PAIN MANAGEMENT ASSOCIATES OF WNY
100 COLLEGE PARK, SUITE 220
WILLIAMSVILLE, NEW YORK 14221
PHONE (716) 626-9900 FAX (716) 626-9100

OFFICE POLICIES AND GUIDELINES
FOR NEW PATIENTS

- **Please mail completed paperwork back to office. Once received you will be called, and an appointment made. Any incomplete forms will not be called.**

New Patients: To avoid delay in being seen on your appointment day, please bring the following with you:

- Copy of all test results, i.e., MRI's CT scans, etc., that you had done previously.
- Please bring all insurance cards and a photo ID, as we must have a copy of these in your chart.
- You must bring all of the current medications prescribed to you by your referring physician and/or primary care physician. Not just a list, but medication bottles. If we need to make a change, we can do so at time of appointment.
- For No Fault and Workers' Compensation cases, we must have date and accident, name and address of insurance carrier, claim number, and the name and phone number of the claim representative.
- Please bring the name and address of your pharmacy also.
- **Written referral from doctor sending to pain management, needed in chart.**

General Office Policies:

- Prescription refills — You must call (716) 626-9900, seven (7) days before your prescription is due. Your prescription will be faxed directly to your pharmacy.
- There is a $10.00 charge for all form completions and fee must be paid before completion. Please allow at least one weeks' time for completion. We will fax or mail your form(s) directly to the appropriate company.
- Co-pays are required at the time of visit, appointment may be cancelled if not paid.
- Unsanctioned changes in pain medications are not advised.
- Per office policy, we do not replace lost or stolen medication, even if police report was obtained.
- In pain management practices with strong medicines, illegal drug use cannot be allowed. To ensure patient compliance, we have a policy of ransom urine toxicology screens. If you have any questions, please speak with one of our associates.

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Patient's Name (First, Middle, Last)	Birth Date	Age	Sex	Social Security #	Marital Status

Street Address	City and State	Zip Code	Home Phone	Cell Phone

Name of Primary Care Physician	Name of Referring Doctor	Referring Doctor Phone

INSURANCE INFORMATION — PLEASE SHOW THE RECEPTIONIST YOUR INSURANCE CARDS

☐ **Medical** *If this box is checked, please answer questions 1 & 2.*	☐ **Workers' Compensation** (work related injury) *If this box is checked, please answer questions 1 through 3.*	☐ **No Fault** (Auto Accident) *If this box is checked, please answer questions 1, 2, and 4.*

Were you injured on the job? ☐ Yes ☐ No	Were you injured in an automobile accident? ☐ Yes ☐ No

1. Primary Insurance

Name of Insurance Carrier:			
Group #	Identification #	Name of Policy Holder	Major Medical or Additional Benefits? ☐ Yes ☐ No

2. Secondary Medical Insurance

Name of Insurance Carrier:			
Group #	Identification #	Name of Policy Holder	Major Medical or Additional Benefits? ☐ Yes ☐ No

3. Workers' Compensation

Is your Workers' Comp. Insurance Carrier currently paying your medical bills? ☐ Yes ☐ No

Name of Insurance Carrier	Address	Zip Code

Carrier Case #	WCB #	Date of Injury	Name of Employer at Time of Injury

Adjuster Name	Phone #

4. No Fault

Name of Insurance Carrier	Claim #	Date of Accident

Authorization to Release Records and Patient Responsibility:

I request that payment of authorized Medicare/Other Insurance Company benefits be made to me or on my behalf to Dr. Eugene Gosy/Dr. James Hitt for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits or the benefits to related services.

I understand I am financially responsible for all charges whether or not paid by said insurance. This authorization will remain in effect until revoked by me in writing. I understand my signature requests payments to be made and authorizes release of medical information necessary to pay the claim.

Signature: _____ Date: _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for commercial insurance or a statement of claim for any commercial or personal insurance benefits containing any material false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who, in connection with such application or claim, knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or any insurance company, commits a fraudulent act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or state claim for each violation.

BACKGROUND AND MEDICAL HISTORY

Date: _____

Name (Last, First) _____ MI _____

Date of Birth: _____ Age: _____ Sex: ☐ F ☐ M Height: _____ Weight: _____

COMPLAINT: Describe your problem as to timing, character, location, intensity, associated symptoms, and preciption/aggravating factors, including dates.)

