Welcome to Comprehensive Pain Management, your appointment with Dr. Lepis is on _____. If your insurance carrier requires referrals, i.e. HMO, POS, you must bring the referral with you at the time of your appointment. **Or your appointment will be rescheduled.**

For your convenience we have mailed the necessary paperwork to you, please fill out completely and bring it back with you to your appointment. **Do not mail it back to the office.**

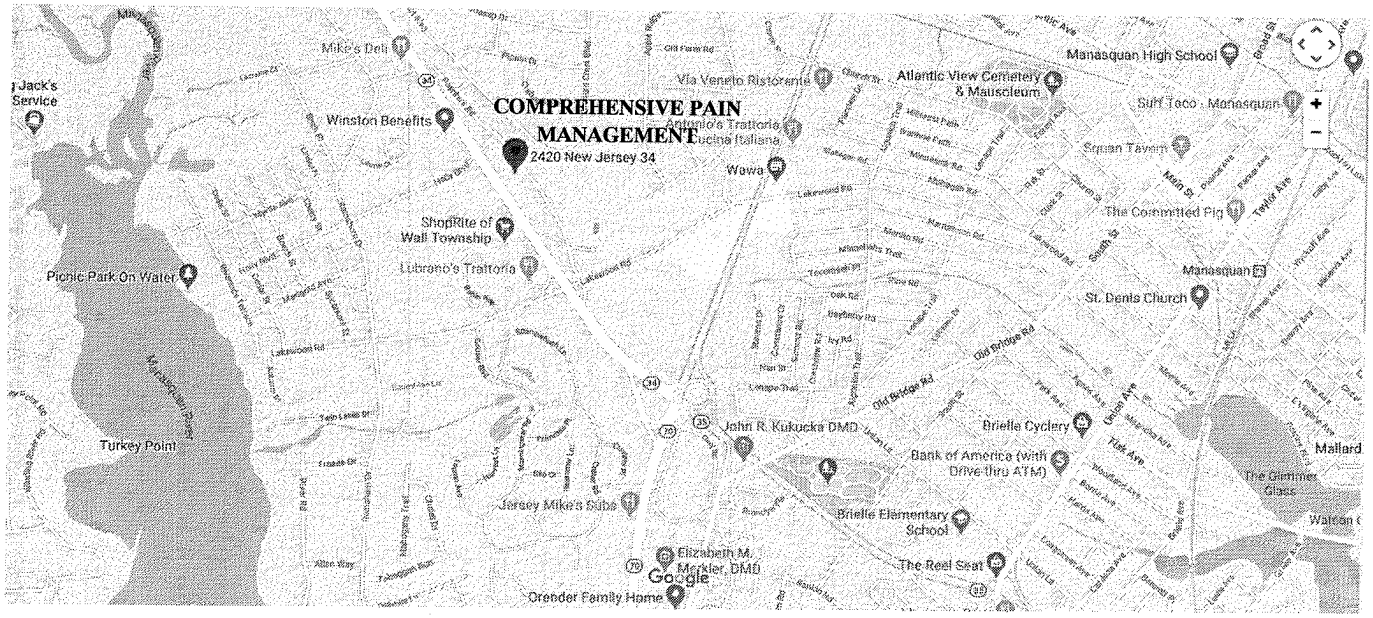
If the necessary paperwork is not complete upon arrival you **WILL BE RESCHEDULED.**

Plan to arrive 10 minutes prior to your appointment time and bring your insurance cards with you. You will also need to pick up your pertinent X-rays, MRI's and radiology reports to bring with you the day of your appointment. Due to limited availability for new patient appointments, if you cancel this appointment you will be required to provide a refundable $100.00 retainer fee in order to reschedule your appointment. Please be aware that a missed rescheduled appointment will result the forfeiture of the retainer fee.

Thank you for your cooperation.

Comprehensive Pain Management

Comprehensive Pain Management
2420 Highway 34
Manasquan, NJ 08736
732-223-2873



FROM THE EAST
TAKE 35N. TURN RIGHT ONTO 34N. WE ARE ON THE RIGHT HAND SIDE.

FROM THE NORTH
TAKE PARKWAY SOUTH TO EXIT 98. FOLLOW SIGNS FOR 34 SOUTH. CONTINUE TO CIRCLE, FOLLOW SIGN FOR 34 SOUTH. 1ST LIGHT IS PAYNTERS ROAD, TAKE JUG HANDLE AT MIKE'S DELI. CROSS OVER RT 34, STAY ON PAYNTERS RD. AFTER A FEW MINUTES YOU WILL SEE A FLAG ON A MAILBOX ON YOUR RIGHT. AFTER A FEW MINUTES YOU WILL SEE A FLAG ON THE MAILBOX ON YOUR RIGHT. WE ARE THE SECOND DRIVEWAY. MAKE THE RIGHT INTO COMPREHENSIVE PAIN MANAGEMENT. PLEASE ENTER THROUGH THE FRONT OF THE BUILDING.

FROM THE SOUTH
TAKE PARKWAY NORTH TO EXIT 90. TURN LEFT ONTO 70. 70 BECOMES 35. STAY IN RIGHT LANE AND TURN ONTO 34N. WE ARE ON THE RIGHT HAND SIDE.

Comprehensive Pain Management
2420 Highway 34
Manasquan, NJ 08736
732-223-2873

Patient Survey:

How did you hear about us?

____Phone Book

____Friend or Relative

Name _____

____Physician

Name _____

____Insurance Company

Name _____

____Other

_____

COMPREHENSIVE PAIN MANAGEMENT

PATIENT INFORMATION

Name _____ Occupation _____

Address _____ Employer _____

City/State/Zip _____ Work Telephone # _____

Home Telephone # _____ **Primary Care Physician** _____

Sex _____ **Phone Number**_____

Date of Birth _____ _____

Social Security # _____ Name of nearest relative not living with you _____

EMAIL ADDRESS_____ _____

GUARANTOR INFORMATION (person responsible for medical bills)

Name _____ Relationship to Patient: □ Self □ Spouse □ Parent

Address _____ □ Step-Parent □ Grandparent

City/State/Zip _____ Social Security # _____

Home Telephone # _____ Employer _____

Work Telephone # _____

PRIMARY INSURANCE INFORMATION

Ins. Co. Name _____ Copay_____ Policy # _____

Address _____ Group # _____

City/State/Zip _____ Effective Date _____

Telephone # _____ _____ Date of Birth _____

Subscriber Name _____ Social Security # _____

SECONDARY INSURANCE INFORMATION

Ins. Co. Name _____ Copay_____ Policy # _____

Address _____ Group # _____

City/State/Zip _____ Effective Date _____

Telephone # _____ _____ Date of Birth _____

Subscriber Name _____ Social Security # _____

OTHER INSURANCE INFORMATION

Is this visit related to:

□ Work Related Injury _____ □ Auto Accident _____ □ Personal Injury _____

Ins. Co Name _____ Date of Injury _____

Address _____ State Injury Occurred _____

City/State/Zip _____ Claim # _____ _____

Ins Co. Telephone # _____ Accident Description _____

Name of Adjuster_____ _____

Name of Attorney _____ Attorney Telephone # _____

Is this claim active? ____ yes _____ no

EMERGENCY INFORMATION

Emergency Contact _____ Relationship _____

Home Telephone # _____ Work Telephone # _____

Patient Information

I hereby authorize Comprehensive Pain Management to release information acquired during the course of my examination & treatment to the Health Care Financing Administration & its agents, or any other third party carrier as necessary to secure payment of any benefits due to me. I hereby assign payment of said benefits to include Medicare directly to Comprehensive Pain Management. I understand that I am responsible for all charges regardless of insurance status as well as any associated costs for collection should such action become necessary. A photocopy of this assignment shall be considered as valid as the original. I have read the above and fully understand the terms therof.

