Pain Management

Union Anesthesia Associates / Raritan Anesthesia Associates

695 Chestnut Street	*40 Route 34*	*141 Main Street*	*654 Broadway Ave*
Union, NJ	*Old Bridge, NJ*	*S. Bound Brook, NJ*	*Bayonne, NJ*

Today's Date: *(Fecha)* ______________________

Reason for visit: ______________________________ Referring doctor: ____________________________
(Razon de la visita) *(Referido por)*

PLEASE PRINT

<table>
<tr><td colspan="9">PATIENT'S NAME (last, first) (Nombre de el paciente)</td></tr>
<tr><td colspan="9">ADDRESS, CITY, STATE, ZIP (Direccion, Cuidad, Estado, Codigo postal)</td></tr>
<tr><td>AGE
(Edad)</td><td>DATE OF BIRTH
(Fecha de nacimiento)</td><td>SEX
(Sexo)</td><td colspan="5">MARITAL STATUS
(Estado Civil)</td><td>SOCIAL SECURITY #
(Numbero de Seguro Social)</td></tr>
<tr><td></td><td></td><td>M F</td><td>S</td><td>M
(C)</td><td>W
(V)</td><td>D</td><td>SEP</td><td></td></tr>
<tr><td colspan="2">Race: ( ) Hispanic ( ) Non-Hispanic
( ) Refuse to disclose</td><td colspan="5">Ethnicity:
( ) Refuse to disclose</td><td colspan="2">Preferred language:</td></tr>
<tr><td colspan="2">HOME PHONE #:(Numero de telefono)</td><td colspan="5">CELLULAR PHONE #: (Celular)</td><td colspan="2">WORK PHONE & EXT. APPLICABLE (Trabajo)</td></tr>
</table>

Employer's Name *(Nombre de su empleado)*	**Address & Title** *(Direccion)*	
		Relationship *(Relacion)*
In case of an emergency contact: *(Contacto de emergencia)*	**Telephone No.** *(Numero de telefono)*	**Relationship** *(Relacion)*

INSURANCE INFORMATION: *(Informacion de Seguro)*

Is your injury a result of an accident? **NO YES** *(Es su herida resultado de un accidente?)* Date of accident: *(Fecha de accidente)* ____________________	If **yes**, please circle what type of accident you had: *(Que tipo de accidente?)* Motor vehicle *(Accidente de carro)* Worker's comp. *(Accidente de trabajo)* Slip & fall *(Caida)*
Primary Insurance Carrier: *(Seguro primario)*	Telephone No.: *(Numbero de telefono)*
I.D. / Claim No. *(Number de identificacion)*	Adjuster / Case Manager: *(Nombre de la persona encargada de su caso)*
Secondary Insurance Carrier: *(Seguro secundario)*	Telephone No.: *(Numbero de telefono)*
I.D. / Claim No. *(Number de identificacion)*	Group No.:
Tertiary Insurance Carrier:	Telephone No.:
I.D. / Claim No.	Group No.:

If you are being represented by an attorney, please supply us with their complete information:
(Si esta siendo representado por un abogado, porfavor escriba la informacion aqui)

Name: ____________________________________ Telephone No.: ________________________________

Address, City, State & Zip: ____

PLEASE PRINT ALL INFORMATION

Height: __________________ **Weight:** ___________________
(Estatura) *(Peso)*

Do you smoke? NO YES (how much?) ____
(Usted fuma?) *(Cuanto)*

Do you consume alcohol? NO YES (how often?) ____
(*Consume alcohol?)* *(Frequencia)*

Please date & list all surgical procedures you have had and describe any problems that might have occurred:
(Por favor de listar todas las operaciones que ha tenido y describa cualquier problema que haga ocurrido)

____
____
____
____

Have you ever had a serious problem with anesthesia? NO YES - Please explain.
(Alguna vez a tenido un problema serio con anesthesia?)

____
____

Please list all allergies to medication or food: *(Alergias a medicamento o comida)*______________________
____
____

Do you have a history of any of the following? (Please check)
(Tiene historia de:)

	YES	NO		YES	NO
Heart Conditions *(Condicion de corazon*			Physical limitations *(Limitacionces fisicas)*		
Mitral Valve Prolapse *(Prolaspse de la valvula mitral)*			Difficulty Urinating (*Dificulta orinado)*		
Pacemaker *(Marcapaso)*			Hearing Impairment *(Problema auditivo)*		
High Blood Pressure *(Presion alta)*			Diabetes *(Diabetes)*		
Asthma / Bronchitis*(Asthma/Bronchitis)*			Emphysema *(Emphysema)*		
Tuberculosis *(Tuberculosis)*			Seizures *(Epilepsia)*		
Ulcers *(Ulcers)*			HIV Positive *(VIH positivo)*		
Hepatitis *(Hepatitis)*			Other:		

*** IF YOU ARE ON ASPIRIN OR ANY BLOOD THINNERS, PLEASE NOTIFY THE DOCTOR FOR INSTRUCTIONS.**

Please list any and all medications, vitamins, and herbal supplements you are taking or have taken in the past 2 months: *(Porfavor de listar todas las medicaciones, vitaminas y suplementos naturals que ha tomado en los pasados dos meses)*

____
____
____

Patient signature: X____________________________________ Date: ______________________
(Firma) *(Fecha)*

Union Anesthesia Associates & Pain Management

695 Chestnut St., Union, NJ 07083 40 Route 34, Old Bridge, NJ 08857 141 Main St., S. Bound Brook, NJ 08880

Patient name: _____________________________ Date: _____________________

ASSIGNMENT OF BENEFITS AND INSURANCE AUTHORIZATION

I hereby authorize ***Union Anesthesia Associates*** to furnish information to insurance carriers concerning my illness & treatments. I hereby assign all payments, for medical services rendered to myself or my dependent, to the physicians. I understand that I am responsible for any amount not covered by my insurance.

