VALLEY PAIN SPECIALISTS, PC
Steven Mortazavi, M.D.
Marissa Marion, PA-C
Katherine Gehringer, PA-C
4250 Fritch Drive
Bethlehem, PA 18020
Telephone: (610) 954-9040
Fax: (610) 954-9093

VPS OFFICE POLICIES

Office Policies and Disclosures

Dear Patient,

Welcome to Valley Pain Specialists, P.C. We would like to briefly state our office policies to you.

1. Insurance Polices

You are required to present your health insurance card at every appointment. Although it is our policy to verify your benefits, please understand that you are responsible for any services not covered by your insurance. We accept Cash, Checks, MasterCard, Discover Card, and Visa. Please be aware we do not accept checks over $100, if your payment exceeds this amount please have two methods of payment. If your health insurance requires a referral, this is your responsibility to obtain from your primary care physician. If you do not have a referral or your insurance cards, you have the option of paying in full for your visit or rescheduling your appointment. Co-payments, deductibles, and co-insurance are due at time of service.

2. Worker's Compensation or Automobile Accident Claim

If you have a worker's compensation or automobile accident claim that we are submitting bills to, we require you present your health insurance card also if the worker's compensation or automobile claim closes or exhausts throughout your treatment time with Valley Pain Specialists, we will bill your private health insurance. If you do not present your insurance to us, or if you have no other health insurance coverage, the bill becomes your full responsibility. We do not accept claims in litigation.

3. Returned Checks

There is a charge of $25.00 for any returned check, plus the amount of the check. If your bank returns one of your checks, you will not be able to make any future payments with a check. You will need to pay by cash or credit card. We do not accept credit card payments under $10.00

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6. Exam Rooms

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7. Missed Appointments or "No Show" Appointments

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9. Prescription Refills

If you need a prescription refill you must call three days (72 hours) in advance and leave a message on our prescription hotline. We will notify you when the prescription is ready for pick up. We do not mail prescriptions. Narcotic prescriptions can only be given to either the patient or someone listed on the patients consent sheet. If someone listed on the patients consent sheet picks up a prescription, they will be asked to provide photo ID. There will be no medication changes made over the phone. Prescription refills will not be given while at Valley Surgical Center. You MUST call the refill line.

10. Advance Directive

I realize that Valley Pain Specialists cannot honor my DNR or Advance Directives (Living Will) if I do not provide these documents.

I have read and fully understand the Notice of Office Practices supplied by Valley Pain Specialists and I understand and agree to the policies as stated above.
By signing below I am also giving my consent for Valley Pain Specialists to take my photo. This photo will be used solely for identification purposes.

CONTROLLED SUBSTANCE AGREEMENT

This agreement relates to my use of controlled substances for chronic pain prescribed by a provider at Valley Pain Specialists, P.C. I have been informed and understand the policies regarding the use of controlled substances that are followed by the staff at Valley Pain Specialists. I understand that I will be provided controlled substances while actively participating in this program only if I adhere to the following conditions:
1.) I will use the substances only as directed by Valley Pain Specialists.
2.) I will not receive replacement medications that I have lost or have been stolen.