Signature _____ Date _____

Comprehensive Pain Management

Michael A. Lepis, M.D.
Medical Billing Department
2420 Highway 34, Manasquan, N.J.08736

Financial Policy

Medicare Financial Policy:

1. After your deductibles have been satisfied, Medicare will pay 80% of allowed charges. If you do not have a secondary coverage as a supplement, you will be responsible for 20% of those charges on the day the services are rendered.

2. Medicare may deny payment for specific procedures or treatment. An ABN gives you the opportunity to accept or refuse the items or services and protects you from unexpected financial liability in cases where Medicare denies payment. You have the option to receive the items or services or to refuse.

Commercial Insurance Financial Policy:

1. All patients are responsible for any additional money owed beyond what their insurance plan covers. If your health plan determines that ANY of the services provided by Comprehensive Pain Management,LLC and/or Dr. Michael Lepis, MD are NOT medically necessary and/or not covered after we have provided all necessary documentation, authorizations and appeals to the health plan, YOU will be responsible for the charges of that visit or procedure according to our Self Pay Rate.
2. If you are a new patient, or an existing patient and your insurance has changed, you must provide us with a copy of your insurance card prior to treatment. This card should be provided to us at the time of service or earlier if requested so that we can verify coverage and your insurance benefits.
3. Some insurance policies require referral from your primary care physician. It is **your responsibility** to make sure we have that referral prior to your first date of treatment. Otherwise, you will be held responsible for the cost of the uncovered service provided.
4. We require payment of co pays and deductibles at the time of service as legally required by your insurance carrier, otherwise the patient will have to reschedule their appointment. Our financial policy no longer allows patients to accrue a balance. If you are unable to pay your bill you will need to speak with Dr Lepis.
5. Once **all** insurance payments have been received we will refund any overpayment promptly.
6. If for any reason you should lose your insurance coverage, you will be classified as a self pay patient that will be limited to three months unless otherwise stipulated by Dr. Lepis.
7. Comprehensive Pain Management,LLC/Dr.Michael Lepis, MD is **not** IN-Network ~~will~~ with all Insurance companies. Prior to your first visit, you will be counseled as to what deductibles, coinsurances and/or estimates of your financial responsibility you will incur for office visits and procedures where Dr. Lepis is the surgeon in regards to Out of Network coverage on your policy.

Miscellaneous Information:

1. We accept cash, debt cards, and checks, Visa, MasterCard and Discover.
2. We require all money due be paid prior to or at the time of the scheduled appointment. For further information regarding your bill you may contact our medical billing department at 732 281 3590. You can also make payments via a credit card by calling the main office at 732-223-2873.
3. The patient is responsible for a returned check fee of $35.00. If you submit a check with insufficient funds, your professional care treatment may be suspended until your balance is paid. Checks will no longer be accepted from a patient who has had a returned check.
4. We require a 24 hour notice if you need to cancel your appointment. The fee for a missed appointment /no show/ less than a 24 hour notice is $25.00 and must be paid before being rescheduled.
5. It is our company's policy that we require our patients to be provided a Urine Drug Screen on every visit if they require narcotic medications. When appropriate, we will submit the claim to your insurance carrier, however if your insurance denies the claim for non-coverage, you will be billed a fee of $25.00 for the required testing.
6. Any patient account balance, which is not being paid in good faith or have a financial payment contract, will be considered for transfer to outside collection agency which will negatively affect the patients credit rating and should be avoided. This includes any patient with an account balance who has defaulted from their financial payment contract.
7. For patients who have had prior account balances and are not willing to enter into a signed financial payment contract, treatment will be appropriately discontinued and potentially terminated at the discretion of Comprehensive Pain Management.

By signing this agreement, whether by original, facsimile or electronic (PDF) signature, I agree to all the terms and conditions contained herein and the agreement shall be in full force and effect.

Patients Name_____Date_____

COMPREHENSIVE PAIN MANAGEMENT

NEW PATIENT INFORMATION FORM

Name: _____ Date: ___/___/___

HISTORY

Chief Complaint: _____

Where is your pain located? _____

When during the day do you have your pain? _____

What makes your pain worse? _____

What makes your pain better? _____

Describe your pain (circle those that apply): Sharp, Burning, Shooting, Achy, Knife-Like, Twisting, Pressure, Lancinating, Tooth-Ache, Deep, Heavy, Gnawing

How severe is your pain? _____

0 (no pain); 1-2 (tolerate without medications); 3-4 (tell someone about my pain, take Aspirin or Motrin); 5-6 (mild narcotic, ex. Tylenol #3); 7-8 (go to the ER, take strong narcotics); 9-10 (admission to hospital for pain control)

PAST MEDICAL HISTORY:

Medication ALLERGIES or other allergies? _____

What MEDICATIONS are you presently taking? _____

_____

_____

MEDICAL ILLNESSES: Diabetic, Asthma, High Blood Pressure, Heart Attack, Stroke, Cancer, Peptic Ulcers, Rheumatic Fever, Heart Murmur, Mitral Valve Prolapse, HIV/AIDs, Hepatitis, Anemia, Seizures, Gall Bladder, Hyper/Hypo Thyroid, Urinary Tract Infections, Pneumonia, Deep Vein Thrombosis, Bowel Disorder.

Other_____

INJURIES: _____

SURGERIES: _____

HOSPITALIZATIONS: _____

FAMILY HISTORY (parents , siblings, children, grandparents): _____

_____

SOCIAL HISTORY:

Marital Status: Married Single Divorced Separated

Employment: _____

Education: Grade School High School GED College Post Graduate

IV Drugs: _____

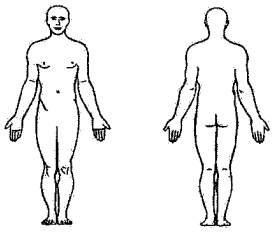
ETOH: Drinks per week? _____ TOBACCO: Packs/Day _____ Years _____

ROS: Constitutional = wt change, weakness, fatigue, fever
Eyes= vision, glasses, pain, tearing, double vision
Earns, Nose, Mouth, Throat,= hearing, tinnitus, vertigo, pain, sinus, colds, gums, sore throat
Cardiovascular = High blood pressure, rheum fever, murmurs, shortness of breath, chest pain, palpitations
Respiratory = cough, sputum, coughing up blood, wheezing, asthma, bronchitis, chest pain
Gastrointestinal = trouble swallowing, heartburn, vomiting, diarrhea, indigestion, pain, blood, stool changes
Genitourinary = pain with urination, urinating at night, blood in urine, urgency, hesitancy, incontinence

ROS; Musculoskeletal = joint pain/ stiffness, cramps, back or neck ache, weakness, loss of range of motion
Skin = rash, lumps, itching, dryness, color change, hair changes, nail changes
Neurological = fainting, blackouts, seizures, paralysis, weakness, numbness, memory loss
Psychological = nervousness, tension, mood changes, depression, anxiety
Endocrine = heat or cold intolerance, sweating, thirst, hunger, change in urination
Hematology/ Lymphatics = bruising, bleeding, transfusion reactions
Allergies/ Immunological = drug, product or other allergies, childhood immunizations

History of IV Drug, Prescription Drug, Illicit Drug Abuse/ Addiction?
History of Alcohol Abuse or Addiction?
History of Psychiatric Illness?
History of Suicide Attempt/ Ideation?
History of Any Addiction?