_____

_____

_____

MEDICAL PROBLEMS	Personal — Past & Present	Family History
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Other Heart Disease	☐	☐
Stroke	☐	☐
Mental Illness	☐	☐
Depression	☐	☐
Diabetes	☐	☐
Cancer	☐	☐
Alcohol/Drug Abuse	☐	☐
Kidney Problem	☐	☐
Lung Problem	☐	☐
Cataract	☐	☐
Asthma	☐	☐
Allergies	☐	☐
Liver/Gallbladder	☐	☐
Ulcer/Stomach	☐	☐
Neurological Problem (Seizures/Parkinson's)	☐	☐
Fracture (Spine/Hip/Leg)	☐	☐
Thyroid/Endocrine	☐	☐
Prostate (Men)	☐	☐
Ovaries (Women)	☐	☐

Surgery/Procedure: (Include dates) _____

_____

_____

Injuries/Accidents: _____

_____

_____

Hospitalization: _____

_____

_____

BACKGROUND AND MEDICAL HISTORY continued

Name (Last, First) _____ MI _____

Name of Pill/Medicine	Dose	How many per day	How helpful is it? Very	Somewhat	It's Not	Not Sure
1. _____	_____	_____				
2. _____	_____	_____	☐	☐	☐	☐
3. _____	_____	_____	☐	☐	☐	☐
4. _____	_____	_____	☐	☐	☐	☐
5. _____	_____	_____	☐	☐	☐	☐
Allergies:			☐	☐	☐	☐

_____

Pervious medical treatments and interventions in the past: _____

_____

_____

_____

SOCIAL:

Marital Status

- ☐ Never married
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widow/Widower

With whom do you live?

- ☐ Alone
- ☐ With spouse
- ☐ With children
- ☐ With relative/friend
- ☐ Retirement home

Ethnic Background

- ☐ White
- ☐ Black
- ☐ Asian
- ☐ Hispanic
- ☐ American Indian
- ☐ Other

OCCUPATION: (if none, what you did in the past) describe your work.

_____

_____

Are you presently working?..... ☐ Yes ☐ No Date last worked _____

Alcohol Use..... ☐ Yes ☐ No How much? _____

Tobacco Use..... ☐ Yes ☐ No How much? _____

DISABILITY STATUS/LEGAL CLAIMS PENDING: _____

_____

_____

DIANOSTIC TESTS: *Include type, when, results (blood test, x-ray, MRI, CT Scan)*

_____

_____

PATIENT COMFORT ASSESSMENT GUIDE

Where is your pain? _____

_____

_____

Circle the words that describe your pain.

	OCCASIONSAL	CONTINUOUS		OCCASIONSAL	CONTINUOUS
Aching	☐	☐	Numb	☐	☐
Throbbing	☐	☐	Nagging	☐	☐
Shooting	☐	☐	Penetrating	☐	☐
Stabbing	☐	☐	Exhausting	☐	☐
Gnawing	☐	☐	Tiring	☐	☐
Sharp	☐	☐	Burning	☐	☐
Tender	☐	☐	Unbearable	☐	☐

What time of day is your pain the worst?

☐ Morning ☐ Afternoon ☐ Evening ☐ Nighttime

Rate your pain by circling the number that best describes your pain:

...at it's *worst* in the last month.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

...at it's *least* in the last month.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

...at it's *average* in the last month.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

...*right now*.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

What makes your pain better? _____

_____

_____

What makes your pain worst? _____

_____

_____

What <u>treatments</u> are you receiving for you pain?

Circle the number to describe the amount of relief the treatment provides you.

A. _____	No Relief	0	1	2	3	4	5	6	7	8	9	10	Complete Relief
B. _____	No Relief	0	1	2	3	4	5	6	7	8	9	10	Complete Relief

What side effects or symptoms are you having due to your medications?

Circle the number that best describes you experience during the past week.

	Barely noticeable										**Severe enough to stop medication**
A. Nausea	0	1	2	3	4	5	6	7	8	9	10
B. Vomiting.....	0	1	2	3	4	5	6	7	8	9	10
C. Constipation.....	0	1	2	3	4	5	6	7	8	9	10
D. Lack of Appetite.....	0	1	2	3	4	5	6	7	8	9	10
E. Tired.....	0	1	2	3	4	5	6	7	8	9	10
F. Itching.....	0	1	2	3	4	5	6	7	8	9	10
G. Nightmares.....	0	1	2	3	4	5	6	7	8	9	10
H. Sweating.....	0	1	2	3	4	5	6	7	8	9	10
I. Difficulty Thinking.....	0	1	2	3	4	5	6	7	8	9	10
J. Insomnia.....	0	1	2	3	4	5	6	7	8	9	10

