

**Intake Questionnaire**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

SS#: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: m / f Height: \_\_\_\_\_ Wt. \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Referring: Doctor, Attorney, Therapist, Trainer, Case Worker, Family, Friend, Advertisement, Other

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Physician or Other Treating Physicians:

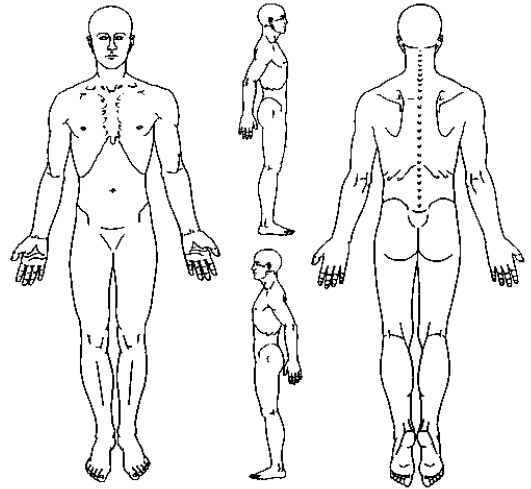
Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

When did your pain begin? \_\_\_\_\_

Please describe how it began: \_\_\_\_\_

\_\_\_\_\_

Where is your pain? (draw on diagram)



**Diagnostic Imaging**

What Imaging have you had for this problem? (Include month and year of study)

- ◇ MRI \_\_\_\_\_
- ◇ Cat/CT Scan \_\_\_\_\_
- ◇ EMG/NCV \_\_\_\_\_
- ◇ X-Ray \_\_\_\_\_
- ◇ Other \_\_\_\_\_

**Current Medications** (List all current medications)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Past Surgeries**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Social History**

Marital Status: \_\_\_\_\_ Occupation: \_\_\_\_\_

Reside with: Spouse Children Alone Roommate/s Other

Do you exercise: Yes / No Hours per week: \_\_\_\_\_

Do you smoke? No / Cigarettes / cigar / pipe / other Amount per day: \_\_\_\_\_

Use of alcohol: beer / wine / liquor / none Amount per week: \_\_\_\_\_

Use of recreational or intravenous drugs: Yes / No

**Review of Systems / Past Medical History** (Circle all that apply currently or in the PAST)

<b>General</b>	Sinus infections	Abdominal pain/cramping	Joint pain/stiffness
Anemia	Hoarseness	Change in bowel/bladder	Leg pain
Change in appetite	<b>Respiratory/Lung</b>	Constipation	Muscle weakness
Change in sleep	Asthma	Diarrhea	<b>Mental Health</b>
Easy bruising	Cough	Hemorrhoids	Anxiety
Fatigue	Emphysema	Hepatitis	Chronic fatigue
Fever	Shortness of breath	Jaundice	Depressed mood
Hair loss	Wheezing	Nausea	Insomnia
Excessive hair growth	<b>Cardiovascular/Heart</b>	Rectal bleeding	Loss of sexual desire
Intolerance to heat/cold	High blood pressure	Ulcers	Nervousness
Night sweats	Chest pain/pressure	Vomiting	Panic attacks
Radiation treatment	Ankle swelling	<b>Urinary system</b>	Tension/Stress (severe)
Rheumatic fever	Blood clots/phlebitis	Frequent urination	<b>Neurological</b>
Weight loss (unexplained)	Cholesterol problem	Blood in urine	Memory loss
<b>Eye, Ear, Nose &amp; Throat</b>	Lightheaded spells	Urgency to urinate	Dizziness
Blurry vision	Irregular heart beat	Urinary hesitancy	Loss of sensation
Change in vision	Murmur	Urinary incontinence	Paralysis
Glaucoma	Heart disease	<b>Gynecological</b>	Seizures
ringing in the ears	Valvular disease	<b>Musculoskeletal</b>	Stroke
Hearing difficulties	Mitral valve prolapse	Arthritis	Tremor
Allergies/ Hay fever	<b>Gastrointestinal</b>	Back pain	Weakness arms / legs
Runny nose/congestion	Abdominal distention	Gout	Headaches/severe

**PATIENT INSURANCE**

**IS THIS INJURY WORK RELATED?** yes / no **IS THIS INJURY MOTOR VEHICLE RELATED?** yes / no.

If this is a worker's compensation or MVA case please fill out insurance information immediately below:

Insurance Company: \_\_\_\_\_ Adjuster/Case Worker: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Address: \_\_\_\_\_