On the diagram below, show where you are experiencing pain and/or numbness
Stabbing <<< Numbness xxxx Achy ^^^^ Burning XXXX Pins & Needles ///



NECK
ROM
Spasms
Pain/Palp
Spurling's
TP's
Facets
Post Elements

MIDBACK
ROM
Spasms
Pain/Palp
TP's
Facets
Post Elements

LOW BACK
ROM
Spasms
Pain/Palp
TP's
Facets
Post Elements
SU Shear
SU PA
PSI
Patrick's
GT
SLR

SHOULDER
ROM
Neers
Hawkin's
GT
Bicep Tendon
Resist AB
Post Elements

KNEE
ROM
Ant Draw
Lockman
VR/VL
Joint Line
Crepitus
McMurray's
Apply
Patella
TT/ Anserine Bursa

_____DO NOT FILL OUT BELOW THIS LINE_____

NEUROLOGICAL EXAMINATION FORM

Vital Signs: BP ___/___ Pulse: _____ RR: _____ Temp: _____ HT/WT: _____/_____

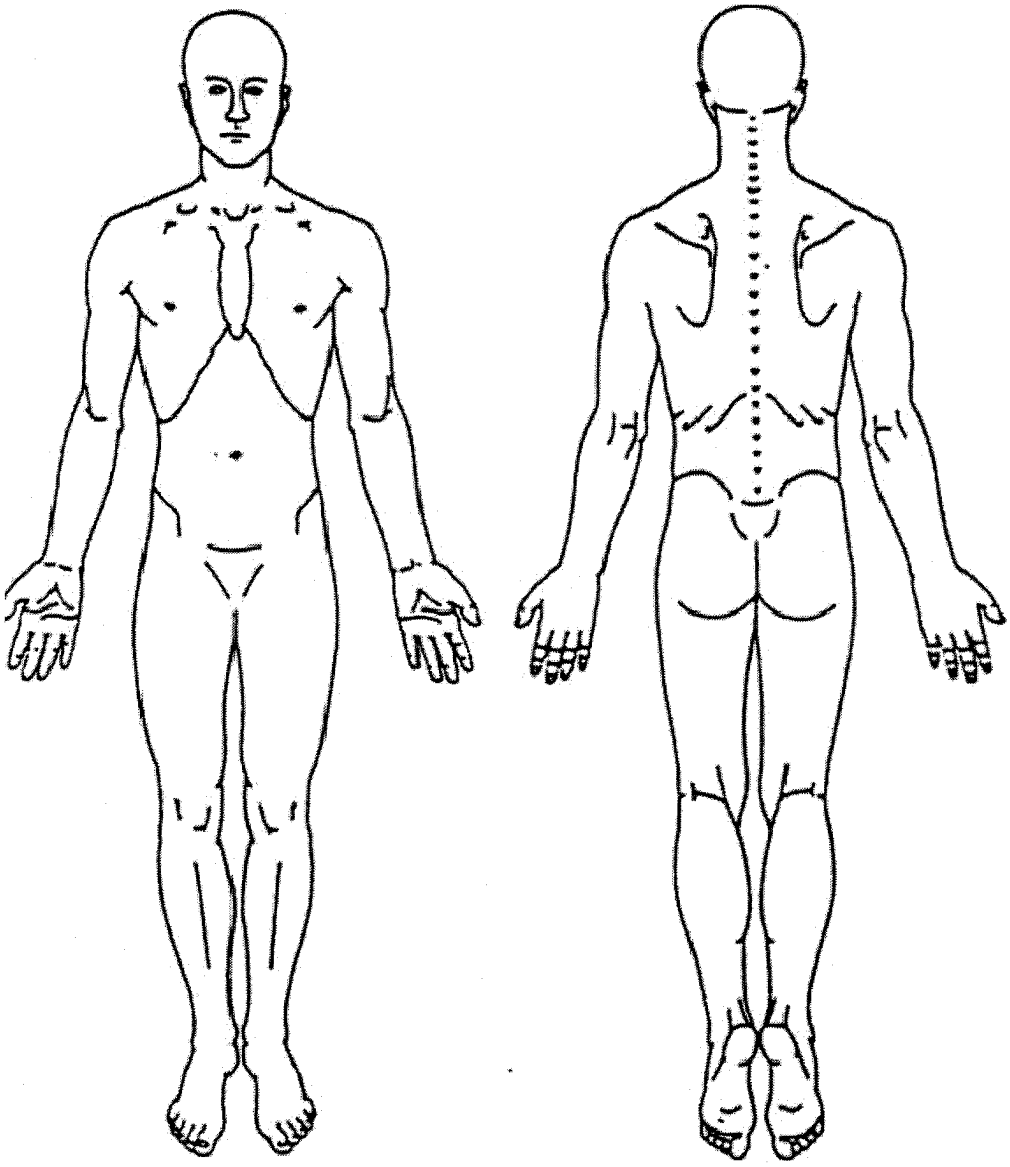
System/ Body area	Pertinent Positives & Negatives
Constitutional: □ well developed, well nourished, in no acute distress	
Eyes: □ Disc flat, no hemorrhages or exudates noted.	
Cardiovascular: □ No Carotid Bruits □ RRR , no murmurs □ No peripheral edema, varicosities, skin warm	
Musculoskeletal; □ Gait coordinated and smooth. □ Muscle strength normal (5 out of 5) in both upper and lower extremities.. □ Muscle tone normal in both upper and lower extremities without spasticity, atrophy, cogwheeling or abnormal movements.	
Neurological: □ Alert and oriented x3 □ Recent and remote memory intact □ Concentrates well, not easily distracted □ Speech: smooth and clear □ Aware of current events □ CN II = Visual fields full of confrontation, vision intact □ CN III, IV, VT= PERRLA, EOMs intact □ CN V = B/L corneal reflexes and facial sensation intact. □ CN VI = Facial movement and strength symmetrical □ CN VIII = B/L hearing with tuning fork equal, whispered voice/finger rub intact □ CN IX = Upward palate movement and pharyngeal muscles contraction, uvula midline. Gag reflex intact. □ CN XI = Normal bilateral shoulder shrug . □ CN XII = Tongue protrusion midline, symmetrical without atrophy, firm pressure. □ Bilateral superficial light touch & pain sensation intact. □ Deep tendon reflexes in both upper and lower extremities intact and normal. Babinski and Hoffman reflexes negative. □ Finger to nose & heel to shin coordination are smooth and accurate	

Patient Name: _____ Date: _____

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark areas of radiation. Include all affected areas. You may use more then symbol. Rate the intensity of all symbols 1-10 with 1 being mild and 10 intolerable.

