JLS Pain Management, LLC
PATIENT INFORMATION

Patient's Name _____

Address _____

Home # _____ Cell # _____ Work # _____

Email Address _____

Sex: ____ Male_____ Female Marital Status_____

Date of Birth_____ Social Security #_____

Employer's Name _____Occupation_____

Who referred you to our office? _____

Is today's visit related to an **Auto Accident** or **Work Injury** (circle one)

Are you currently working? (circle one) **YES** or **NO** / If **YES**, are you working full duty? **YES** or **NO**

Out of work since: DATE: _____

INSURANCE INFORMATION

Name of Insured_____ SS # of insured_____

Name of Primary Insurance Co._____ Phone #_____

Address of Carrier_____

Insurance ID#_____ Group#_____

Subscriber Sex:_____ Male _____Female Subscriber Date of Birth_____

Relationship to patient:_____

SECONDARY INSURANCE

Name of Insured_____ SS # of insured_____

Subscriber Date of Birth_____ Sex: Male/Female Relationship to patient_____

Insurance Carrier_____Address_____

Insurance Phone #_____ Insurance ID#_____ Group #_____

Emergency Contact: Name_____ Phone#_____

Relationship to Patient_____

Address_____

PHARMACY NAME: _____Phone#_____ Address_____

JLS Pain Management, LLC

WORKERS COMPENSATION- EMPLOYEE ACCIDENT FORM

Patient's Name:	Date of Birth: Sex: **Male** OR **FEMALE**	
Employer name:	Date of Accident:	Time of Accident:
Workers Compensation Insurance:	Claim #:	
Please describe why you are here:		
Please describe how your got hurt and when the injury occurred:		
Where are you feeling pain? Please describe:		
Previous Workers Compensation Claims: YES or NO Date of Accident: **Please describe:**		
Have you ever been treated for this issue in the past or something similar? If yes, please provide name of the physician who treated you.		
Please list any medications you are taking for this condition or injury.		
Have you ever been in a motor vehicle accident (MVA)? YES or NO **If yes, please provide date of MVA and details of injury:**		
Have you ever seen a Chiropractor? YES or NO ***If YES:*** **Name: Address: Date:**		
Name of Primary Care Provider (PCP):	**Address:** **Phone #:**	
Have you ever received pain management treatment? If yes, please provide name of physician and time frame of treatment.		
Are you involved in any recreational or sporting activities? If yes, please describe....		
I CERTIFY THAT THE ABOVE ANSWERS MADE BY ME ARE CORRECT.		

Patient Signature: _____ Today's Date: _____

JLS PAIN MANAGEMENT

MEDICAL HISTORY

DATE: _____

NAME_____**SEX**_____**AGE**_____

HEIGHT_____ **WEIGHT**_____ **DATE OF BIRTH**_____

SMOKER: YES NO AMOUNT PER DAY_____ **ALCOHOL:** YES NO HOW OFTEN_____

MEDICAL HISTORY:	YES	NO	**FAMILY:**	YES	NO
DIABETES	___	___		___	___
CANCER	___	___		___	___
HIGH BLOOD PRESSURE	___	___		___	___
ASTHMA	___	___		___	___
KIDNEY DISEASE	___	___		___	___
ULCERS	___	___		___	___
ARTHRITIS	___	___		___	___
DEPRESSION	___	___		___	___

ALLERGIES:	YES	NO	**NAME OF DRUG**	**REACTION**
ANTIBIOTICS	___	___	_____	_____
SHELLFISH/IODINE	___	___	_____	_____
MEDICATIONS	___	___	_____	_____
ANESTHESIA	___	___	_____	_____

