



Dear Patient,

We would like to thank you and extend a warm welcome and our personal greetings for choosing us for your pain management needs. We are committed to doing everything possible to provide you with high quality state of the art treatment. Our office caters to patients who suffer with pain by making your visit pleasant and comfortable.

Please review the attached paperwork and fill out all forms in their entirety in the privacy of your home. Bring all completed paperwork to your initial appointment. Should you have any questions regarding this paperwork, please do not hesitate to contact our office for assistance. This information will allow us to treat you effectively and safely.

Please bring shorts and a t-shirt (sports bra or tank top for women) with you for your exam. We also ask that you do not wear any perfumes, colognes, or scented lotions on the day of your visit.

If possible, please have your referring physician's office fax your pertinent medical records and/or testing to our office at (757) 689-4357 prior to your scheduled appointment date. If you have had any diagnostic testing performed it would be very helpful for us to have those reports as well.

When you come to your appointment, please make sure to bring your photo ID, your insurance card(s), your co-pay, and a referral from your primary care physician if your insurance company requires one.

At the time of your first appointment, we will listen closely to your concerns and construct a thorough comprehensive musculoskeletal and neurological examination. We will take the time to give you the personal attention that you deserve. Before any treatment begins, we will sit down with you and review your treatment options. This will allow you to make an informed choice regarding the best course of treatment for your specific needs. We respect our patients and our goal is to provide you with the highest quality care in an atmosphere of mutual trust.

If you have any questions, please feel free to contact us at (757) 496-2050.

Sincerely,

Dr. Gershon and Staff



PATIENT QUESTIONNAIRE

Name _____ Age _____ Right Handed Left Handed

Referring Physician _____

When did your pain first Begin? _____

Who have you seen for this pain and what treatment and tests have you undergone? _____

Describe your pain (Please check all that apply):

- | | | | | |
|------------------------------------|-----------------------------------|----------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Dull | <input type="checkbox"/> Burning | <input type="checkbox"/> Aching | <input type="checkbox"/> Knife-like |
| <input type="checkbox"/> Pulsating | <input type="checkbox"/> Pressure | <input type="checkbox"/> Deep | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Stinging |

Where is your pain currently located? _____

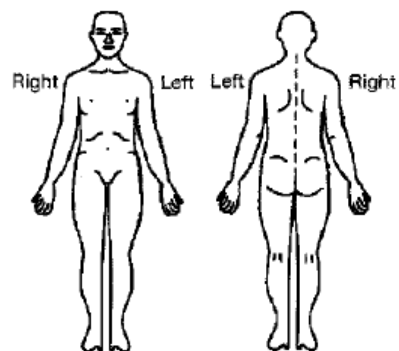
Does it shoot or refer anywhere? _____

Is your pain present constantly or intermittently? If you answer intermittently, how long does it last and is there a time of day that is better or worse? _____

PATIENT QUESTIONNAIRE (continued)

How severe is your pain?

- 0 No Pain
- 1-2 Mild pain, requires no medication
- 3-4 Mild-moderate pain, requires mild medications
- 5-6 Moderate pain, requires strong medication
- 7-8 Moderate-Severe, constant pain, requires narcotic or ER visit
- 9-10 Severe, constant pain, requires admission to hospital



PLEASE DRAW AN ARROW TO THE LOCATION OF YOUR PAIN USING THE ABOVE ILLUSTRATION

What makes your pain better? (Examples: rest, stretching, changing positions) _____

What makes your pain worse? (Examples: activity, prolonged sitting/standing) _____

Do you experience any of the following? (Please check all that apply)

- Numbness
- Tingling
- Pins & Needles
- Burning
- Weakness
- Sleep Disturbance
- Sexual Dysfunction
- Incontinence

Past Medical History: Please list any medical problems that you have or have been treated for in the past.

(Examples: diabetes, heart disease, lung disease, hypertension, high cholesterol, vascular disease, cancer, etc.)

Please list any surgeries: _____

Please list current medications: _____

Please list any allergies to medications: _____

PATIENT QUESTIONNAIRE (continued)

REVIEW OF SYSTEMS: (Please check all that apply)

Constitutional: Fever Chills Sweats Anorexia Fatigue Malaise Weight loss Weight Gain Insomnia

Eyes: Blurring Double Vision Irritation Discharge Vision Loss Eye Pain Photophobia

ENT: Ear Pain Tinnitus Decreased Hearing Nosebleeds Sore Throat Hoarseness Difficulty Swallowing

CV: Chest Pain Palpitations Syncope PND Orthopnea Peripheral Edema Cold Hands/Feet

Resp: Cough Dyspnea Excessive Sputum Coughing up Blood Wheezing Asthma Emphysema

GI: Nausea Vomiting Diarrhea Constipation Abdominal pain Melena Blood in Stool Jaundice