Numbness xxxxxxx **Pins & Needles ////////** **Burning ^^^^^^**

Ache ———— **Other >>>>>>>>** **Stabbing <<<<<<<**



PAIN

1. Please circle the number that best describes your level of pain right now.

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

2. Please circle the number that best describes the average pain you have experienced since your last visit.

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

3. Please circle the number that best describes the worst pain you have experienced since your last visit.

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

4. Please circle the number that best describes the least pain you have experienced since your last visit.

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

5. Please circle the percentage of pain relief that you have obtained since your last visit.

No relief 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% Complete Relief

6. Since last visit, please circle the number of emergency room visits that you have had due to pain.

0 1 2 3 4 5 or more

7. Since last visit, please mark any reason for which you had to call the Pain Treatment Center.

□ uncontrolled pain □ lab/radiology results □ medication changes

□ medication side effects □ prescription refills

FUNCTION

Since your last visit how much has you pain interfered with the following areas:

8. **Ability to work:**

   Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

9. **Ability to sleep:**

   Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

10. **Ability to participate in social activities:**

    Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

11. **Ability to do household chores:**

    Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

12. **Relationship with family:**

    Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

13. **Sexual activities:**

    Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

14. **General Mood:**

    Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely Interferes

15. Do you need to lie down during the day due to pain? □ Yes □ No

16. If so circle how many times on average you need to lie down during the day. 1 2 3 4

17. Do you wake up during the night because of pain? □ Yes □ No

18. Do you feel rested in the morning? □ Yes □ No

19. Please circle the average number of hours you sleep at night?

    0 1 2 3 4 5 6 7 8 9 10

MEDICATIONS

20. Please mark any medications that you may be on and write in the daily dosage:

    □ Oxycontin □ MS Contin □ Methadone □ Fentanyl Patch □ Ora morph □ Kadian

    Dosage: _____

    □ Oxycodone □ Percocet □ MSIR

    Dosage: _____

    Please list any other medications with dosages that you are taking: _____

    _____

    _____

21. Please circle the percentage of pain relief that you get from your medications.

No Relief 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% Complete Relief

22. Please mark any bothersome side effects that you may have experienced since your last visit.

□ nausea	□ constipation	□ itching	□ sleepiness
□ vomiting	□ urine problems	□ mood changes	□ inability to concentrate

23. Please circle the statement that best describes how satisfied you are with your care at the Pain Treatment Center.

Not Satisfied Somewhat satisfied Satisfied Very satisfied Completely

Additional Comments

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Signature _____

Thank you for completing this form

Name: _____

Date: _____

COMPREHENSIVE PAIN MANAGEMENT

INSTRUCTIONS

This questionnaire contains groups of statements. Pick out the one statement in each group that best describes the way you feel today. Circle the number beside each statement you have chosen. If several statements in the group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

1.	0	I do not feel sad.
	1	I feel sad.
	2	I am sad all the time and I can't snap out of it.
	3	I am so sad or unhappy that I can't stand it.
2.	0	I am not particularly discouraged about the future.
	1	I feel discouraged about the future.
	2	I feel I have nothing to look forward to.
	3	I feel that the future is hopeless and that things cannot improve.
3.	0	I do not feel like a failure.
	1	I feel I have failed more than the average person.
	2	As I look back on my life, all I can see is a lot of failures.
	3	I feel I am a complete failure as a person.
4.	0	I get as much satisfaction out of things as I used to.
	1	I don't enjoy things the way I use to.
\	2	I don't get real satisfaction out of anything anymore.
	3	I am dissatisfied or bored with everything
5.	0	I don't feel particularly guilty.
	1	I feel guilty a good part of the time.
	2	I feel quite guilty most of the time.
	3	I feel guilty all of the time.
6.	0	I don't feel I am being punished.
	1	I feel I may be punished.
	2	I expect to be punished.
	3	I feel I am being punished.
7.	0	I don't feel disappointed in myself.
	1	I am disappointed in myself.
	2	I am disgusted with myself.
	3	I hate myself.
8.	0	I don't feel I am any worse than anybody else.
	1	I am critical of myself for my weakness or mistakes.
	2	I blame myself all the time for my faults.
	3	I blame myself for everything bad that happens.
9.	0	I don't have any thoughts of killing myself.
	1	I have thoughts of killing myself, but I would not carry them out.
	2	I would like to kill myself.
	3	I would kill myself if I had a chance.
10.	0	I don't cry any more than usual.
	1	I cry more now than I use to.
	2	I cry all the time now.
	3	I used to be able to cry, but now I can't cry even though I want to.

Name: _____

Date: _____

11.	0	I am no more irritated by things that I ever am.
	1	I am slightly more irritated now than usual.
	2	I am quite annoyed or irritated a good deal of the time.
	3	I feel irritated all the time now.
12.	0	I have not lost interest in other people.
	1	I am less interested in other people than I used to be.
	2	I have lost most of my interest in other people.
	3	I have lost all of my interest in other people.
13.	0	I make decisions about as well as I ever could.
	1	I put off making decisions more than I used to.
	2	I have greater difficulty in making decisions than before.
	3	I can't make decisions at all anymore.
14.	0	I don't feel that I look any worse than I used to.
	1	I am worried that I am looking old or unattractive.
	2	I feel that there are permanent changes in my appearance that make me look unattractive.
	3	I believe that I look ugly.
15.	0	I can work as well as before.
	1	It takes an extra effort to get started at doing something.
	2	I have to push myself very hard to do anything.
	3	I can't do any work at all.
16.	0	I can sleep as well as usual.
	1	I don't sleep as well as I used to.
	2	I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
	3	I wake up several hours earlier than I used to and cannot get back to sleep.
17.	0	I don't get more tired than usual.
	1	I get tired more easily than I used to.
	2	I get tired from doing almost nothing.
	3	I am too tired to do anything.
18.	0	My appetite is no worse than usual.
	1	My appetite is not as good as it used to be.
	2	My appetite is much worse now.
	3	I have no appetite at all anymore.
19.	0	I haven't lost much weight, if any, lately.
	1	I have lost more than five pounds.
	2	I have lost more than ten pounds.
	3	I have lost more than fifteen pounds.
20.	0	I am no more worried about my health as usual.
	1	I am worried about physical problems such as aches and pains, or upset stomach, or constipation.
	2	I am very worried about physical problems and it's hard to think of much else.
	3	I am so worried about my physical problems that I cannot think about anything else.
21.	0	I have not noticed any recent changes in my interest in sex.
	1	I am less interested in sex now than I used to be.
	2	I am much less interested in sex now.
	3	I have lost interest in sex completely.

Name: _____

Date: _____

INSTRUCTIONS

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life, Please answer every section, and mark in each section only the *one box* that applies to u. We realize you may consider that two statements in any one section relate to you, but please just *mark the box that most closely describes your problem.*

Section 1- Pain Intensity

- □ I can tolerate the pain I have without having to use pain killers.
- □ The pain is bad but I manage with taking pain killers.
- □ Pain killers give complete relief from pain.
- □ Pain killers give moderate relief from pain.
- □ Pain killers give very little relief from pain.
- □ Pain killers have no effect on the pain and I do not use them.

