Onyx Medical Practitioner PC
NuWave Medical PLLC

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NEW PATIENT INTAKE FORM

Pain Management

PLEASE PRINT AND COMPLETE ALL ENTRIES

FIRST NAME	LAST NAME	DATE OF BIRTH
		_____/_____/_____

SEX	SOCIAL SECURITY	PHONE NUMBER	EMAIL ADDRESS
❑ Male ❑ Female			

ADDRESS		
CITY	STATE	ZIP CODE

MARITAL STATUS	SPOUSES NAME	SPOUSE PHONE NUMBER
❑SINGLE ❑MARRIED		
EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER

INSURANCE INFORMATION

DO YOU HAVE INSURANCE?	PRIMARY CARD HOLDER	PRIMARY POLICY HOLDER NAME
❑YES ❑NO	❑SELF ❑SPOUSE. ❑PARENT. ❑OTHER_____	
PRIMARY INSURANCE COMPANY	PRIMARY ID NUMBER	PRIMARY GROUP NUMBER
DO YOU HAVE SECONDARY INSURANCE?	SECONDARY CARD HOLDER	SECONDARY POLICY HOLDER NAME
❑YES ❑NO	❑SELF ❑SPOUSE. ❑PARENT. ❑OTHER_____	
SECONDARY INSURANCE COMPANY	SECONDARY ID NUMBER	SECONDARY GROUP NUMBER

PAYMENT POLICIES

- You are financially responsible for anything insurance does not cover. All copays are due and payable at each visit. The amount your insurance will allow and pay for and your financial responsibility is determined by your insurance company and the policy you have chosen. Your claim will be processed according to the benefits of your insurance plan. The deductible, co-insurance and co-pay are your financial responsibility. It is your responsibility to understand your insurance plan.
- $50 No Show Fee for any Missed Appointment that was not cancelled or rescheduled 24 hours prior to the appointment. Please be considerate and call at least 24 hours before your appointment if you cannot come in.
- $35 NSF charge for any returned check from the bank.
- If you are a private patient without insurance, all charges are due at the time of the visit.

PRESCRIPTION POLICY

PHARMACY NAME	PHARMACY PHONE NUMBER

- Please do not wait until your last pill to call for a refill. There is a 72 hour turn around for prescription refills. If you have not seen the Physician in six months, the prescription will be Denied.

PATIENT SIGNATURE	**DATE**

PATIENT NAME: _____ DOB: _____

PATIENT MEDICAL HISTORY

Allergies

❑ NONE/Known Allergies ❑ Adhesive Tape ❑ Anesthesia ❑ Aspirin ❑ Codeine
❑ Dairy Products ❑ Iodine/Shellfish/Contrast ❑ Latex ❑ Morphine ❑ Penicillin

OTHER:

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	FATHER
Anesthesia Problems		
Arthritis		
Cancer		
Diabetes		
Heart Problems		
Hypertension		
Stroke		
Thyroid Disorder		

SOCIAL HISTORY

☐**Yes** ☐**No -** Do you drink alcohol? ☐ Daily ☐Weekly ☐Infrequently ☐ Recovering Alcoholic
☐**Yes** ☐**No -** Do you smoke? ☐ Smoke (___packs per day) ☐ Chew
☐**Yes** ☐**No -** Do you drink caffeine? ☐ Daily ☐Weekly ☐Infrequently
☐**Yes** ☐**No –** Are you sexually active?
☐**Yes** ☐**No –** Do you wish to be checked for STDs?

Surgical History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

Medical History: Have you ever had any of the following?

❑ NONE of the problems listed
❑ Allergies
❑ Anemia
❑ Arthritis conditions
❑ Asthma
❑ Arterial fibrillation
❑ Bleeding problems
❑ BPH
❑ CAD coronary artery disease
❑ Cancer
❑ Cardiac arrest
❑ Celiac disease
❑ Chest pain
❑ Congestive heart failure
❑ Chronic fatigue syndrome
❑ Depression
❑ Diabetes
❑ Drug/alcohol abuse
❑ Erectile dysfunction
❑ Fibromyalgia
❑ Gerd
❑ Heart disease
❑ Hyperinsulinemia
❑ Hyperlipidemia
❑ Hypertension
❑ Hypogonadism male
❑ Hypothyroidism
❑ Infection problems
❑ Insomnia
❑ Irritable bowel syndrome
❑ Kidney problems
❑ Menopause
❑ Migraines/headaches
❑ Neuropathy
❑ Onychomycosis
❑ Organ injury
❑ Osteoporosis
❑ Pulmonary embolism
❑ Seizure disorders
❑ Shortness of breath
❑ Sinus conditions
❑ Stroke
❑ Syndrome X
❑ Tremors
❑ Wheat allergy

Medications: List any medications you are currently taking (please include over the counter medications):

PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

MEDICATION	DOSAGE	PRESCRIBING DOCTOR

PATIENT NAME: _____ DOB: _____

Is the pain you are experiencing part of a No Fault or Worker's Comp case: Yes___ No ____

Where are you experiencing pain? _____
Did you experience an injury? _____
Are there other associated areas of pain? No __ Yes_____ Where? _____
When did the pain start? _____
How often do you have this pain? ____ Continuously ___Comes and goes
It is: ____getting better ____getting worse ____staying the same

How would you describe your pain? (Check all that apply):

	Mild	Moderate	Severe
Throbbing			
Shooting			
Stabbing			
Tingling			
Cramping			
Burning			
Aching			
Numb			
Heavy			
Tender			
Tiring			

What Treatments have you tried for pain? (Check all that apply)

( ) Exercise ( ) Massage ( ) Chiropractor ( )Acupuncture ( ) Brace
( ) Physical Therapy ( ) Warm Pack ( ) Ice Pack ( ) Nerve Block ( ) Biofeedback
( ) TENS Unit ( ) Traction ( ) Psychologist ( ) Psychiatrist ( ) Surgery

Previous Medications Tried: (Check all that apply)

NSAIDS: ( )Aspirin ( )Ibuprofen ( )Advil ( )Motrin ( )Naprosyn _____

Relaxants: ( )Flexural ( )Valium ( )Xanax ( )Ativan ( )Librium_____

Sleep Medications: ( )Ambien ( )Restoril ( )Benadryl ( )Halcion_____

Narcotics: ( )Vicodin ( )Darvocet ( ) Tylenol 3 ( )Codeine ( )Percocet
( )MS Contin ( )Oxytocin ( ) Demerol ( )Morphine ( )Methadone ( )Dilaudid

Neuropathic Pain Medications: ( )Neurontin ( ) Klonopin ( )Tegretol ( )Dilantin
( )Ultram ( )Prazosin ( )Maxtil ( )Prazosin

PATIENT NAME: _____ DOB: _____

Notice of Privacy Practices
Onyx Medical Practionier PC
Officer: Sekuleo Gathers, MD

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. It also discusses the uses and disclosure we will make of your protected health information. We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of the notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a written copy of our most current privacy policy notice from the Practice's Privacy Officer.

This office has always recognized the importance of privacy; this new federal law formalizes practices that have been followed routinely.

By the law, consent is not required to discuss your medical treatment with your other doctors or healthcare providers. This also allows for a prescription to be called into your pharmacy. Additionally, none is needed in the course of carrying out healthcare operations, such as quality assessment, or in communication with your insurance carrier for payment related issues, or for incidental uses, such as announcing a name in a waiting room or the use of sign-in sheets.

However, this office has always gone one step further in protecting you and does not believe in releasing specific information about you to any business or governmental entity without your written consent. Specific authorization is required to disclose protected information in non-routine circumstances, such as your employer or for use in marketing a product to you.

Medical information about you may be released for research and public health uses, as long as you are not individually identified.

We may contact you to provide appointment reminders for treatment or medical care, and also to recommend possible treatment alternatives or other health-related benefits and services that may be if interest to you.

You have the right to review when and to whom your information was released.

You may suggest additional restrictions with regard to certain uses and disclosures, if you wish.

Should you believe that your privacy rights have been compromised, you may report the violation, without penalty to you to, this office or the Secretary of Health.

This law requires that you acknowledge receipt of this notice; this has been included on the signature release on the bottom of this form.

You have the right to inspect and copy your health information; you must submit your request in writing to the Practice's Privacy Officer. If you request a copy of your health information, we may charge you a fee for the costs of copying and mailing your records, as well as other costs associated with your request.

In order to inspect and copy your health information, you must submit your request in writing to the Practice's Privacy Officer. If you request a copy of your health information, we may charge you a fee for the costs of copying or mailing your records, as well as other costs associated with your request.

I acknowledge that I have read and understand the above Notice of Privacy Practices.

Signature:_____ Date:_____

Print Name:_____

Relationship to the Patient:_____

Onyx Medical Practitioner PC

I, _____, the undersigned, understand that should my insurance company make reimbursement of benefits to me, I agree to send or deliver payment promptly upon receipt to Onyx Medical Practitioner PC/ Sekuleo Gathers, MD for services rendered to be by Onyx Medical Practitioner PC.
Date:_____ Signature:_____

Assignments And Instructions For Direct Payment To Doctor

I hereby instruct and direct the _____ Insurance Company to pay by check made out a mailed directly to Onyx Medical Practitioner PC/ Sekuleo Gathers, MD.

OR

If my current policy prohibits direct payments to doctor, then I hereby also instruct and direct you to make out the check to me for professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay in a current manner, any balance of said professional fees for non-covered services and/or fees over and above insurance payment or as required by my insurance policy.

A photocopy if this Assignment shall be considered as effective and valid as the original. I also authorize the release of any medical or other information necessary to process claims for the doctor and authorize payment of medical benefits to the physician Onyx Medical Practitioner PC/ Sekuleo Gathers, MD.

