTHCARE PAIN CENTERS LLC is bound by restrictions to which it agrees.

I request the following restrictions to how my health information is used or disclosed:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

I have the right to revoke this consent by notifying HEALTHCARE PAIN CENTERS LLC in writing, except to the extent that HEALTHCARE PAIN CENTERS has taken action in reliance on my consent.

| | |
|---|---|
| ______________________________ | ______________ |
| SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE | DATE |
| ______________________________ | ______________ |
| PRINTED NAME OF PATIENT OR PATIENT'S REPRESENTATIVE | RELATIONSHIP TO PATIENT |

Diplomate
American Board of
Physical Medicine & Rehabilitation

Diplomates
American Board of
Pain Medicine

# HEALTHCARE PAIN CENTERS, LLC

FRANCISCO DELVALLE, M D.
Ph. 201 342 1205 Fax: 201 342 1259

## INSURANCE COVERAGE AND NOTICE OF CANCELLATION OF APPOINTMENTS FOR OFFICE VISITS AND HOSPITAL PROCEDURES

Please be informed that it is your responsibility to check with your plan and/or primary care physician to know what service (s) are covered and which are not. It is your responsibility to know if you need a referral from prior to each visit and/or procedure.

If your insurance company requires you to obtain a referral, it is your responsibility to obtain a REFERRAL FORM prior to any office consultations/visits, injections procedures, EMG or any nerve testing, X-rays, MRI and all other tests and procedures.

AN APPROPIATE FORM MUST BE AVAILABLE AT THE TIME OF VISIT.
Scripts written on prescription pads are not valid as an official referral form. Referral forms usually have authorization number from your insurance company. In the event this is not possible, an appropriate form must be furnished within three business days.

**We require a minimum of 48-hour cancellation notice for any office visits, treatments and/or procedures in the office or the hospital. You will be charged $30.00 each time for failure to do so.**

It is your responsibility to be sure that all procedures are followed so that full, valid reimbursement is received.

Thank you for your cooperation.

I have read and understood the above agreement and I accept it.

PRINT PATIENT'S NAME: ______________________________

PATIENT OR RESPONSIBLE PARTY SIGNATURE: ______________________________

DATE: ______________________________

Diplomate
American Board of
Physical Medicine & Rehabilitation

Diplomates
American Board of
Pain Medicine

HEALTHCARE PAIN CENTERS, LLC
FRANCISCO DELVALLE, M.D.
Ph 201 342 1205 Fax. 201 342 1259

## DISCLOSURE OF FINANCIAL INTEREST AND OUT OF NETWORK ELECTION

"In addition to such other information as the board determines necessary, the disclosure shall inform the patient whether any services or facility fees associated with the referral will be considered to be and reimbursed at an "out-of-network" level by the patient's insurance carrier or other third-party payer (cf:P.L. 1989. C.19, s3).

"disclosure of the referring practitioner's signature beneficial interest in the practice or facility is made to the patient in writing, at or prior to the time that the referral is made, consistent with the provisions of section 3 of P.L. 1989, c3 19 (C. 45:9-22.6)"

Public law of the State of New Jersey and rules of the board of Medical Examiners mandates that a physician, podiatrist and all other licensees of the Board of Medical Examiners inform patients of any significant beneficial interest held in a health care services.

Accordingly, take notice that practitioners in this office do have a significant beneficial interest in the following health care service (s) to which patients are referred: (facility name)

________________________________________________________

________________________________________________________

________________________________________________________

This basically means that the doctor is and owner/partner in the surgery center you are being referred to, and you may, of course, seek treatment at a health care service provider of your own choice. A listing of alternative health care service providers can be found in the classified section of your telephone directory under the appropriate heading.

I have discussed with my physician or his representative the health care service that he will provide to me in connection with my treatment and I understand that services or facility fees associated with my referral to the above named facility will be considered to be, and reimbursed at an "out of network" level by my insurance carrier or other third party payer (cf: P.L. 1989, c19, s.3)

Additional CMS (Medicare) requirement effective May 18, 2009
We are proud to announce the ownership interest of the above physicians in the Surgical Center.

I hereby acknowledge receipt of the "Patient Rights" and "Ownership Disclosure".

DATE: ____________ PRINT PATIENT'S NAME ____________________

PATIENT'S SIGNATURE: ________________________________

PATIENT/GUARDIAN SIGNATURE______________________________

# HealthCare Pain Centers, LLC

Name: ______________________________ Age: __ Sex: M/F Height: ___ Weight:___

**Recent Blood Pressure:** ______ Pharmacy/ Phone: __________________________

# Medical Questionnaire

What is the reason for your visit? ________________________________________

__ High Blood pressure
__ Diabetes
__ Heart Attack/ Chest Pain
__ Heart Failure/ Other heart condition
__ Heart Rhythm problems
__ Mitral Valve Prolapse
__ Use a pacemaker
__ High Cholesterol
__ Stroke/ TIA
__ Seizure disorder
__ Bleeding Disorder
__ Enlarged Prostate
__ HIV
__ Asthma/ COPD
__ Cancer (What Kind?) ___________
__ Are you pregnant? _____
__ Sleep Apnea / Do you use CPAP___