Section 2- Personal Care (Washing, Dressing, etc.)

- □ I can look after myself normally without causing extra pain.
- □ I can look after myself normally but it causes extra pain.
- □ It is painful to look after myself and I am slow and careful.
- □ I need some help but manage most of my personal care.
- □ I need help every day in most aspects of self care.
- □ I do not get dressed, wash with difficulty and stay in bed.

Section 3- Standing

- □ I can stand as long as I want without extra pain.
- □ I can stand as long as I want but it gives me extra pain.
- □ Pain prevents me from standing for more than 1 hour.
- □ Pain prevents me from standing for more than 30 minutes.
- □ Pain prevents me from standing for more than 10 minutes.
- □ Pain prevents me from standing at all.

Section 4- Sleeping

- □ Pain does not prevent me from sleeping well.
- □ I can sleep well only by using tablets.
- □ Even when I take tablets I have less than six hours sleep.
- □ Even when I take tablets I have less than four hours sleep.
- □ Even when I take tablets I have less than two hours sleep.
- □ Pain prevents me from sleeping at all.

Section 5- Lifting

- □ I can lift heavy weights without extra pain.
- □ I can lift heavy weights but it gives extra pain.
- □ Pain prevents me from lifting heavy weights off the floor,, but I can manage if they are conveniently placed.
- □ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently placed.
- □ I can lift only very light weights.
- □ I cannot lift or carry anything.

Name: _____

Date: _____

Section 6- Pain Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than ½ mile.
- ☐ Pain prevents me from walking more than ¼ mile.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 7- Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me sitting more than 1 hour.
- ☐ Pain prevents me sitting more than ½ hour.
- ☐ Pain prevents me sitting more than ¼ hour.
- ☐ Pain prevents me from sitting at all.

Section 8- Sex Life

- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal but causes some pain.
- ☐ My sex life is normal but it is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all

Section 9- Social Life

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, eg dancing etc.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my house.
- ☐ I have no social life because of pain.

Section 10- Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I can manage journeys over two hours.
- ☐ Pain restricts me to journeys of less than 1 hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital

Name: _____

Date: _____

INSTRUCTIONS

Mark an "X" along the line that expresses your thoughts from 0% to 100% in each section. Read each statement carefully. There are words that help you with each statement. If you need help, please ask.

Section I- Pain Intensity

To what degree do you rely on pain medications or pain relieving substances for you to be comfortable?

None — Some — All the time

0% (_____:_____:_____:_____:_____:_____:_____)100%

Section II- Personal Care

How much does pain interfere with your personal care (getting out of bed, teeth brushing, dressing, etc.)?

None (no pain) — Some — I cannot get out of bed

0% (_____:_____:_____:_____:_____:_____:_____)100%

Section III- Lifting

How much limitation do you notice in lifting?

None (I can lift as I did) — Some — I cannot lift anything

0% (_____:_____:_____:_____:_____:_____:_____)100%

Section IV- Walking

Compared to how far you could walk before your injury or back trouble, how much does pain restrict your walking now?

I can walk the same — Almost the same — Very Little — I cannot walk

0% (_____:_____:_____:_____:_____:_____:_____)100%

Section V- Sitting

Back pain limits my sitting in a chair to:

None, pain Same as before — Some — I cannot sit at all

0% (_____:_____:_____:_____:_____:_____:_____)100%

Name: _____

Date: _____

Section VI- Standing

How much does your pain interfere with your tolerance to stand for long periods?

None, pain Same as before — Some — I cannot stand

0% (_____:_____:_____:_____:_____:_____:_____:_____)100%

Section VII- Sleeping

How much does pain interfere with your sleeping?

None Same as before — Some — I cannot sleep at all

0% (_____:_____:_____:_____:_____:_____:_____:_____)100%

(_____ X 3 = _____ % Daily Activities Interference)

Section VIII- Social Life

How much does pain interference wish your social life (dancing, games, going out, eating with friends, etc.)?

None Same as before — Some — No activities total loss

0% (_____:_____:_____:_____:_____:_____:_____:_____)100%

Section IX- Traveling

How much does pain interfere with traveling in a car?

None Same as before — Some — I cannot travel

0% (_____:_____:_____:_____:_____:_____:_____:_____)100%

Section X- Vocational

How much does pain interfere with your job?

None No interference — Some — I cannot work

0% (_____:_____:_____:_____:_____:_____:_____:_____)100%

(_____ X 5 = _____ % Work/Leisure Activities Interference)

Name: _____

Date: _____

Section XI- Anxiety/ Mood

How much control do you feel that you have over demands made on you?

(No Change)
Total Some None
100% (_____:_____:_____:_____:_____:_____:_____)0%

Section XII- Emotional Control

How much control do you feel that you have over your emotions?

(No Change)
Total Some None
100% (_____:_____:_____:_____:_____:_____:_____)0%

Section XIII- Depression

How depressed have you been since the onset of pain?

Not Depressed Significantly Overwhelmed by Depression
0% (_____:_____:_____:_____:_____:_____:_____)100%

(_____ X 5 = _____ % Anxiety/Depression Interference)

Section XIV- Interpersonal Relationships

How much do you think your pain has changed your relationships with others?

Not Changed Drastically Changed
0% (_____:_____:_____:_____:_____:_____:_____)100%

Section XV- Social Support

How much support do you need from others to help you during this onset of pain (taking over chores, fixing meals, etc.)??

None Needed Some All the Time
0% (_____:_____:_____:_____:_____:_____:_____)100%

Section XVI- Punishing Response

How much do you think others express irritation, frustration or anger toward you because of your pain?

None Some All the Time
0% (_____:_____:_____:_____:_____:_____:_____)100%

(_____ X 5 = _____ % Social Interest Interference)

COMPREHENSIVE PAIN MANAGEMENT

MEDICATION TREATMENT CONTRACT

The treatment of chronic pain may involve the use of many different modalities such as nerve blocks, exercise, surgery, psychology techniques, and pain medications. Some of the medication prescribed by your doctor may include substances such as ibuprofen (Motrin & Advil), amitriptyline (Elavil, an antidepressant drug that may decrease pain), and carbamazepine (Tegretol, an anti-seizure drug that may decrease pain). Your doctor may also decide to do a trial with an opioid analgesic, such as morphine, to assess its efficacy in treating your pain. The goal of this practice is to identify the source of your pain and assist in your treatment of your pain disorder.

Long term narcotic control of your pain may be necessary if other means of treatment do not provide any significant relief. We will assist your primary care physician in developing a narcotic/medication regimen to control your symptoms in that case, but will not thereafter provide long term management. Once a narcotic/medication regimen has been established we will help in transitioning your care to your family physician or internist. If you do not have a primary care physician we will assist you in finding one. No controlled substances will be prescribed until after a review of your medical records and signing of this agreement.