Claim #: \_\_\_\_\_ Attorney: \_\_\_\_\_

Employer: \_\_\_\_\_

**PRIMARY INSURANCE COVERAGE**

Circle Type of Coverage: HMO, POS, PPO, MEDICARE, SCHOOL, SELF PAY, OTHER

Name of Insurance Plan: \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_

SEX: \_\_\_\_ male \_\_\_\_ female RELATIONSHIP TO PATIENT: \_\_\_\_\_

**SECONDARY INSURANCE COVERAGE**

Circle Type of Coverage: HMO, POS, PPO, MEDICARE, SCHOOL, SELF PAY, OTHER

Name of Insurance Plan: \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_\_

SEX: \_\_\_\_ male \_\_\_\_ female RELATIONSHIP TO PATIENT: \_\_\_\_\_

**INSURANCE POLICY**

**Please read the following:**

- 1. This is a direct assignment of my insurance policy to directly pay Chronic Pain Solutions, LLC.
- 2. **Patients are only responsible for co-pay's**, if co-payments are associated with your insurance plan we can accept it at time of service. If your insurance company chooses to send payment to the patient for services rendered, charges will become patient responsibility.
- 4. I hereby authorize the release of my information relating to my care directly to my insurance company, attorney, school or other treating specialist.

**PLEASE SIGN BELOW**

I have reviewed and am aware of the above insurance policies of Chronic Pain Solutions, LLC.

\_\_\_\_\_/\_\_\_\_/\_\_\_\_      \_\_\_\_\_      \_\_\_\_\_      \_\_\_\_\_

Signature of responsible party      Date      Signature of patient      Date



New Jersey Department of Banking and Insurance

CONSENT TO REPRESENTATION IN APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS IN UM APPEALS AND INDEPENDENT ARBITRATION OF CLAIMS

APPEALS OF UTILIZATION MANAGEMENT DETERMINATIONS

You have the right to ask your insurer, HMO or other company providing your health benefits (carrier) to change its utilization management (UM) decision if the carrier determines that a service or treatment covered under your health benefits plan is or was not medically necessary.\* This is called a UM appeal. You also have the right to allow a doctor, hospital or other health care provider to make a UM appeal for you.

There are three appeal stages if you are covered under a health benefits plan issued in New Jersey. Stage 1: the carrier reviews your case using a different health care professional from the one who first reviewed your case. Stage 2: the carrier reviews your case using a panel that includes medical professionals trained in cases like yours. Stage 3: your case will be reviewed through the Independent Health Care Appeals Program of the New Jersey Department of Banking and Insurance (DOBI) using an Independent Utilization Review Organization (IURO) that contracts with medical professionals whose practices include cases like yours. The health care provider is required to attempt to send you a letter telling you it intends to file an appeal before filing at each stage.

At Stage 3, the health care provider will share your personal and medical information with DOBI, the IURO, and the IURO's contracted medical professionals. Everyone is required by law to keep your information confidential. DOBI must report data about IURO decisions, but no personal information is ever included in these reports.

You have the right to cancel (revoke) your consent at any time. Your financial obligation, IF ANY, does not change because you choose to give consent to representation, or later revoke your consent. Your consent to representation and release of information for appeal of a UM determination will end 24 months after the date you sign the consent.

INDEPENDENT ARBITRATION OF CLAIMS

Your health care provider has the right to take certain claims to an independent claims arbitration process through the DOBI. To arbitrate the claim(s), the health care provider may share some of your personal and medical information with the DOBI, the arbitration organization, and the arbitration professional(s). Everyone is required to keep your information confidential. The DOBI reports data about the arbitration outcomes, but no personal information will be in the reports. Your consent to the release of information for the arbitration process will end 24 months after the date you sign the consent.

CONSENT TO REPRESENTATION IN UM APPEALS AND AUTHORIZATION TO RELEASE OF INFORMATION IN UM APPEALS AND ARBITRATION OF CLAIMS

I, [PRINT NAME], by marking [ ] (or [x]) and signing below, agree to:

- [ ] representation by Chronic Pain Solutions, LLC in an appeal of an adverse UM determination as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI, its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner.
[ ] release of personal health information to DOBI, its contractors for the Independent Claims Arbitration Program, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months.

Signature: \_\_\_\_\_ Ins. ID#: \_\_\_\_\_ Date: \_\_\_\_\_
Relationship to Patient: [ ] I am the Patient [ ] I am the Personal Representative (provide contact information on back)

\* If the patient is a minor, or unable to read and complete this form due to mental or physical incapacity, a personal representative of the patient may complete the form.

Health Care Provider: The Patient or his or her Personal Representative MUST receive a copy of both sides/pages of this document AFTER PAGE 1 has been completed, signed and dated.