Circle the one number that describes how during the past week *<u>pain has interfered</u> with you:*

	Dose not interfere										**Completely Interferes**
A. General Activity.....	0	1	2	3	4	5	6	7	8	9	10
B. Mood.....	0	1	2	3	4	5	6	7	8	9	10
C. Normal Work.....	0	1	2	3	4	5	6	7	8	9	10
D. Sleep.....	0	1	2	3	4	5	6	7	8	9	10
E. Enjoyment of Life.....	0	1	2	3	4	5	6	7	8	9	10
F. Ability to Concentrate.....	0	1	2	3	4	5	6	7	8	9	10
G. Relations with Others.....	0	1	2	3	4	5	6	7	8	9	10

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Pain Management Agreement

1. I understand that I am entering into an agreement with my physician(s) to manage my pain with opioids (narcotic) medication. I have been advised that the purpose of this agreement is to avoid misunderstandings about medications I will be taking, and to comply with the law regarding narcotics.
2. Medication(s) and dosage(s) prescribed: _____
   _____
   _____
   _____
3. The potential side effects of narcotic medications have been explained to me. These include but are not limited to:
   - Decreased appetite, constipation
   - Increased drowsiness or sleepiness
   - Confusion or difficulty thinking
   - Balance/coordination problems
   - Respiratory depression (breathing too slowly)
   - Tolerance (require more medication to get the same effect)
   - Physical dependence (abruptly stopping the medication can trigger symptoms of withdrawal)
   - Physical dependence of newborn's whose mothers take these drugs during pregnancy
   - Psychological dependence (stopping the medication may cause you to miss/crave it)
4. I agree to provide my doctor with a complete and accurate medical history, including my past medical treatment, any other medications I am currently taking, and any history of alcohol or drug addiction or dependency. If I am a female of childbearing age, I agree to inform my doctor immediately if there is a possibility that I might be pregnant.
5. I agree to inform my doctor of the identity of all other providers from whom I receive medical treatment. I represent that I currently do not have a problem with substance abuse or dependence.
6. I agree to communicate fully with my doctor about the character and intensity of my pain, the side effect of the pain on my daily life, how the medicine is helping to relieve the pain, and any side effects or problems related to the medication I am taking.

7. I agree to take my medications as prescribed. If I take my medication more often or at a or at a higher dosage than prescribed, I understand that I may be without the medication until the expected renewal date.
8. I agree that I will not attempt to obtain any controlled medications, including opioid pain medications, controlled stimulants, or anti-anxiety medicines from any other health care provider. I agree to inform my doctor if I see another provider in an emergency and receive pain medication.
9. I agree to follow my doctor's instructions about operating heavy machinery, including but not limited to driving a motor vehicle, since these medications can cause increased drowsiness or sleepiness.
10. I agree that I will not use alcohol or any other prescription drugs without my doctor's prior knowledge and agreement. I will not use any illegal controlled substances, including but not limited to marijuana, cocaine, heroin, or other similar substances.
11. I agree that I will not sell, possess illegally, divert or transport any controlled substances. I further agree not to hoard, share, sell, or trade my medication with nay other individual.
12. I agree that I will not alter any of my prescriptions. I understand that if I do so, I will be discharged from the practice immediately.
13. I agree to safeguard my pain medication from loss, theft, or damage. Per office policy, we do not replace lost or stolen medication, even if a police report was obtained.
14. I agree to keep all my scheduled appointments with my doctor and bring all unused pain medicine with me to every office visit. I understand that if I miss scheduled appointments, my physician may discontinue my medication. If I believe that I need to be seen before my next scheduled appointment, I agree to contact my doctor.
15. I agree to participate actively in any additional pain therapies my doctor recommends. If my doctor determines that I have become dependent on controlled substances, I agree to participate in a program from chemical dependency.
16. I agree to submit to a urine test or pill count whenever requested by my doctor. If the results reveal that I have failed to comply with this agreement and my pain treatment plan, I understand that my doctor may elect to decrease or discontinue my medications.
17. I authorize my doctor and his office staff to communicate with my pharmacist regarding my compliance with this agreement.
18. I further authorize both my physician(s) and my pharmacist to cooperate fully with any city, county, state or federal law enforcement agencies, the New York State Board of Pharmacy, the Bureau of Controlled Substances, and the Federal Drug Enforcement Agency in the investigation of any possible misuse, sale, or diversion of my pain medicine. I authorize my doctor to provide a copy of this agreement to any of these agencies and to my pharmacy. I understand that I waive any applicable privilege, right of privacy or confidentiality concerning requests for my protected health information from these agencies.