Some patients have an excellent response to morphine and morphine-like drugs (opioids) These patients experience a notable decrease in their pain without interfering side effects, such as sedation and nausea. This favorable response allows these patients to increase their function. Unfortunately, not all patients have a favorable response to morphine and morphine-like medications and may experience significant side effects that prevent further use of this type of pain medicine. Additionally, these drugs do not decrease all pain syndromes. Your doctor has no way of knowing which side effects you may experience or how much pain relief you may experience. Furthermore, these medicines may cause unintended psychological effects such as a false sense of well being and improved ability to cope with problems. Sometimes patients who experience these psychological effects may use these medicines in a way other than prescribed.

There exists significant misunderstandings' regarding the use of opioid analgesics. The following definitions are important for you to understand.

> Physical Dependence- is a pharmacologic property of certain drugs, such as caffeine and opioids, that cause biochemical changes in the body such that abruptly stopping these drugs will result in a "withdrawal" response.
>
> Addiction- is a psychological and behavioral syndrome in which there is drug craving and drug seeking behavior, for purposes other than those intended by your physician. For example, addictive behavior would include increasing your usual dose of opioid (without prior discussion with your doctor) for psychological benefit to self-medicate during a stressful situation.
>
> Tolerance – is a pharmacologic property of certain drugs defined by the need for increasing the dose to maintain effect.

The risk of addiction in patients we do not have a prior addiction history (to and substance) is extremely low. The risk of addictive behavior is much higher in patients who have a prior history of addiction. If you do develop an addiction problem your doctor will help you with this. Your doctor may decide that you should not continue on the particular drug or may decide that you may continue on the medicine, but only with very careful treatment guidelines

INFORMED CONSENT

I understand that the use of opioid analgesics can be safe and effective treatment for my chronic pain. I also understand that there exists a risk of developing an addiction disorder; however, I also understand that this is extremely rare in patients who have no prior addiction history. I have truthfully advised my doctor that I have no history of addiction to any narcotic medication, controlled substances, illicit drugs, alcohol, gambling or any other type of addiction. I

understand that I will not increase my dose unless I discuss this with my doctor first. I agree to fill my prescriptions with one pharmacy. If I change to another pharmacy for any reason, I agree to notify my doctor of the change with the new address and phone number prior to filling any prescriptions. I will not dispose or throw away any of my medication that I receive from my doctor for any reason; but rather, I will return any unused portion to my doctor or to my designated pharmacy. I am the only one allowed to pick up my prescriptions and will not have anyone else (family member, etc.) pick up my prescriptions. I will not obtain opioid analgesics from any other health care professional or anyone else for that matter unless I first discuss this with my doctor. If I require treatment in an emergency room (ER) which necessitates opioids. I will inform the ER physician of my present medication regimen and ask him/her to call my doctor prior to instituting treatment with opioids. I will not give, share, trade or sell my medication for money, goods, services or any reason whatsoever. Early refills on medication will not be provided or tolerated by this office. Stolen, lost or misplaced medications will not be refilled or replaced by my doctor and may be grounds for immediate discharge from the practice. I will not alter my prescriptions in any way. I will not use any illegal controlled substances, including marijuana, cocaine, etc. I understand that misinformation or withholding information regarding previous alcohol, illicit drug, , or prescription drug abuse/addiction or regarding any information about medical history is a breach of this contract. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the prescription of my medications, and I authorize my doctor to provide this information to any person or facility that he/she deems appropriate and necessary. My doctor may fax this contract to any physician involved in my care, pharmacy, ER , hospital, or any person or facility that he/she deems appropriate and necessary, even if such disclosure may be adverse to my interests (eg. law enforcement personnel). I agree to submit to psychological testing, urine drug screen and/or blood drug screen testing at the request of my doctor and within the time period specified by my doctor, to evaluate appropriateness and compliance of opioid therapy for my pain syndrome (I understand that I may be responsible for the cost of such testing if not covered by my insurance carrier). I understand that if someone else in my family (immediate or relative) is taking opioids for pain control, my doctor may elect not to prescribe opioids for my pain syndrome. I will not miss two consecutive follow up visits, for whatever circumstances, without notifying my doctor in a timely manner. I will not use profound language or behave/act inappropriately in front of my doctor or his/her staff. I may be required from time to time by my doctor to obtain additional past medical records during my care. I understand that if I violate this medication treatment contract as outlined here I will be immediately discharged from this practice and my doctor's care. My doctor also reserves the right to discharge me from his/her practice and care with or without cause at any time. The term doctor in this document refers to any physician or physician assistant of Comprehensive Pain Management that provides treatment for me whether or not that doctor is my primary treating physician or not.

Patient Name _____ Patient Signature _____

Date _____ Witness _____

Pharmacy Name _____ Address _____

City _____ State _____ Zip _____

Phone Number _____ Fax Number _____

Physician Obtaining Consent _____

Physician Signature _____

EXHIBIT D

COMPREHENSIVE PAIN MANAGEMENT, L.L.C.
2420 Hwy 34
Manasquan, NJ 08736
Authorization to Release Medical Information

Patient Name: _____ D.O.B. ____/____/____

Address: _____

1. I authorize the use or disclosure of the above named individual's health information, as described below.
2. Comprehensive Pain Management, L.L.C. is authorized to make the disclosure set forth below.
3. The information may be disclosed to, and used by, the following individuals or organizations:
   Name (s): _____
   Address: _____
   For the following purpose (s): _____
   _____
4. The information to be disclosed shall be limited to that information necessary to fulfill the above stated purpose(s) and may include the following items (unless crossed out by me).

   Drug and Alcohol abuse information.
   Information regarding Human Immunodeficiency Virus (HIV), including laboratory test results.
   Diagnosis of AIDS or ARC, if applicable.
   History and Physical examination.
   Consultations.
   Genetic testing and counseling, if applicable.
   Diagnostic testing, excluding HIV testing.
   Discharge summary.
   Psychological history.
   Treatment recommendations.
   Other (specify): _____
5. This authorization may be revoked by me at any time except to the extent that Comprehensive Pain Management, L.L.C. has already acted in reliance on this authorization. If I revoke this authorization, I need to do so in writing and mail or hand deliver it to the HIPAA Privacy Officer, Comprehensive Pain Management, L.L.C., 2420 Highway 34, Manasquan, New Jersey 08736. If not revoked by me, this consent will terminate on: _____.
6. I have a right to inspect the information to be disclosed.
7. I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.
8. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA.

Signature of Patient or Legal Representative: _____ **Date:** _____

If signed by a Legal Representative, relationship to patient: _____

Signature of Witness_____

EXHIBIT E

Notice of Privacy Practices of
COMPREHENSIVE PAIN MANAGEMENT, L.L.C.
2420 Hwy 34
Manasquan, NJ 08736

I. **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

II. **WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).**

Pursuant to the Privacy Rules established by the Health Insurance Portability and Accountability Act of 1996, we are legally required to protect the privacy of your health information. We call this information "protected health information," or "PHI" for short. It includes information that can be used to identify you and that we've created or received about your past, present, or future health condition, the provision of health care to you, or the payment for this health care. We are required to provide you with this notice about our privacy practices. It explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Whenever we make an important change to our policies, we will promptly change this notice and post a new notice in the main reception area. You can also request a copy of this notice from the contact person listed in Section VI below at any time and can view a copy of this notice on our Web site at http://painknowmore.com/.

III. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

We use and disclose health information for many different reasons. For some of these uses and disclosures, we need your specific authorization. Below, we describe the different categories of uses and disclosures.

A. Uses and Disclosures Which Do Not Require Your Authorization.

We may use and disclose your PHI without your authorization for the following reasons:

1. For treatment. We may disclose your PHI to hospitals, physicians, nurses, and other health care personnel in order to provide, coordinate or manage your health care or any related services, except where the PHI is related to HIV/AIDS, genetic testing, or federally-funded drug or alcohol abuse treatment facilities, or where otherwise prohibited pursuant to State or Federal law. For example, if you're being treated for a knee injury, we may disclose your PHI to an x-ray technician in order to coordinate your care.

2. To obtain payment for treatment. We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing staff and your health plan to get paid for the health care services we provided to you. We may also disclose patient information to another provider involved in your care for the other provider's payment activities.

3. For health care operations. We may disclose your PHI, as necessary, to operate this organization. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we're complying with the laws that affect us.

4. When a disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement. For example, we may disclose PHI when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot or other wounds; for the purpose of identifying or locating a suspect, fugitive, material witness or missing person; or when subpoenaed or ordered in a judicial or administrative proceeding.

5. For public health activities. For example, we may disclose PHI to report information about births, deaths, various diseases, adverse events and product defects to government officials in charge of collecting that information; to prevent, control, or report disease, injury or disability as permitted by law; to conduct public health surveillance, investigations and interventions as permitted or required by law; or to notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.

6. For health oversight activities. For example, we may disclose PHI to assist the government or other health oversight agency with activities including audits; civil, administrative, or criminal investigations, proceedings or actions; or other activities necessary for appropriate oversight as authorized by law.

7. To coroners, funeral directors, and for organ donation. We may disclose PHI to organ procurement organizations to assist them in organ, eye, or tissue donations and transplants. We may also provide coroners, medical examiners, and funeral directors necessary PHI relating to an individual's death.

8. For research purposes. In certain circumstances, we may provide PHI in order to conduct medical research.

9. To avoid harm. In order to avoid a serious threat to the health or safety of you, another person, or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

10. For specific government functions. We may disclose PHI of military personnel and veterans in certain situations. We may also disclose PHI for national security and intelligence activities.

11. For workers' compensation purposes. We may provide PHI in order to comply with workers' compensation laws.

12. Appointment reminders and health-related benefits or services. We may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer. Please let us know if you do not wish to have us contact you for these purposes, or if you would rather we contact you at a different telephone number or address.

B. Uses and Disclosures Where You to Have the Opportunity to Object:

1. Disclosures to family, friends, or others. We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part.

c. All Other Uses and Disclosures Require Your Prior Written Authorization. Other than as stated herein, we will not disclose your PHI without your written authorization. You can later revoke your authorization in writing except to the extent that we have taken action in reliance upon the authorization.

D. Authorization for Marketing Communications. We will obtain your written authorization prior to using or disclosing your PHI for marketing purposes. However, we are permitted to provide you with marketing materials in a face-to-face encounter, without obtaining a marketing authorization. We are also permitted to give you a promotional gift of nominal value, if we so choose, without obtaining a marketing authorization. In addition, as long as we are not paid to do so, we may communicate with you about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings. We may use or disclose PHI to identify health-related services and products that may be beneficial to your health and then contact you about the services and products.

E. Sale of PHI. We will disclose your PHI in a manner that constitutes a sale only upon receiving your prior authorization. Sale of PHI does not include a disclosure of PHI for: public health purposes; research; treatment and payment purposes; sale, transfer, merger or consolidation of all or part of our business and for related due diligence activities; the individual; disclosures required by law; any other purpose permitted by and in accordance with HIPAA.

F. Fund raising Activities. We may use certain information (name, address, telephone number, dates of service, age and gender) to contact you for the purpose of various fundraising activities. If you do not want to receive future fundraising requests, please write to the Privacy Officer at the below address.

G. Incidental Uses and Disclosures. Incidental uses and disclosures of information may occur. An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure. However, such incidental uses or disclosure are permitted only to the extent that we have applied reasonable safeguards and do not disclose any more of your PHI than is necessary to accomplish the permitted use or disclosure. For example, disclosures about a patient within the office that might be overheard by persons not involved in your care would be permitted.

H. Business Associates. We may engage certain persons to perform certain of our functions on our behalf and we may disclose certain health information to these persons. For example, we may share certain PHI with our billing company or computer consultant in order to facilitate our health care operations or payment for services provided in connection with your care. We will require our business associates to enter into an agreement to keep your PHI confidential and to abide by certain terms and conditions.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI.

You have the following rights with respect to your PHI:

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to request in writing that we limit how we use and disclose your PHI. You may not limit the uses and disclosures that we are legally required to make. We will consider your request but are not legally required to accept it. Notwithstanding the foregoing, you have the right to ask us to restrict the disclosure of your PHI to your health plan for a service we provide to you where you have directly paid us (out of pocket, in full) for that service, in which case we are required to honor your rn_quest. If we accept your request, we will put any limits. in writing and abide by them except in emergency situatrons. Under certain circumstances, we may terminate our agreement to a restriction.

B. The Right to Choose How We Send PHI to You. You have the right to ask that we send information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, via e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the manner you requested.

C. The Right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.

If you request a copy of your information, we will charge reasonable fees for the costs of copying, mailing or other costs incurred by us in complying with your request, in accordance with applicable law. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance. Note also that, you have the right to access your PHI in an electronic format (to the extent we maintain the information in such a format) and to direct us to send the e-record directly to a third party. We may charge for the labor costs to transfer the information; and charge for the costs of electronic media if you request that we provide you with such media.

**Please note, if you are the parent or legal guardian of a minor, certain portions of the minor's records may not be accessible to you. For example, records relating to care and treatment to which the minor is permitted to consent himself/herself (without your consent) may be restricted unless the minor patient provides an authorization for such disclosure. **

D. The Right to Get a List of the Disclosures We Have Made. You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures made for purposes of treatment, payment, or health care operations, those made pursuant to your written authorization, or those made directly to you or your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or prior to April 14, 2003.

We will respond within 60 days of receiving your written request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide one (1) list during any 12-month period without charge, but if you make more than one request in the same year, we will charge you $10 for each additional request.

To the extent that we maintain your PHI in electronic format, we will account all disclosures including those made for treatment, payment and health care operations. Should you request such an accounting of your electronic PHI, the list will include the disclosures made in the last three years.

E. The Right to Receive Notice of a Breach of Unsecured PHI. You have the right to receive notification of a "breach" of your unsecured PHI.

F. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request, in writing, that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request in writing. We may deny your request if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to have your request and our denial attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

F. The Right to Get This Notice by E-Mail. You have the right toget a copy of this notice by e-mail. Even if you have agreed toreceive notice via e-mail, you also have the right to request a paper copy of this notice.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Ave., S.W.; Room 61 5F; Washington, DC 20201. We will take no retaliatory action against you if you file a complaint about our privacy practices

VI. PERSON TO CONTACT FOR INFORMATIO ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you have any questions about this notice or any complaints about our privacy practices, please contact our HIPAA Privacy Officer at 732-223-2873. Written correspondence to the Privacy Officer shouldbe sent to Comprehensive Pain Management, L.L.C., 2420 Highway34, Manasquan, New Jersey 08736, Attention: Privacy Officer.