GU: Pain with urination Frequent nighttime urination Urinating blood Impotence Incontinence Genital Sores Decreased Libido

MSK: Back Pain Joint Pain Joint Swelling Muscle Cramps Muscle Weakness Stiffness Arthritis

Neuro: Transient Paralysis Weakness Paresthesias Seizures Syncope Tremors Vertigo Headaches

Psych: Depression Anxiety Memory Loss Mental Disturbance Suicidal Ideation _____

Endo: Cold Intolerance Heat Intolerance Polydipsia Polyphagia Polyuria _____

Heme: Abnormal Bruising Bleeding Enlarged Lymph Nodes Sickle Cell _____

Immun: Urticaria Hay Fever Persistent Infections HIV Exposure _____

Integ: Itching Rash Hives Skin Cancer Dermatitis Eczema _____

Please list job title and employer: _____

Single Married Widowed Separated Divorced

Please list ages of children (if applicable): _____

Do you smoke? Y / N Have you ever smoked in the past? Y / N

How much alcohol do you drink per week? _____

Please list major medical problems of family members (such as hypertension, diabetes, heart disease, strokes, cancer, etc.) _____

What do you hope to accomplish with this visit today? _____



PATIENT UPDATE FORM

Patient's Name: _____
Last First Middle

Street Address: _____

City/State/Zip: _____

Social Security Number: _____ Birth Date: _____ Sex: M F

Home Phone: () _____ Work Phone: () _____

Cell Phone: () _____ E-mail: _____

Emergency Contact: _____ Phone: () _____

Patient's Employer: _____ Phone: () _____

Full Address: _____

Primary Health Insurance: _____ Effective Date: _____

Phone: () _____ Subscriber: ___ Self ___ Spouse ___ Parent ___ Other

Subscriber's Name: _____ Birth Date: _____

Subscriber's ID#: _____ Group #: _____

Social Security of Subscriber (if different from self): _____

Secondary Insurance: ___ Yes ___ No Carrier Name: _____ Effective Date: _____

Phone: () _____ Subscriber: ___ Self ___ Spouse ___ Parent ___ Other

Subscriber Name: _____ DOB: _____

Subscriber's ID#: _____ Group #: _____

Social Security # of Subscriber (if different from self): _____



NOTICE AND ACKNOWLEDGEMENT

I acknowledge that I have read the Notice of Privacy Practices for Gershon Pain Specialists.

Patient Signature or Personal Representative's Signature

Date

*If Personal Representative's signature appears above, please describe Personal

Representative's relationship to the patient: _____



POLICIES

INSURANCE:

If you have insurance, we will help you receive maximum benefits. Insurance is a contract between you and your insurance company. We are not a party to this contract. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary.

FINANCIAL:

You are responsible for the timely payment of your account. We expect payment in full or payment arrangements at the time of service. If your insurance company has not paid the full balance within 45 days, you have 15 days to pay the balance. When the insurance company makes payment on the submitted charge, you will be sent a notice of this payment. Any remaining balance will be due at that time. If making a credit card payment by mail or phone, I authorize Gershon Pain Specialists to process my payment using the credit card information provided. If the balance is not paid within 30 days, the account will be turned over to our collection agency for collection. All accounts turned over to our collection agency for collection will be responsible and billed for attorney fees (33.3%) and court cost.

APPOINTMENTS:

Our goal at Gershon Pain Specialists is to make sure that all patients are seen in a timely manner. Therefore any patient that fails to show up for their regularly scheduled office appointment time or give 24 hours advance notice for a cancellation or reschedule will be assessed a \$25.00 fee. EMG and procedure appointments that fail to show or give 24 hours advance notice for a cancellation or reschedule will be assessed a \$50.00 fee.

RETURNED CHECK POLICY:

In the event that a check is returned for insufficient funds, a \$50.00 charge will be added to your account. If any balance is not paid in full within 3 business days, an additional \$55.00 fee will be added, and we will forward your returned check to Harvey L. Bryant, Commonwealth Attorney – City of Virginia Beach, for prosecution.

COLLECTIONS:

I, _____, hereby authorize Gershon Pain Specialists to apply and receive benefits on my behalf for services rendered. I request that payment be made directly to Gershon Pain Specialists. I certify that the information provided herein regarding insurance coverage is current, true, and accurate, to the best of my knowledge. I further authorize the release of any necessary medical or other relevant information for this or any related claim to my insurance company(ies), including Workers' Compensation carriers who either have a pending or accepted case. I permit a copy of this authorization and assignment to be used in place of the original. This will remain in force and effect unless and until revoked by me in writing. I understand and agree that I am financially responsible for all charges whether or not billed to or paid by said insurance. I agree to assume responsibility for all charges incurred should collection of this balance become necessary, including court costs and attorneys' fees of 33.3%.