19. **MEDICATION REFILLS WILL ONLY BE MADER DURING REGULAR OFFICE HOURS, MONDAYTHROUGH FRIDAY, 8:00 A.M. TO 4:00 P.M. REFILLS WILL NOT BE MADE NIGHTS, WEEKENDS, AND HOLIDAYS, unless my doctor determines in his/her sole discretion that extraordinary circumstances justify a refill outside of regular office hours. I AM AWARE THAT I MUST CALL 7 BUSINESS DAYS BEFORE I NEED MY PRESCRIPTION REFILLED.**

20. I agree to use the following pharmacy to fill prescriptions for all my pain medicine:

    Pharmacy name: _____

    Located at: _____

    Telephone number: _____

21. I understand that my compliance with the terms of this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor's treatment will be based on this agreement. Failure to comply with all of the conditions in this agreement may result in:
    - Danger to my life and health.
    - My doctor electing to decrease or discontinue prescribing these medications. If this occurs, my doctor may choose to taper the medication over a period of several days, to avoid withdrawal symptoms when discontinuing it.
    - Discharge from my doctor's practice.

22. The terms and conditions of this agreement have been fully explained to me. All of my questions and concerns regarding both my treatment and this agreement have been answered to my satisfaction. I have been given a copy of this document.

This agreement is entered into on: _____

Patient signature: _____

Physician signature _____

Witnessed by: _____

HIPAA

Health Insurance Portability & Accountability Act

Acknowledge of Receipt of Notice

PAIN MANAGEMENT ASSOCIATES OF WNY

I authorize the following communication regarding my medical information listed bellow.

Please list any person to which you authorize us to disclose verbal communication via phone or in person.

APPOINTMENT INFORMATION

- ☐ Home Phone
- ☐ Mobile Phone
- ☐ Mobile Text
- ☐ Work Phone
- ☐ With Another Person
- ☐ Send via Mail
- ☐ Send via E-Mail

MEDICAL INFORMATION

- ☐ Home Phone
- ☐ Mobile Phone
- ☐ Mobile Text
- ☐ Work Phone
- ☐ With Another Person
- ☐ Send via Mail
- ☐ Send via E-Mail

NAME: _____ ☐ Medical Information ☐ Script Pick Up

NAME: _____ ☐ Medical Information ☐ Script Pick Up

NAME: _____ ☐ Medical Information ☐ Script Pick Up

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

PRINT: _____ DATE: _____

SIGN: _____ PHONE: _____

SUMMART OF PRIVACY PRACTICES

PAIN MANAGEMENT ASSOCIATES OF WNY

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, a doctor may use the information in your medical record to determine which treatment option, such as drug or procedure best addresses your health needs.

Payment: Your health information may be used to seek payment from your health plan; from other sources of coverage such as a No Fault, Workers' Compensation carrier or from credit companies that you may use to pay for services.

Health Care Operations: Your health information may be used as necessary to support day to day activities and management of Pain Management Associates of WNY. For example, information may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

Law Enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections to facilitate law enforcement investigations and to comply with government mandated reporting.

Public Health Reporting: As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medication, and reporting disease or infection exposure.

Other Uses and Disclosures Require Your Authorization: Other disclosures of your health information or its use for other than the reasons listed above, requires your specific written authorization. If you change your mind after authorizing, you may submit a written revocation of the authorization. However, your revocation will not affect or undo any use or disclosure that occurred before you notified us of your decision.

Additional Use of Information: Your health information will be used by our staff to send any appointment reminder deemed necessary.

Individual Rights: You have certain rights under federal privacy standards including:

* The right to request restrictions on the use and disclosure of your health information.
* The right to receive confidential communications concerning your medical condition & treatment.
* The right to inspect and obtain a copy of your health information.
* You can request to amend or submit corrections to your health information.
* The right to receive an accounting of how and to whom your health information was disclosed.
* The right to receive a printed copy of this summary and Pain Management Associates of WNY's Notice of Privacy Practices, which provides a more complete description of information uses and disclosures.

