



Madan K. Raj, M.D., F.A.A.P.M.R

600 Northern Blvd., Suite 113, Great Neck, NY 11021 (516) 478-0010 FAX (516) 482-0143
353 Veterans Memorial Hwy., Suite 303, Commack, NY 11725 (631) 864-3900 FAX (631) 864-2954
www.nspc.com

Pain Management Registration Form

Name, Address, Home#, Cell#, Work#, Sex, Email Address, Occupation, Employer's Name and Address, Referring MD, PCP, Emergency Contact, Address, Phone, Relationship, Contact#

Insurance Information

Primary Insurance, Policy Holder's Name, Policy Holder's DOB, ID#, Policy Holder's SS#, Relationship, Group#, Secondary Insurance, Policy Holder's Name, Policy Holder's DOB, ID#, Policy Holder's SS#, Relationship, Group#

Worker's Compensation

Insurance Carrier Name, Insurance Carrier Address, Carrier Case#, WCB#, Date of Accident, Case Manager, Phone#, Fax#, Employer, Phone#, Employer Address

No Fault

Insurance Carrier Name, Insurance Carrier Address, Policy#, Claim#, Date of Accident, Case Manager, Phone#, Fax#

The above information is true and to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Neurological Surgery, PC or insurance company to release information required to process my claims.

Signature, Date



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Patient Name: _____ **DOB:** _____

To be completed by patient:

History of present illness:

When did your pain first begin? _____

Were there any particular events that started your pain?

Was your pain the result of an accident? Yes No

Was your pain due to a work related injury?Yes No

What is the quality of your pain? _____

Sharp like a knife?Yes No

Dull/Achy?Yes No

Does the pain feel like pins and needles?Yes No

Does the pain feel hot/burning?Yes No

Does the pain feel numb?Yes No

Does the pain feel like electric shock?Yes No

Do you have any radiation of pain to arms or legs on coughing or sneezing?Yes No

Is the pain worse with the touch of clothing or bed sheets?Yes No

Does the pain move from back to any part of your leg?Yes No

Does the pain move from neck to any part of your arm?Yes No

Does the area of your pain ever change color?Yes No

How strong is your pain? _____

No Pain _____ **Unbearable Pain**

0 1 2 3 4 5 6 7 8 9 10

Are any of these symptoms associated with your pain?

Numbness in arms, legs or buttock area?Yes No

Weakness in arms or legs?Yes No

Urinary retention?Yes No

Urinary incontinence?Yes No

Loss of bowel control?Yes No

Sexual Difficulty?Yes No

Balance problem during walking?Yes No

Do you drop things from your hand?Yes No

Do you have any clumsiness of hand?Yes No



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The Impact of your pain:

Please answer the following questions briefly:

What activities or movements bring on your pain?

What makes your pain better?

Does your pain interfere with your ability to fall asleep? Or awaken you from sleep?

Does your pain get better over the course of the day?

Does your pain interfere with your daily activities?

Does pain affect your sexual activity?

Are you depressed because of your pain?

The following questions are given to all patients who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0=Never, 1=Seldom, 2=Sometimes, 3=Often, 4=Very Often

- | | |
|--|-----------|
| 1. How often do you have mood swings? | 0 1 2 3 4 |
| 2. How often do you smoke a cigarette within an hour after you wake up? | 0 1 2 3 4 |
| 3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs? | 0 1 2 3 4 |
| 4. How often have any of your close friends had a problem with alcohol or drugs? | 0 1 2 3 4 |
| 5. How often have others suggested that you have a drug or alcohol problem? | 0 1 2 3 4 |
| 6. How often have you attended an AA or NA meeting? | 0 1 2 3 4 |
| 7. How often have you taken medication other than the way it was prescribed? | 0 1 2 3 4 |
| 8. How often have you been treated for an alcohol or drug problem? | 0 1 2 3 4 |
| 9. How often have your medications been lost or stolen? | 0 1 2 3 4 |
| 10. How often have others expressed concern over your use of medication? | 0 1 2 3 4 |
| 11. How often have you felt a craving for medication? | 0 1 2 3 4 |
| 12. How often have you been asked to give a urine screen for substance abuse? | 0 1 2 3 4 |
| 13. How often have you used illegal drugs (marijuana, cocaine, etc.) in the past five years? | 0 1 2 3 4 |
| 14. How often, in your lifetime, have you had legal problems or been arrested? | 0 1 2 3 4 |



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Past Pain Interventions:

Specialist	Intervention	Success (yes/no)
Acupuncturist _____		
Chiropractor _____		
Pain Specialist _____		
Physiatrist _____		
Neurosurgeon _____		
Physical therapy for how many weeks? _____		
Others _____		

Imaging Studies:

Have you had any studies?

- MRI _____
- CT Scan _____
- Bone Scan _____
- Plain X-ray _____
- EMG/NCV _____

Discogram

When was the last study done and where? _____

Pain Medications:

Please make sure you write the correct name and dosage. Please write on separate sheet and attach to this form if your list is large.