MEDICATIONS PRESENTLY TAKING: _____

PAST SURGICAL PROCEDURES AND DATE: _____

COULD YOU BE PREGNANT TODAY? _____

FAMILY PHYSICIAN: _____ **ADDRESS:** _____ **PHONE:** _____

JLS PAIN MANAGEMENT

PAIN DIAGRAM

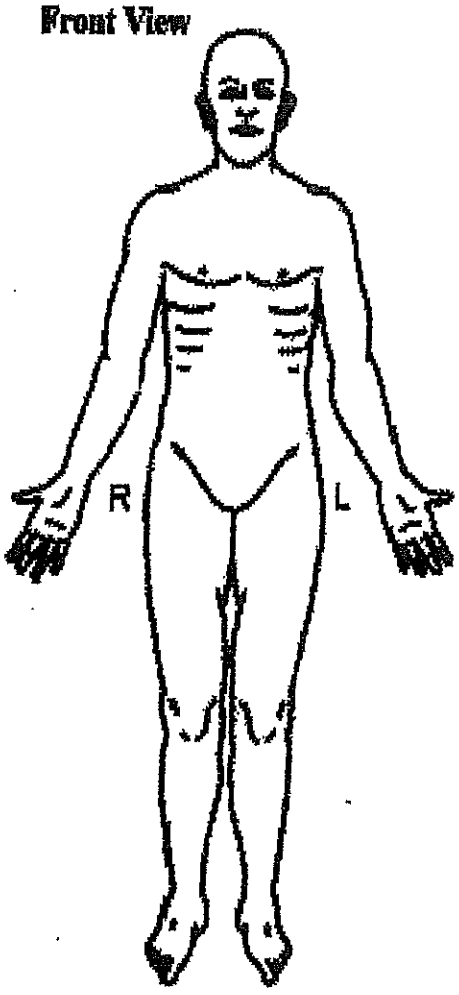
NAME_____ DATE_____

WHERE IS YOUR PAIN NOW?

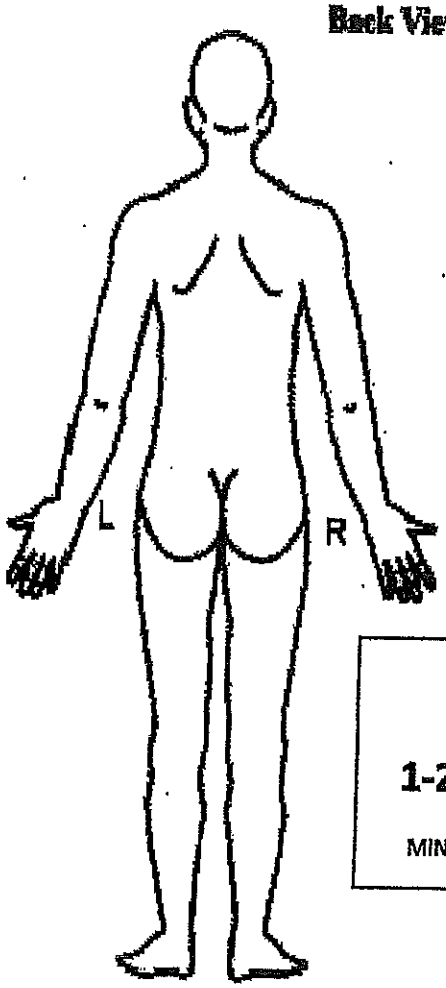
MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS

ACHE NUMBNESS PINS & NEEDLES BURNING STABBING

Front View



Back View



PAIN SCALE
(CIRCLE ONE)

1-2-3-4-5-6-7-8-9-10

MINIMUM----------MAXIMUM

JLS PAIN MANAGEMENT
JENNIFER H. YANOW, MD
1450 RT. 22 West, Suite 200
Mountainside, NJ 07092

PATIENT'S NAME_____

INSURANCE AUTHORIZATION AND ASSIGNMENT (please read and sign)

The patient is responsible for all fees, deductible and co-payments regardless of insurance coverage unless forbidden by prior insurance contracts. You are expected to pay for services at time they are rendered unless arrangements have been made in advance.

I hereby authorize payment to JLS Pain Management/Jennifer Yanow, MD of any benefits otherwise payable to me for their services.