Date:_____ Signature:_____

Informed Consent To Receive Treatment

I hereby give consent to treatment and certify that I understand the above authorization and the risks of possible complications. I have been adequately informed, and any questions I have asked have been satisfactorily answered. It has also been satisfactorily explained to me, the treatments which are being offered, and the anticipated risks, benefits, and experience of receiving such treatments. I represent that I am seeking pain management to further my own health and for no other reason. I am aware that I may withdrawal this consent and stop treatment at any time.

Date:_____ Signature:_____

In the event that your Insurance Company makes payment directly to you:

We ask that you should receive a check (&EOB) that you kindly bring it in during your next treatment or mail it directly to Onyx Medical Practitioner PC, at the **address above**. If you have one of the insurances above (**BCBS, GHI, & Oxford)** we ask that you send in your EOB, **even if NO PAYMENT WAS MADE,** so that we may note your account. This can be done by mail, drop off at your Trigger Point office, fax or email for your convenience.

I have read and understood the above.

Signature:_____ Name:_____

Informed Consent for Trigger Point Therapy

Patient Name:_____ Date of Birth:_____

The purpose of this informed consent is to provide written information regarding the risks. Benefits and alternatives of the procedure named above. This material serves as a supplement to the discussion you have with your doctor/health care provider. It is important that you fully understand this information, so read this document thoroughly. If you have any questions regarding the procedure, ask your healthcare provider prior to signing the consent form.

THE TREATMENT:

Trigger point injections is used to treat extremely painful, tender areas of muscles. Normal muscles contacts and relaxes when it is active. A trigger point if a knot or tight band in the muscle that forms when muscles fail to relax. The knot often can be felt under the skin and may twitch involuntarily when touched (called a jump sign) . The trigger point can trap or irritate surrounding nerves and cause referred pain - pain felt in another part of the body or in the teeth. Scar tissue and loss of range of motion and weakness may form over time. A small needle is inserted into the trigger point and a local anesthetic (e.g., lidocaine, procaine) botulinum or anti-inflammatory steroid is injected. Trigger point injections have been found to be very effective in relieving pain, and may be used for home exercise, heat, cold, and an individualized medication program.

RISKS AND COMPLICATIONS:

Before undergoing this procedure, understand the risks is essential. No procedure is completely risk-free. The following risks may occur, but there may be unforeseen risks and risk that are not included on this list. Some of these risks, if they occur, may necessitate additional surgery, prolonged hospitalization, and/or extended outpatient therapy to permit adequate treatment. It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance such risks include but are not limited too:

1) You may develop infection. 2)You may experience bleeding. 3) You may develop irritation at the injection site
4) There may be skin changes. 5) You may develop bruising, redness or swelling
6) The lung may be punctured if the procedure is performed in a muscle near the ribcage.
7) The procedure may fail to reduce pain symptoms

Initial: _____

PREGNANCY, ALLERGIES & NEUROLOGIC DISEASE

I am not aware that I am pregnant, and I am not trying to get pregnant, I am not lactating (nursing). I do not have any significant neurologic disease including but not limited to myasthenia gravis, MS, Lambert-Eaton syndrome, ALS and Parkinson's. I do not have any allergies to lidocaine, botulinum toxin or to human albumin. **Initial:_____**

ALTERNATIVE PROCEDURES:

Alternatives to the procedures and options that I have volunteered for have been fully explained to me**.** **Initial:_____**

RESULTS:

You may receive the following benefits. The doctor cannot guarantee you will any of these benefits. Only you can decide if your benefits are worth the risks. Trigger Point Injections can be used to alleviate myofascial pain syndrome (chronic pain involving tissue that surrounds the muscle) that does not respond to other treatments, although there is some debate over its effectiveness. Many muscles groups, especially those in the arms, legs, lower back, and necks are treated by this method. Trigger point injections can also be used to treat fibromyalgia, tension headaches, TMJ dysfunction, and other types of orofacial pain.

I understand this is an elective procedure and I hereby voluntarily consent to treatment with trigger point injections for TMJ dysfunction, bruxism and types of orofacial pain including headaches and migraines. The procedure has been fully explained to me. I also understand that any treatment preformed is between me and the doctor/healthcare provider who is treating me and I will direct all Post-Op questions or concerns to the treating clinicians. I have read and understand it. My questions have been answered and I accept the risks and complications of the procedure and understand that no guarantees are implied as to the outcome of the procedure. I also certify that if I have any changes in my medical history, I will notify the doctor/healthcare provider immediately. I also tstae I read and write in English.

_____

Patient Name (Printed) Signature Date

***I am the treating healthcare professional. I discussed the above risks, benefits and alternatives with the patient. The patient has an opportunity to have all questions answered and was offered a copy of this informed consent. They have been told to call the office if they have any questions or concerns.**