a) I understand that I am responsible for the medication and prescriptions used in my treatment. I must be discreet about my possession of narcotics and I will keep my medications and prescriptions in inaccessible places so that they are not lost or stolen.
3.) I will receive controlled substances only from Valley Pain Specialists staff.
4.) I will not expect to receive additional medications prior to the time of my next scheduled refill, even if my prescription runs out.
a.) Running out of medications prior to your next scheduled refill may result in discharge.
5.) If it appears to the physician that there are is no clear benefits to your daily function or quality of life from the controlled substance, the provider will gradually taper my medication as directed by the prescribing physician.
6.) I agree to submit to urine and blood screens to detect the use of non-prescribed medications (including "street" drugs) at any time. I realize there may be some cost to me for this test if I have no insurance, or if my insurance does not cover the test in full.
7.) I recognize that my chronic pain represents a complex problem, which may benefit from interventional treatments, physical therapy, psychotherapy and behavioral medicine strategies. I also recognize that my active participation in the management of my pain is extremely important. I agree to actively participate in all aspects of the Pain Management Program to maximize function and improve coping with my condition.
8.) I agree to schedule and keep scheduled follow-up appointments with my Valley Pain provider at the recommended intervals. I understand that failure to do so may lead to discontinuation of treatment and/or discharge from the practice.
9.) I am responsible for keeping track of the amount of medication I have left and to plan ahead for arranging the refill of my prescriptions in a timely manner so I will not run out. I realize that this may affect travel plans, etc...
10.) I agree to use one pharmacy for filling all my prescriptions except in case of emergency.
11.) If the violation involves obtaining controlled substances or any prescription for my pain condition from another individual, or if I engage in any illegal activity such as altering a prescription, I understand that the incident may be reported to my Valley Pain provider, to other physicians caring for me, local medical facilities, pharmacies, and other authorities such as the local police department, DEA, etc. as deemed appropriate for the situation.
12.) **Agree not to seek pain medication after office hours, on the weekend, or on holidays.**
13.) Understand that attempting to obtain pain medication after office hours, on the weekend, on holidays, or from other physicians may result in discontinuing pain medications and/or discharge from the Practice.
14.) I understand that I have been given informed consent about the risks of opioid addiction and readdiction. **I realize that I must take my pain medications exactly as prescribed and that not doing so may result in overdose or death. I also understand that taking legal or illegal drugs with my pain medications without my doctors knowledge may result in overdose or death.**
15.) If I violate any of the above conditions, my obtaining prescriptions and/or treatment at Valley Pain Specialists, PC may be terminated.
MEDICATION REFILL INFORMATION:
a.) Refill requests should not be made prior to (72) hours before you are due for a refill.
b.) Requests for scheduled refills must be telephoned to our prescription refill line (610)-954-9040. Refills will not be made at night, on holidays or weekends,or in Valley

Surgical Center.
c.) Most controlled substances cannot be telephoned into a pharmacy. You must make arrangements to pick up your prescriptions during regular business hours. Prescriptions will not be mailed.
d.) Prescriptions refills will not be able to be picked up more than 48 hours before your scheduled due date.

THIS AGREEMENT WILL SUPERSEDE ALL OTHER AGREEMENTS!
BY SIGNING BELOW, I INDICATE THAT I UNDERSTAND AND AGREE TO ALL THE TERMS OF THE AGREEMENT. I RESERVE THE RIGHT TO REQUEST A COPY OF THIS AGREEMENT.

If you have any questions, please contact our Practice Administrator at (610) 954-9040.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

This acknowledgement of notice and consent authorizes Valley Surgical Center/Valley Pain Specialists to use and disclose health information about you for treatment, payment, and healthcare operations purposes.

Notice of Privacy Practices: Valley Surgical Center/Valley Pain Specialists has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

Amendments: We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to contact our Privacy Officer

VALLEY SURGICAL CENTER, INC.
VALLEY PAIN SPECIALISTS
4250 Fritch Drive
Bethlehem, PA 18020

Acknowledgement and Consent

I have received the Notice of Privacy Practices for Valley Surgical Center/Valley Pain Specialists and authorize them to use and disclose health information about myself regarding treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

_____

Signature date

Valley Pain Specialists, P.C.
Valley Surgical Center, Inc

Please fill out all information that applies, if it does not apply, please put N/A

Name		Home Phone#
Address		Cell Phone #
		Date of birth:
SS#	Gender: □ Male □ Female	Race:
Emergency Contact or Spouse		Phone:
Patient's Employer		Work Phone:

Referring Physician:	Phone & Address:
PCP/Family Physician:	Phone & Address:
Pharmacy:	Phone & Address:
Prescription Plan Name:	ID # and phone:

Primary Insurance Personal Coverage	**Secondary Insurance Personal Coverage**
Company Name	Company Name
Policy #/ID / Group#	Policy #/ID / Group#
Name of subscriber	Name of Subscriber
Subscriber SS# Subscriber DOB	Subscriber SS# Subscriber DOB

Fill out this block if your medical expenses will be covered by Worker's Compensation or Auto Insurance	
Insurance Company	Claim/Policy #
Phone #	Address:
Date of Injury:	Employer name/address:
Area of Injury:	Adjuster:

I hereby acknowledge and accept final responsibility for payment of charges for medical services rendered. I hereby consent to treatment for myself. The release of medical information to any insurance carrier and direct payment to Valley Pain Specialists, P.C. and Valley Surgical Center, Inc for treatment or examination rendered is authorized.