I am assigning all my rights unconditionally to ***Union Anesthesia Associates*** to pursue any medical bills, relating to treatment or care by this office in addition to the above.

X_______________________________

Patient signature

**** In the event written consent is required by the responsible insurance carrier for an assignment, then this is a request to the responsible insurance carrier to either approve or deny this assignment. If no response is received from the responsible insurance carrier, within ten (10) business days of mailing/fax, it will be interpreted as an approval of this assignment.***

NO FAULT AND/OR WORKER'S COMPENSATION PATIENTS

I hereby authorize the release of my medical chart, bills and/or any other information related to my treatment, to my attorney __________________________. I further authorize ***Union Anesthesia Associates*** to pursue payment of my bills.

I understand that all medical bills will be submitted to the responsible insurance carrier and will ***only*** be submitted to my medical insurance carrier in the event that payment is denied and/or there is a remaining balance, which I am responsible for.

I understand that I am directly and fully responsible for all medical bills submitted by you for services rendered to myself or my dependent and that this agreement is made solely for your additional protection & in consideration of your awaiting payment. I further understand that your attorney, if needed will arbitrate my bills for payment.

Please return to receptionist

X_______________________________

Patient signature

HIPPA PRIVACY ACKNOWLEDGEMENT

I acknowledge that I have been provided with a copy of Union Anesthesia Associates, P.A. privacy notice. This notice is effective as of today's date.

X_______________________________

Patient Signature

"Public law of the State of New Jersey mandates that a physician, chiropractor or podiatrist inform his patients of any significant financial interest he may have in a health care service."

Accordingly, we wish to inform you that the doctors of Union Anesthesia Associates do have a financial interest in:

Middlesex Surgery Center
Surgery Center at Millburn
Endo SurgiCenter
Union Surgery Center

You may, of course, choose to have your treatment at any of the health care facilities that we are on staff with. Please note: If you request or require anesthesia at Middlesex Surgery Center or Endo SurgiCenter, it will be provided & billed by Outpatient Anesthesia Associates, LLC, which is the same ownership as Union Anesthesia Associates.

I have read the above and understand.

X____ Date: __________________

Signature of patient

Pain Management
Union Anesthesia Associates
Medication Protocol

We are committed to doing all we can to treat your chronic pain condition. In some cases, controlled substances are used as a therapeutic option in the management of chronic pain, which is strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and the physician by establishing guidelines, within the laws, for proper and controlled substance use. The words "we" and "our" refer to the facility and the words "I," "you," "me," or "my" refer to you, the patient.

1. All controlled substances must come from the physician whose signature appears below or, during his/her absence, by the covering physician, unless specific authorization is obtained for an exception, I understand that I must tell the physician whose signature appears below or, during his/her absence, the covering physician, all drugs that I am taking, have purchased, or have obtained, even over-the-counter medications. Failure to do so may result in drug interactions or overdoses that could result in harm to me, including death; I will not seek prescriptions for medication by more than one physician at a time without each physician's knowledge. I also understand that it is unlawful to obtain or to attempt or obtain a prescription for a controlled substance by knowingly misrepresenting facts to a physician, or his/her staff, or knowingly withholding facts from a physician or his/her staff (including failure to inform the physician or his/her staff of all controlled substances that I have been prescribed).

2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. **The pharmacy that you have selected is**:

______________________________________ Phone: ______________________________

3. You may not share, sell, or otherwise permit others; including spouse or family members, to have access to any controlled substances that you have been prescribed.

4. Unannounced urine or serum toxicology specimens may be requested from you, and your cooperation is required. Presence of unauthorized substances in urine or serum toxicology screens may result in your discharge from this facility.

5. I will not consume excessive amounts of alcohol in conjunction with controlled substances. I will not use, purchase, or otherwise obtain any illegal drugs, including marijuana, cocaine, etc. I understand that driving while under the influence of any substance, including a prescribed controlled substance, or any combination of substances (e.g., alcohol and prescription drugs) which impairs my driving ability, may result in DUI charges.

6. Medications or written prescriptions may not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen it will not be replaced unless explicit proof is provided with direct evidence from authorities. A report narrating what you told authorities is not enough.

7. Early refills will not be given. Renewals are based upon keeping scheduled appointments. Please do not phone for prescription after hours or on weekends.

8. in the event you are arrested or incarcerated related to legal or illegal drugs (including alcohol); refills on controlled substances will not be given.

9. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribed by this physician and other physicians at the facility and that law enforcement officials may be contacted.

10**.** I affirm that I have full right and power to sign and be bound by this agreement, and that I have read it and understand and accept all of its terms. A copy of this document has been given to me.

Refills must be authorized by your treating physician and will only be given to a covering doctor should your doctor be on vacation.

Dr. Fleischhacker and Dr. Novik are available in the Union office on Tuesdays and Thursdays. Dr. Wilcenski is available on Mondays and Wednesdays. Because your doctor may not be available the same day as your request, please call or have your pharmacy contact us 2 days prior to running out of medication. Please do not phone for prescription after hours or on weekends.

Please be advised the prescriptions for narcotics can NOT be called in or mailed. Prescriptions must be picked up at our Union location by you or a designated person, unless arrangements are made to pick the prescription up at one of our satellite locations.

______________________________________ ______________________

Patient's signature Date

______________________________________ ______________________

Print name Date