__ Arthritis
__ GERD / Gastritis
__ Liver problems/ Hepatitis
__ Peptic Ulcer Disease
__ Diverticulitis
__ Kidney Problems/ Dialysis
__ Bladder/Bowl Incontinence
__ Hearing problems
__ Visual problems (Cataract/ Glaucoma, ETC)
__ Headaches/ Migraine
__ Depression
__ Anxiety/ Panic Attacks
__ Thyroid condition (Hypothyroidism)
__Thyroid Condition (Hyperthyroidism)
__ Psoriasis
__ Last Menstrual Period? ___________
__ Sinusitis

***Other Medical Conditions***? ________________________________________

Date of last Colonoscopy? __________ Result: Normal Yes? ___ No? ___
Date of last MAMMOGRAM? __________ Result: Normal Yes? ___ No? ___
Date of last PAP SMEAR? __________ Result: Normal Yes? ___ No? ___

**Surgical History**: List ALL Surgeries since you were born (Tonsillectomy, Appendectomy, Hernia, Cataract, Cosmetic, C-Section Surgery ETC)

________________________________________________________________________

________________________________________________________________________

**Medications / Dosage:**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

**Allergies:** ________________________________________________________________

## HealthCare Pain Centers (Page 2)

**Family History:** Is your father alive? Y/N List all medical problems ____________________

Is your mother alive? Y/N List all medical problems ____________________

As best as you know, do any of your brothers/sisters/cousins/relatives/etc currently suffer from or have died from any medical/ psychiatric conditions? Y/N If yes to above, Pls specify:

____________________

**Social History:**

Do you smoke? Y/N If yes, how many packs, how many years? ____________

Do you drink alcohol? If yes, what kind, how many and how often? ____________

Any History of substance/ drug abuse: Y/N If yes, what kind? ____________

**Marital Status:** Single Married Divorced widowed (Please encircle)

Number of children: ________

Present or previous occupation (if not working now): ____________

Present working status: Full time ___ Part time ___ Disability___ Retired______

Recreational Activities/Hobbies: ____________________

**Do you have an advanced directive?**

Yes______ No__________

**Miscellaneous:** If you are seeing Dr. Del Valle for a pain problem, have you seen any other doctors/therapist/ chiropractor/ etc. for your current pain problem(s) before coming to this office? Yes ___ No ____
If yes pls specify doctors/therapist's names, specialists, treatments rendered and approximate dates:

____________________

____________________

Have you ever been seen or treated by a physiatrist? Yes ____ No____

If yes, for what condition? ____________________

Is your present condition due to accident? Yes ___ No____

If yes, what type: Car Accident: ____ Slip & Fall ____ Work Injury___ Assault___

Is there an ongoing lawsuit to the above incident? Yes ____ No ______

**I HERBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE OF THE OF THE BEST OF MY KNOWLEDGE**

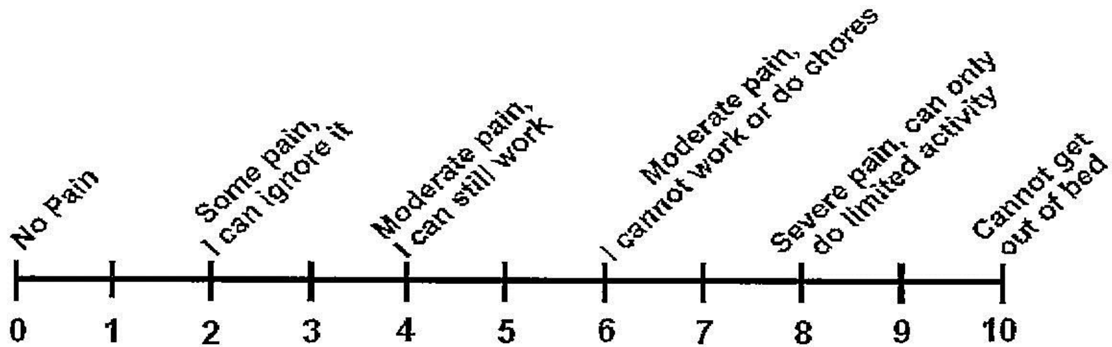
Patients Signature: ____________________ Date: __________

# HealthCare Pain Centers LLC
# PAIN QUESTIONNAIRE

Name: ______________________________ Date: ______________

This is a personal self-evaluation of your pain condition. So as to better assess your current pain, kindly fill-out the items asked below.

1. Rate your present pain using the scale below. **CIRCLE** the number that best scores your pain **AT ITS WORST**. Place a **SQUARE** around the number that represents your pain **AT ITS LEAST**.




**2. What makes your pain worse:**

_____ prolonged sitting
_____ prolonged standing
_____ walking
_____ lifting objects
_____ bending over
_____ laying down
_____ reaching upwards
_____ head turning
_____ computer work
_____ change in weather
_____ OTHERS:

**3. What relieves your pain:**

_____ sitting
_____ laying down on my back
_____ laying down on my side
_____ stretching painful part
_____ hot packs
_____ ice or Ben Gay over area
_____ massage
_____ medications
_____ OTHERS:

**4. What have you tried:**

_____Home Exercise, Stretching, Gym
_____Physical Therapy, Chiropractor
_____Motrin, Aleve, Ibuprofen, Etc
_____Muscle Relaxers

5. On the body diagram below, **DARKLY** shade the area that shows us where in your body the pain is mostly concentrated in; LIGHTLY shade areas where the pain may spread or radiate to.