Pain Medicines:

_____	_____
_____	_____
_____	_____

Regular Medicines:

_____	_____
_____	_____
_____	_____

Are you taking any Aspirin, Coumadin, Warafin, Plavix, or herbal remedies?



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Allergies:

Are you allergic to any medications or had any bad reactions from any medications?

Local Anesthetic (Novocain or Lidocaine)	Yes	No
Steroids?	Yes	No
Contrast dye/IVP dye?	Yes	No
Penicillin?	Yes	No
Antibiotics?	Yes	No
Any other medications?	Yes	No
Latex Allergy?	Yes	No

Review of Systems: Have you had any of the following symptoms in the last few weeks?

<u>General</u>	<u>Endocrine</u>	<u>Skin</u>
Unexpected weight loss _____	Appetite change _____	Rash _____
Fever _____	Cold Intolerance _____	
<u>GI/Abdomen</u>	<u>Hematologic/Hepatic</u>	<u>Neurological</u>
Nausea/vomiting _____	Jaundice _____	Headaches _____
Constipation _____		Dizziness _____
Abdominal pain _____		
Blood in Stool _____	<u>Eyes</u>	<u>Genitourinary</u>
<u>Musculoskeletal</u>	Visual disturbance _____	Urinary _____
Muscle weakness _____		Blood in urine _____
Swelling of extremities _____	<u>Cardiopulmonary</u>	Abnormal menstrual cycle _____
<u>Ear, Nose & Throat</u>	Chest pain _____	
ringing in ears _____	Fast heart rate _____	
Hearing disturbance _____	Cough _____	
Bleeding gums _____	Wheezing _____	
	Shortness of breath _____	

Medical History:

Hypertension _____ Diabetes _____ Heart Disease _____ Arterial Fibrillation _____
 Cancer _____ Other Medical problems? _____

Past Surgical History:

Pain Injections: _____
 How many Injections: _____
 Date of Injections: _____
 Back Surgery: _____ Surgeon: _____
 Any other surgeries: _____



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Implantable devices (pacemaker, spinal cord stimulator, cochlear implants, etc.), please explain: _____

Family History:

Please check if anyone in your family (mother, father, siblings) has had any of the following conditions:

Rheumatoid Arthritis _____	Blood Disorder _____
Cancer _____	Heart Disease _____
Lupus _____	Fibromyalgia _____
Diabetes _____	Headaches _____

Other Diseases _____

Deceased - age at death and cause: _____

Social History:

Occupation: _____

Are you currently working?	Yes	No - If no, are you collecting unemployment benefits	Yes	No
Married?	Yes	No - Are you pregnant, or think you might be?	Yes	No

Present living situation: _____

Do you feel safe at home? **Yes** **No – If no why not?** _____

Do you drink alcohol on a regular basis? **Yes** **No**

Substance intake per day:

Nicotine (cigars, cigarettes, pipe, etc) _____ **pk/day** _____ **years**

Recreational substances (marijuana, cocaine, heroin, hallucinogens, methyl amphetamine, etc).
Yes **No** **Former Abuser:** **Yes** **No**

Do you find life particularly stressful? **Yes** **No**

Has a psychiatrist, for any reason, ever treated you? **Yes** **No**

Are you involved in any lawsuits concerning your pain? **Yes** **No**

Are you considering suing someone for your pain? **Yes** **No**



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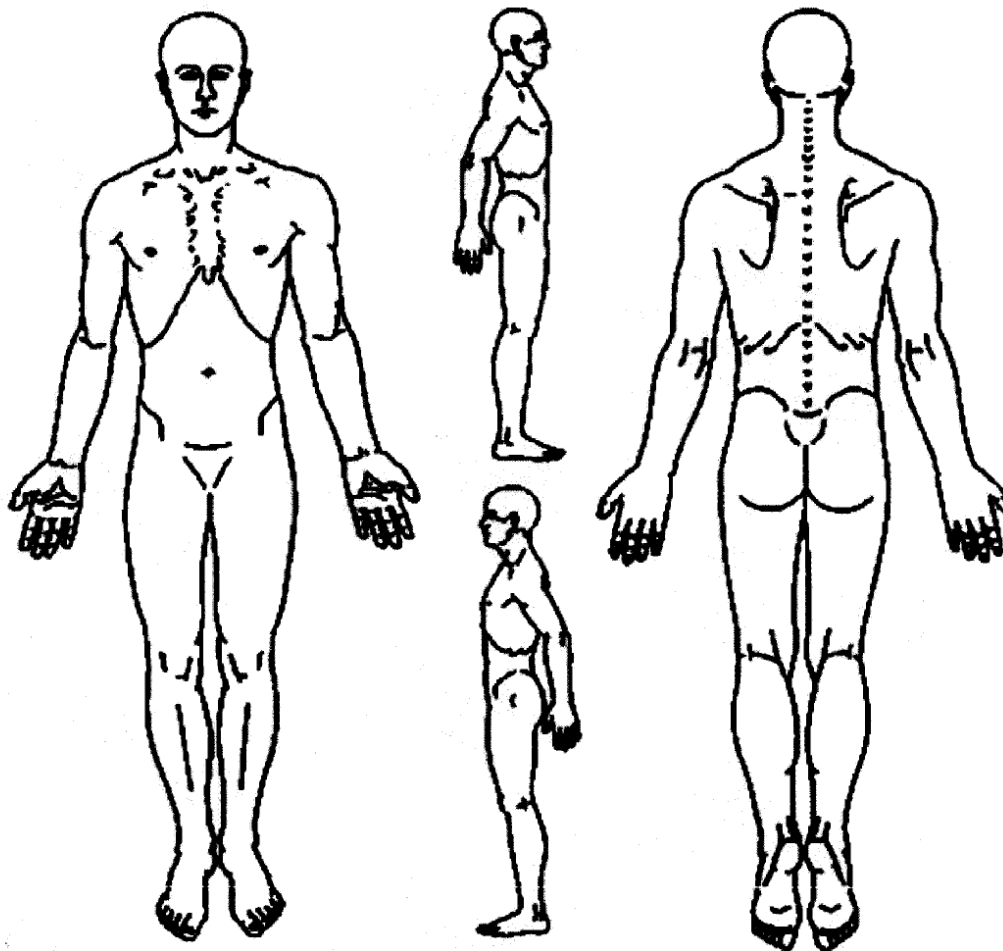
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PAIN DIAGRAM