I hereby authorize JLS Pain Management/Jennifer Yanow, MD Therapy to receive and furnish to insurance companies, their representatives or designated attorney and requesting physicians, any information concerning my treatment.

I hereby assign to JLS Pain Management/Jennifer Yanow, MD all payments for medical services rendered to my dependants or myself. I agree that if my insurance company sends me a check for services rendered by JLS Pain Management/Jennifer Yanow, MD to my dependants or me, I will enclose this check and forward it to JLS Pain Management/Jennifer Yanow, MD within 5 days.

If any collection proceedings are required to cover any outstanding balance, I understand I will be responsible for said costs including attorney fees of 33.3% of the unpaid balance. These costs are above and beyond for services rendered.

JLS Pain Management/Jennifer Yanow, MD Therapy reserves the right to charge 1.5% interest per month on any balance that remains after 60 days.

SIGNATURE OF PATIENT_____ DATE_____

SIGNATURE OF INSURED_____ DATE_____

JENNIFER H. YANOW, MD
1450 RT. 22 WEST, SUITE 200
MOUNTAINSIDE, NJ 07092

PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____ **DOB:** _____

I hereby authorize the release any and all of my medical records to **JLS Pain Management/Jennifer Yanow MD** if requested for the purpose of continued care, nsurance, legal or personal reasons.

I understand this consent is voluntary and that I may revoke this authorization at any time (except to the extent that action based on this consent has already been taken) by written, dated and signed communication.

ignature: _____

oday's Date: _____

JLS PAIN MANAGEMENT
JENNIFER H. YANOW, MD
1450 RT. 22 WEST, SUITE 200
MOUNTAINSIDE, NJ 07092

FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize the use and/or disclosure of my protected health information as described below.

1. My authorization applies to the information described below. Only his information may be used and/or disclosed pursuant to this authorization.

   _____All information/no restrictions
   _____Restrictions as listed_____
   _____

2. I authorize the following persons (or class of person) to make the authorized use and/or disclosure of my protected health information.

   _____Physician: Jennifer Yanow, MD
   _____Physician Staff: Medical Assistant, Receptionist, Biller, Collectors, Physical Therapist

3. I authorize the following persons (or class of persons) to receive my protected health information.

   _____Family (please list names)_____
   _____No Fault Carriers (Automobile) and adjustors associated with No Fault (automobile)
   _____Medical Insurance Company
   _____Workers Compensation including adjusters and case managers associated with my case and any insurance claim review companies associated with Workers Compensation insurance.
   _____Employer_____

4. I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

6. I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

7. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that the persons that I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

JLS PAIN MANAGEMENT
JENNIFER H. YANOW, MD
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8. This authorization expires upon 3 years after my last treatment by JLS Pain Management or Jennifer Yanow, MD

9. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from JLS Pain Management, nor will it affect my eligibility for benefits.

10. My protected health information will be used or disclosed upon request for the following purpose.
    - Obtaining authorization for treatment
    - Disability (with proper authorization)
    - Scheduling treatment (hospital, outpatient facility, physical therapy facility, pain management facility, diagnostic facility)
    - Social Security (with proper authorization)
    - Collecting payment for medical services
    - Attorney (when appropriate authorization from attorney is received)
    - Billing for medical services
    - Referral to other physicians by JLS Pain Management

11. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed.

12. Changes to the above document must be submitted in writing to JLS Pain Management. Changes will be effective immediately upon receipt of request.

By signing this form, you are granting consent to JLS Pain Management to use and disclosure your protected health information for the purpose of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy before you sign this consent, and 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.

You have a right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

JLS PAIN MANAGEMENT
JENNIFER H. YANOW, MD
1450 RT. 22 WEST, SUITE 200
MOUNTAINSIDE, NJ 07092

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

_____ _____

Signature Date

_____

Name

_____ _____

Name of personal representative Relationship to patient

If you have any questions, please feel free to speak to any of the staff members.

Thank you.