I HEARBY ACKNOWLEDGE THIS COMPANY'S PRIVACY PRACTICES

_SIGN DATE

EXHIBIT G

COMPREHENSIVE PAIN MANAGEMENT, L.L.C.
2420 Hwy 34
Manasquan, NJ 08736

Communications Regarding Protected Health Information

Patient Name: _____ D.O.B. ____/____/____

Authorized Individuals

I understand that Comprehensive Pain Management L.L.C. (the "Covered Entity") may release my PHI to family member, friend, or other person I indicate is involved in my care unless I object. I designate the following person(s) listed below as a person or persons involved with my health care and/or payment for any health care (circle as applicable), to whom the information circled "yes" below may be released:

Name: _____ Relationship: _____

Address/ Phone: _____

Health Info: Yes/No (circle as applicable) Payment Info: Yes/No (circle as applicable)

Name: _____ Relationship: _____

Address/ Phone: _____

Health Info: Yes/No (circle as applicable) Payment Info: Yes/No (circle as applicable)

Name: _____ Relationship: _____

Address/ Phone: _____

Health Info: Yes/No (circle as applicable) Payment Info: Yes/No (circle as applicable)

Name: _____ Relationship: _____

Address/ Phone: _____

Health Info: Yes/No (circle as applicable) Payment Info: Yes/No (circle as applicable)

Contact Information

I wish to be contacted in the following manner (Please check all that apply):

□ Home Telephone	□ Detailed Message	□ Call Back Number Only
□ Work Telephone	□ Detailed Message	□ Call Back Number Only
□ Cell Telephone	□ Detailed Message	□ Call Back Number Only
□ Mail to Home Address	□ Mail to Work Address	

Marketing Communications

I understand that the Covered Entity must have my permission for an use of disclosure of my protected health information for marketing communications for which the Covered Entity receives direct or indirect financial remuneration from or on behalf of a third party whose product or service is being described. I understand that the word "marketing" *does not include* a communication made (a) to provide refill reminders or communicate about a drug or biologic currently being prescribed to me; or (b) for treatment by the health care provider, including case management or case coordination, or to direct or recommend alternate treatments, therapies, providers or settings. Also, marketing does not include communications in the form of (a) a face-to-face communication made by the Covered Entity; or (b) a promotional gift of nominal value provided by the Covered Entity. Thus, no consent or permission is required for the Covered Entity to engage in these non-marketing activities.

I □ DO or □ DO NOT [check the appropriate box] give my permission for the Covered Entity to use or disclose my health information for marketing purposes. I understand that the Covered Entity may or does receive financial remuneration from third parties for these activities.

Sale of PHI

I understand there are circumstances in which the Covered Entity may wish to use or disclose my health information in a manner that constitutes a "sale" of my protected health information, which means the Covered Entity receives direct or indirect remuneration in exchange for such information. A "sale" does *not* include disclosures that are made for any of the following purposes even if remuneration is received by the Covered Entity: (a) for public health purposes; (b) research purposes, where the only remuneration received by the Covered Entity is a reasonable cost- based fee to cover the cost to prepare and transit the information for such purposes; (c) for treatment and payment purposes; (d) for the sale, transfer, merger, or consolidation of all or part of the Covered Entity's business and for the due diligence related thereto; (e) to or by the Covered Entity's business associates for activities that the business associate undertakes on behalf of the Covered Entity; (f) to an individual who is the subject of the protected health information; (g) when required by law; and (h) for any other permitted disclosures of protected health information where the only remuneration received by the Covered Entity is a reasonable, cost-based fee to cover the cost to prepare and transmit the PHI.

I □ DO or □ DO NOT [check the appropriate box] give my permission for the Covered Entity to use or disclose my health information for purposes which will constitute a sale of my protected health information. I understand that the Covered Entity may or does receive financial remuneration from third parties for these activities.

I have read and understand the terms of this document. I have had an opportunity to ask questions about the use or disclosure of my health information and about the contents of this form. I acknowledge and agree to the terms and conditions of this document:

Patient Name: _____

Date: _____

Patient Signature: _____

Authorized Individual (Parent/Guardian) Name _____

Authorized Individual Signature _____

COMPREHENSIVE PAIN MANAGEMENT

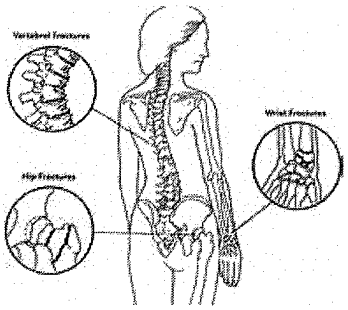
I, _____ certify
(print name)

That I am not currently involved in a Workman's Comp or Auto Claim. I also declare that my health insurance will be my primary method of payment while a patient of Comprehensive Pain Management. If at any time, should the information change, I must notify Comprehensive pain Management of that change. If I fail to do so, I will be solely responsible for any and all changes that I incur.

Signature: _____

Date: _____

Name: _____ Date: _____



Osteoporosis Survey: Are You at Risk ?

Please check all that apply:

( ) Current age greater than 65 (risk increases with age).
( ) Early menopause (before age 45)
( ) History of low estrogen levels
( ) Women/Men on hormone replacement therapy
( ) History of Hypogonadism/ Low testosterone levels in men
( ) Vertebral compression fracture or fragility fracture after age 40
( ) Postmenopausal women with history of fracture.
( ) Caucasian (White)/ Asian women
( ) Low weight or weight loss (Weight less than 127 pounds)
( ) Family members with osteoporosis
( ) Systematic glucocorticoid therapy of more than three months' duration
( ) History of primary hyperparathyroidism
( ) History of frequent falls
( ) History of osteopenia apparent on X-ray film
( ) Non-use of estrogen replacement
( ) No regular exercise or an inactive lifestyle
( ) Limited ability to stand; wheelchair or bed dependent
( ) Excessive use of alcohol, coffee or tea (Caffeine)
( ) Low calcium and vitamin D intake (Low-calcium diet)
( ) Use of thyroid drugs or anticonvulsants drugs
( ) Use of Aluminum-containing antacids or cholesterol-lowering drugs
( ) History of long term heparin therapy
( ) History of Liver disease, including cirrhosis
( ) History of Hyperthyroidism
( ) History of Scurvy, Cushing's, Marfan's or Ehler- Danlos syndromes
( ) History of cancer, including lymphoma
( ) History of gastrointestinal disorders/ malabsorption syndrome
( ) Current use or history of use of immunosuppressant drugs such as prednisone, steroids, methotrexate, cyclosporine drugs
( ) Family history of osteoporotic fracture (especially hip fracture)
( ) Abnormal cessation of menstrual periods (amenorrhea) due to anorexia nervosa, rigorous exercise, or an endocrinological problem

Please circle one of the following:

1) Have you ever been diagnosed with osteoporosis? Yes No
2) Have you ever had a bone density test/ Dexa Scan? Yes No
If you had a bone density test, please give an approximate date of the test and the result if known: _____