NAME _____ DATE _____

How long have you had pain _____ years _____ months _____ weeks

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now. Please complete both sides of this form.



A = ACHE

B = BURNING

N = NUMBNESS

P = PINS & NEEDLES

S = STABBING

O = OTHER

The Spine
Center

AT NEUROLOGICAL SURGERY, P.C.



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Please sign your name below, verifying that the above medical history is correct:

Patient name: _____ **Signature:** _____

Thank you for taking the time to complete this questionnaire.

Madan K. Raj, M.D. F.A.A.P.M.R.

Physician Signature _____ **Date:** _____



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HIPAA SIGNATURE PAGE

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices and have therefore been advised of how medical information about me may be used and disclosed by NEUROLOGICAL SURGERY, P.C. and how I may obtain access to this information

Signature of Patient/Personal Representative

Print Name of Patient or Personal Representative

Date _____

Many times family members of patients will call to obtain and discuss treatment records on behalf of the patient. If there are only certain family members that you would wish Dr. Raj to discuss your care with, please indicate their names below. Dr. Raj will not speak with any other family member other than those listed.

Name _____ Relation to Patient _____

Name _____ Relation to Patient _____

Name _____ Relation to Patient _____

Name _____ Relation to Patient _____

Your Name (print) _____

Signature _____ Date _____



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Medical Records Release Authorization

To:

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO/FROM:

Madan K. Raj, M.D.

**The Spine Center at Neurological Surgery,
PC**

600 Northern Blvd, Suite 113

Great Neck, NY 11021

Tel (516)478-0010 Fax (516)482-0143

Madan K. Raj, M.D.

**The Spine Center at Neurological Surgery,
PC**

353 Veterans Memorial Hwy, Ste 303

Commack, NY 11725

Tel (631)864-3900 Fax (631)864-2954

THE COMPLETE MEDICAL RECORDS IN YOUR POSSESSION, CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE PERIOD FROM MY INITIAL EVALUATION TO THE PRESENT.

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY AND THAT I HAVE A RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME BY WRITING TO THE ENTITY IN POSSESSION OF MY MEDICAL RECORDS.

Name: _____

Address: _____

Date: _____

Signature (or authorized representatives' signature)

Name of authorized representative (if signed above)



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PAYMENT POLICY

Thank you for choosing us as your provider. We are committed to providing you with quality and affordable healthcare. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We accept most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Copayment and Deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.
4. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
5. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
6. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.



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Our practice is committed to providing the best treatments to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I authorize payment of medical benefits to Neurological Surgery, PC for professional services. I have read and understand the payment policy and agree to abide by its guidelines.

Date _____

Signature of patient or responsible party



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Long-term Controlled Substances Therapy for Pain

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

1. All controlled substances must come from the physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor condition of treatment.)
2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:

_____ phone: _____

3. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.
4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.
5. You may not share, sell, or otherwise permit others to have access to these medications.
6. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.
7. Unannounced urine or serum toxicology screens may be requested, and your cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorder.
8. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.



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9. Original containers of medications should be brought in to each office visit.
10. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.
11. Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made.
12. Early refills will generally not be given.
13. Prescriptions may be issued early if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date.
14. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.
15. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.
16. Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.
17. It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit.
18. The risks and potential benefits of these therapies are explained elsewhere [and you acknowledge that you have received such an explanation].
19. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

Physician Signature

Patient Signature

Date

Patient Name (Printed)