POLICIES (continued)

BLOOD TESTING:

If health care workers are accidentally exposed to my blood or other bodily fluids in the course of providing health care to me, I agree to have my blood tested for any infections diseases which might be transmitted to them through this exposure, including HIV/AIDS and hepatitis.

TREATMENT:

I hereby consent to treatment by the Gershon Pain Specialists and/or affiliated medical staff members on behalf of my minor child/children and myself. I accept responsibility for payment of fees for such medical services. I understand that treatment may include injections, manipulations, medication management, and/or other procedures as deemed necessary and appropriate.

RELEASE OF INFORMATION:

I hereby authorize the release of any and all medical and/or charge information as is necessary for third-party reimbursement from any governmental agency or insurance payer involved in the payment of my or my child's/children's treatment. I authorize the release of any and all medical information to any physician and/or hospital involved in my or my child's/children's care. I authorize the use of limited medical information for the purpose of improving healthcare operations and clinical care when such information is utilized within the law. I further authorize representatives of Gershon Pain Specialists to leave appointment and testing reminders on my answering machine.

ACKNOWLEDGEMENTS/CERTIFICATIONS:

I, Parent/Guardian/Patient, acknowledge that I was provided with Gershon Pain Specialists' Patients Rights & Responsibilities and given an opportunity to ask questions about the information provided. I have read and agree to the terms of the Patient Financial Policy. I certify that I understood the contents of this form. Furthermore, I permit a copy of this document to be used in place of the original. I acknowledge that I have read the Notice of Privacy Practices for Gershon Pain Specialists.

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE POLICIES.

Patient Signature (Parent or Guardian, if under 18)

Date

Witness

Date



AUTHORIZATION FOR RELEASE OF INFORMATION

Please forward a copy of all medical records pertaining to the below-noted patient:

PATIENT NAME: _____

SS#: _____

DOB: _____

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulation.

PATIENT SIGNATURE

DATE

PLEASE NOTE: All records pertaining to the above-mentioned patient may be faxed to (757) 689-4357. Please call Gershon Pain Specialists at (757) 496-2050 with any questions.

Thank you for forwarding this patient's medical records.

***AUTHORIZATION FOR RELEASE
OF CONFIDENTIAL HEALTH CARE INFORMATION***

Patient Name:		Date of Birth:
Street Address:		
City	State	Zip

This authorizes _____ to request and receive
Prescriber's Name

from the Virginia Department of Health Professions any and all records held by the Department relating to Schedule II-V controlled substances dispensed to the patient named above.

I understand that this authorization permits the Department of Health Professions to disclose confidential health care records to the prescriber named above. A copy of this authorization shall be included with my original records. There is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure as permitted or required by law.

I understand that, if not previously revoked, this consent will expire one year after the date of my signature unless otherwise specified.

Patient Signature:	Date:
Guardian Signature:	Date:

NOTE: This authorization form is in addition to and separate from any other disclosure forms that you may have signed.



**ADVANCED BENEFICIARY NOTICE
NON-COVERED SERVICES
MEDICAL NECESSITY FORM**

Medicare and many other insurance plans will only pay for services that they determine to be “reasonable and necessary” under Section 1862 (a) (1) of the Medicare law. If they determine that a particular service as described below is not “reasonable and necessary” under Medicare program standards, they will deny payment for that service. We believe that in your case, Medicare and your other insurance carriers are likely to deny payment for the specific service(s) indicated below with a check mark in the box because these services are not services for which Medicare and other insurance carriers provide coverage. In addition this agreement is not limited to the below listed procedures and covers any service performed by Gershon Pain Specialists, LLC, which your insurance company may deny.

- BOTOX INJECTIONS – Please note that all BOTOX injections are “pre-authorized.” This means that the insurance company may pay for costs related to BOTOX injections. BOTOX injections are used to treat severely spastic muscles that do not respond to other treatment strategies.
- NEURAL THERAPY – These are superficial injections of a local anesthetic and sometimes other medications into scars and other areas of the body where there is “electrical instability.” This technique is commonly done in Europe and works similarly to acupuncture. Neural therapy is safe and works well for some people.
- OSTEOPATHIC MANIPULATIVE TECHNIQUES (OMT) – Most Sentara/Optima plans and other insurance carriers deny this as a covered benefit. Therefore, the cost must be paid by the patient at the time of the service.
- PROLOTHERAPY INJECTIONS - These sclerosing injections target injured or weakened ligaments that support joint function. Prolotherapy is safe and effective, but not covered by Medicare and some commercial carriers.

Also, please be advised that some insurance companies have a sixty (60) consecutive day (per condition) limitation for rehabilitation/physical therapy services. By signing this form, you are accepting financial responsibility for treatment in the event your rehabilitation benefits have been exhausted.