Please Sign _____
Signature of Patient or Guardian Date

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Valley Pain Specialists, P.C. and Valley Surgical Center, Inc, for any services furnished me by the physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Please Sign _____
Signature of Patient or Guardian Date

VALLEY PAIN SPECIALISTS, PC
Steven Mortazavi, M.D.
Marissa Marion, PA-C
Ashley Lane, PA-C
4250 Fritch Drive
Bethlehem, PA 18020
Telephone: (610) 954-9040
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Patient Authorization for Release of Medical Records

Patient's Name:

Address:

DOB:

Please check all information that applies:
☐ Chart Notes-entire record
☐ Chart Notes for the period of ___/___/_____ to ____/___/_____
(Please note if you are establishing your care elsewhere, they may not want your ENTIRE record. Please specify the exact time span above)
☐ MRI report
☐ X-rays
☐ CAT Scan
☐ Other (please specify):

Please include dates, body side and body part:

☐ I want Valley Pain Specialists to receive my records. Therefore, I give my authorization to have the above protected information released to VALLEY PAIN SPECIALISTS, PC

☐ I want Valley Pain Specialists to send my records to another medical provider. Therefore, I am authorizing VALLEY PAIN SPECIALISTS, PC to disclose or release the above protected health information to the following person or organization. The following will receive and use my protected health information:

Name:
Address:
Fax #:

Select one of the following choices:
☐ This authorization will end on the following date: ___ /____ / _____
☐ This authorization will end when the following event happens. The event must relate to the individual or the purpose of the authorized use/or disclosure. Describe the event below:

Signature of Patient: _____

Name of Patient: _____

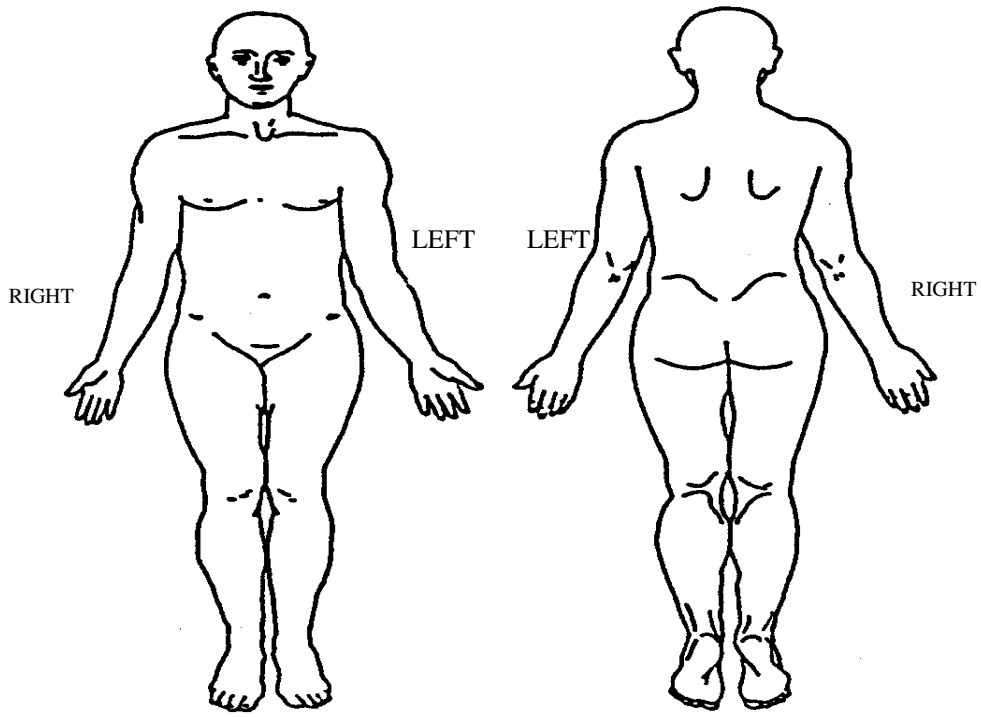
Date: ____ /_____ /_____

Rev 11.12.14

Valley Pain Specialists:
Patient Questionnaire

Name: _____ DOB: _____ Today's date:_____

1. Where is your pain located? Shade in the area on diagram below:



2. **When** did your pain begin? _____
3. **How** did your pain begin? (injury from workman's compensation, auto accident?)