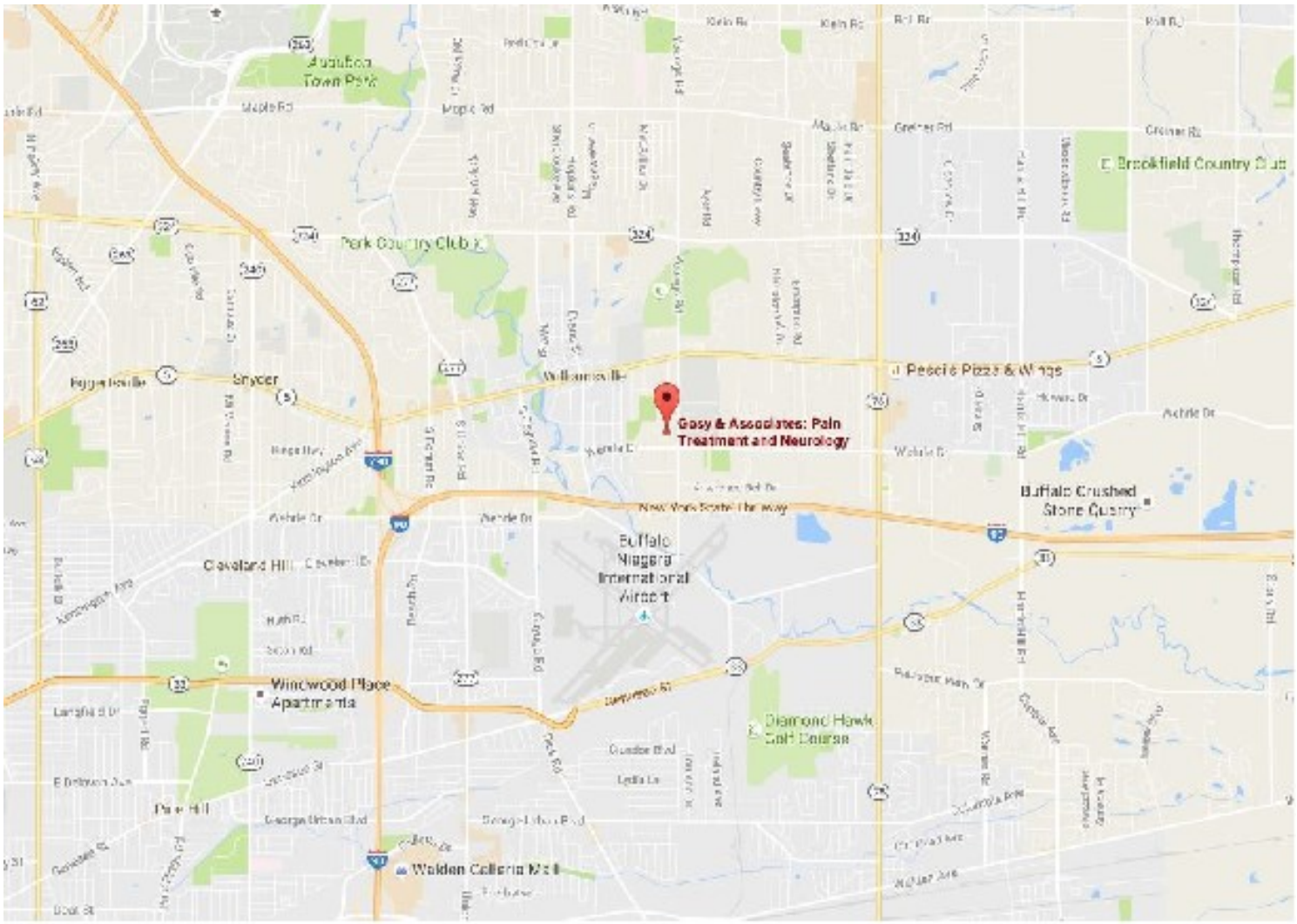
Pain Management Associates of WNY Duties: We are required to maintain the privacy if your health information and to provide you with our Notice of Privacy Practices. We reserve the right to amend or modify our privacy policies and practices. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

You may generally inspect your health information. As permitted by federal regulation, we require that such request must be submitted in writing to Pain Management Associates of WNY, Att: Office Manager. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny your request.

If you would like to submit a comment or complaint about our privacy practices, you will not be penalized or otherwise retaliated against for filing. You may request a copy of our Complaint Form, which you will fill out and submit to Pain Management Associates of WNY, Att: Office Manager, 100 College Parkway, Suite 220, Williamsville, NY 14221.

For further information concerning our privacy policies, please contact the Office Manager at the above address.

The effective day of this notice is: November8, 2016.


Gasy & Associates: Pain Treatment and Neurology
Park Country Club
Snyder
Buffalo Niagara International Airport
Cleveland Hill
Windwood Place Apartments
Pine Hill
Walden Galleria Mall
Buffalo Crushed Stone Quarry
Diamond Hawk Golf Course
Brookfield Country Club