BENEFICIARY AGREEMENT

I have been notified by my physician that he/she believes that my insurance company may deny payment for the specific service(s) identified above. I am also aware this agreement is not limited to only those service(s) listed above, but also includes any service(s) performed by Gershon Pain Specialists, LLC that Medicare or my insurance carrier may deny. Should any of these services be deemed necessary as part of my treatment, I agree to be personally and fully responsible for payment at the time of service. If an authorization has been obtained or not needed and procedures are submitted to the carrier and denied, I accept responsibility for payment of those services upon receipt of a bill.

Signature of patient/responsible party

Date

Printed Name of patient/responsible party

Witness

Account #: _____



Please take a few moments to answer these pre-screening questions, they may be required if we need to schedule any diagnostic testing for you as a part of your visit today or for any future visits.

Thank you.

Patient Name: _____

Date: _____

Have you ever had surgery to the body part which we are treating today? (ex: neck, low back, head, extremity)? **Y / N**

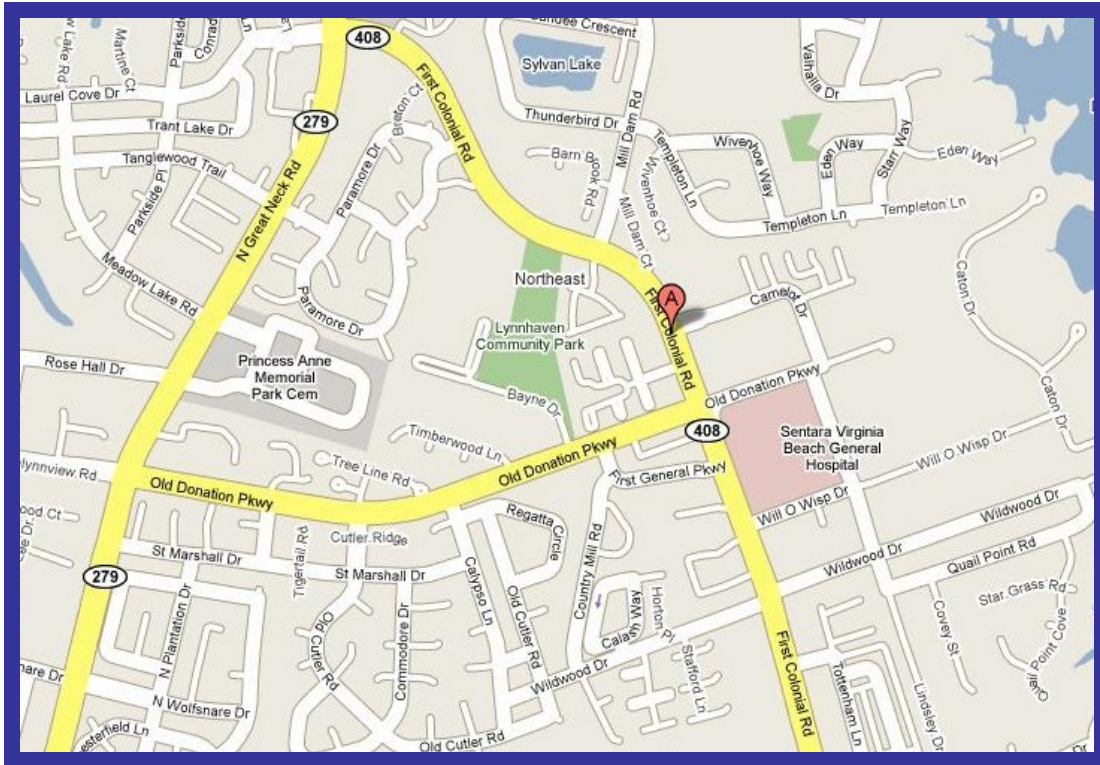
Are you claustrophobic? **Y / N**

Do you have any metal or implants in your body? **Y / N**

Have you had any recent x-rays of the body part which we are treating today? (ex: neck, low back, head, extremity)? **Y / N**

GERSHON PAIN SPECIALISTS

YOUR PATH TO PAIN RELIEF



Gershon Pain Specialists is located at 1133 First Colonial Road.

From Interstate 264:

1. Take the First Colonial Road North Exit, 21B.
2. Continue on First Colonial Road past Sentara Virginia Beach General Hospital.
3. We are located in a 1-story L-shaped, brick building on the left side of the street, just past the light at Old Donation Parkway, directly across from the Bank of the Commonwealth.
4. You will actually pass the building and need to make a u-turn on First Colonial Road to turn into the parking lot.

From Great Neck Road:

1. Turn onto First Colonial Road.
2. Go through the light at Mill Dam Road.

We are located in a 1-story L-shaped, brick building on the right side of the street, past Mill Dam Road, directly across from the Bank of the Commonwealth.