_____

_____

_____

4. How do you **describe your pain**? (Circle all that apply)
   Sharp Stabbing Gnawing Dull Burning Heavy Shooting
   Exhausting Throbbing Cramping Numbing Aching Other_____

5. Is your pain constant or on and off? _____

6. What kind of things **help** to relieve your pain? (heat, ice, standing, sitting, etc…)

_____

7. What kind of things make your pain **worse**? (stairs, standing, walking, etc…)

_____

8. On a scale of 0-10 circle your average pain over the last month with 10 being the worst pain and 0 being no pain.

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain

Valley Pain Specialists:
Patient Questionnaire

9. What treatments have you tried for your pain? (Circle all that apply)

Physical therapy Biofeedback TENS Unit Acupuncture Chiropractic care

Medications Counseling Hypnosis Injections (list type and dates)

Any not listed please explain: _____

_____

_____

What tests have you had to evaluate your pain?

Test	Date	Location	Results/ Do you have the CD?
MRI			
CT-Scan			
X-Rays			
Myelogram			
EMG			
Other			

10. CURRENT Medication List

If you have a list already made with all this info, please hand it in with your paperwork, if there is not enough space to list all your medications please ask the receptionist for an extra sheet of paper. (**List all that apply, including herbal supplements and over the counter medications**)

Medication Name	**Dose (in mg)**	**How many/How Often?**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

12. List any allergies and/or intolerances you have: **Check here if none**: _____
What happens when you take it?

_____

_____

13. Have you ever been exposed to or diagnosed with MRSA? □ YES□ NO
If yes please explain_____

14. List all surgeries or procedures you have had done and when:

_____

_____

_____

_____

Valley Pain Specialists:
Patient Questionnaire

15. Do you have a history of: (circle all that apply)

Cardiovascular
□ Heart Disease
□ High Blood Pressure
□ Pacemaker/AICD
□ Heart attack(s), year(s) ____
□ Congestive Heart Failure
□ Irregular heartbeat/A-Fib

Hematologic
□ Bleeding Tendency
□ Blood Transfusion(s),
□ Anemia, type: _____

Respiratory
□ Seasonal Allergies
Sleep Apnea
□ Asthma
□ COPD/Emphysema

Gastrointestinal
□ Problems chewing/swallowing
□ Crohns Disease
□ Hiatal Hernia
□ Acid Reflux
□ Irritable Bowel Syndrome

Misc
□ HIV/AIDS (please circle one)
□ High Cholesterol
□ Thyroid Disease
□ Diabetes (Type 1 or Type 2- circle one)
□ Cancer, type _____

Urology/Nephrology
□ Renal/Liver Failure
□ Prostate Disease
□ Hepatitis (please circle one: A, B, C)
□ Kidney Stones
□ Incontinence

Psychological
□ Depression
□ Anxiety
□ Bipolar Disorder
□ Dementia/Alzheimer's

Neurological
□ Seizures Do you have Epilepsy? (yes/no)
□ Stroke(s), year(s)_____
TIA(s), year(s)_____

If you have any other diagnosed medical problems Please list them here:
_____
_____
_____

16. Do you take any **blood thinners** such as Aspirin, Coumadin, Plavix, Effient, Pradaxa, Lovenox, Aggrenox, Xarelto or NSAIDS? □ YES □ NO
If yes, please list what medication and dose_____

17. Does anyone in your family have a history of spinal problems? □ YES□ NO
If yes, who/what? _____

18. Does anyone in your immediate biological family have medical problems?

Medical Problems

Father	
Mother	
Brothers	
Sisters	

Valley Pain Specialists:
Patient Questionnaire

19. What is your current occupation:_____

20. Are you involved in workers compensation? □ YES□ NO
    If yes, what was the date of the injury? _____

21. Are you involved in litigation? □ YES □ NO
    If yes, what is the name of your attorney: _____

22. Are you (Circle one):
    Single Married Widowed Divorced Separated

23. Do you have children? □YES □ NO if yes how many? _____

24. **Health Habits** (Indicate frequency in comments) include past and present

	Comments
□ Tobacco	_____
□ Alcohol	_____
□ Recreational Drugs	_____
□ Prescription Drug Abuse	_____

25. Do you have any of the following?

	No	Yes	Explain
Chest pains			
Shortness of breath			
Leg swelling			
Depression			
Constipation			
Cancer			
Bleeding problems			

26. Has there been a change in any of the following?

	No	Yes	Explain
Sleep			
Weight			
Appetite			
Bowel/ Bladder patterns			
Hearing			
Vision			

11.12.14

Valley Surgical Center
Pre-Operative Assessment

Name: _____ DOB: _____ Ht: _____Wt: _____

Planned Surgical Procedure: _____ Family Physician: _____

Do you take any <u>blood thinners</u> such as Aspirin, Coumadin, Plavix, Effient, Pradaxa, Lovenox, Aggrenox, or Ibuprofen? □ YES □ NO
If yes please list what **<u>medication and dose</u>**, and **<u>the date your last dose was taken</u>**: _____

Do you reside in a Nursing Home/Assisted Living Facility/Skilled Nursing Facility? Y / N
If yes, please provide Facility Name: _____

Do you live alone? Y / N
If yes, is there someone available to stay with you for the next 24 hours if necessary? Y / N

Do you have an Advanced Directive? Y / N If yes, was a copy given to the facility? Y / N

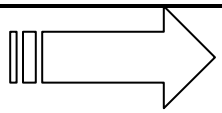
Have you fallen or been hospitalized within the last (6) months? Y / N
If yes, please describe _____

Do you have a history of: (circle all that apply)

<u>IF NOTHING HAS CHANGED WRITE SAME</u>

Cardiovascular	**Comments**	**Misc**
Heart Disease	_____	Renal/Liver failure
High Blood Pressure	_____	Hepatitis (A, B, C)
Pacemaker/AICD	_____	HIV/AIDS
Heart attack	_____	Thyroid Disease
Congestive Heart Failure	_____	Diabetes
Irregular heartbeat/A-fib	_____	
	_____	**Neurologic**
Respiratory	_____	Serious Head Injury
Asthma	_____	Seizures
COPD/Emphysema	_____	Stroke/TIA
Sleep Apnea	_____	
	_____	**Psychological**
Gastrointestinal	_____	Anxiety
Hiatal Hernia/Acid Reflux	_____	Depression
Crohns/Irritable Bowel	_____	Bipolar Disorder
	_____	
Hematologic	_____	**Urology/Nephrology**
Bleeding Tendency	_____	Incontinence
Anemia	_____	Kidney Stones
		Prostate Disease

Cancer (type): _____



11.12.14

List any surgeries or procedures you have had and when you had them:

(IF NOTHING HAS CHANGED WRITE SAME)

_____
_____
_____

Current Medication History

(List all that apply, including herbal supplements and over the counter medications)

If you have a list please give it to the healthcare provider, if there is not enough space to list all your medications please ask the receptionist for an extra sheet of paper.

IF NOTHING HAS CHANGED WRITE SAME

Medication	Dose	Comment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any allergies you have and your reaction: none: _____

_____
_____

Sensitivity to latex □ YES □ NO **Sensitivity to topical iodine: □ YES □ NO**

Have you or any of your biological relatives had a serious reaction to general anesthesia □ YES □ NO

Do you have any dental or oral appliances, loose or capped teeth or piercings? □ YES □ NO
If yes are they removable? □YES/□NO

Any possibility of pregnancy? □ YES □ NO When was your last menstrual cycle? _____

Name **Phone Number**

Individual that will be taking you home: _____ _____

Can we call you to follow up and see how you're feeling after the procedure? □YES □ NO
Best number to contact you at _____

Can we leave a message if you do not answer? □ YES □ NO

Can we speak to someone else if they answer? □ YES □NO

With my signature I acknowledge I have received a Pre-Procedure Instructions Sheet

Patient signature: _____ Date: _____

By signing below, VSC nursing personnel have reviewed and or updated the above information which is accurate and up to date:

VALLEY PAIN SPECIALISTS. PC
Steven Mortazavi, M.D.
Marissa Marion, PA-C
Ashley Lane, PA-C
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Rev 11.19.14

Valley Pain Specialists, P.C.
4250 Fritch Dr.
Bethlehem, PA 18020
610-954-9040

RE: Worker's Compensation (W/C), Motor Vehicle Accident (MVA), and Litigation

It is the policy of this office to request your health insurance information in addition to your worker's compensation or other information you may have already provided to us.

Your health insurance will be billed ***only*** in the event your claim or litigation is denied.

It is also your responsibility to understand and follow the guidelines of your health insurance. If you are enrolled in a health maintenance organization (HMO) that requires referral forms from your primary care physician in order to be treated by a specialist, this office strongly suggests that you follow through with obtaining the appropriate referrals. Again, your insurance will ***only*** be billed in the event your W/C or MVA claim is denied.

In the event that your W/C or MVA claim is denied, and you have not followed the guidelines of your health insurance, ***you will be liable for all outstanding balances.***

It is our goal to have all your claims paid by your insurance carriers, therefore, we ask for your cooperation in this matter.

Your signature is required in order to process your claim completely, otherwise, we reserve the right to postpone or reschedule your appointment.

Signature: _____ Date: _____