ACCELERATED REHAB & PAIN MANAGEMENT, PA

IRFAN A. ALLADIN, M.D.

•••• 1279 Route 45 East, Parsippany, New Jersey ••••

Welcome and thank you for your cooperation. We ask that you complete this registration form...Please print clearly.

Date:	Patient Last Name, First Name & Middle Initial:	Date of Birth:	☐ Female ☐ Male	Social Security Number:

Patient Address:

Street City State Zip Code

Patient Home Phone Number:	Patient Work Number:	Patient Cell Phone/Pager Number:
( )	( ) EXT	( )

Patient Employer:

Reason For This Visit: ☐ Injury ☐ Detox / Suboxone ☐ Worker's Comp ☐ Motor Vehicle Accident

Date of Injury or Onset of Problem:	Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other	Patient is: ☐ Single ☐ Married ☐ Other

Name of Referring Physician or Person:	Telephone Number & Address of Referring Physician or Person:

*** POLICY HOLDER INFORMATION – THIS SECTION MUST BE COMPLETED ***
PLEASE MAKE COPIES OF FRONT & BACK OF ALL INSURANCE CARDS

Name of ***Primary Insurance*** Carrier:	Member ID Number:	Group Number:
Name of ***Secondary Insurance*** Carrier:	Member ID Number:	Group Number:

*** MOTOR VEHICLE ACCIDENT OR WORKER'S COMP – THIS SECTION MUST BE COMPLETED ***
PLEASE MAKE COPIES OF DRIVER'S LICENSE

Auto Insurance Company or Worker's Compensation Contact:	Policy Number:	Claim Number:

Address:

City State Zip

Adjuster Name:	Adjuster Telephone Number:	Adjuster Fax Number:

Attorney Name, Address & Telephone Number:

Circle One: Driver Passenger Pedestrian Bus Workman's Comp. Slip & Fall	Date of Accident:

I hereby authorize insurance benefits be paid directly to Dr. Alladin MD. I authorize the physician to file insurance claims without my signature and to release any information required processing the claim. *I understand and agree that I am ultimately responsible for the balance of my account for any professional services rendered.* I have read the entire information of this form and have completed the questions above. I will notify you of any changes regarding the information contained herein.

Emergency Contact: _____ Phone # : _____

_____ _____
Signature Date

_____ _____
Parent/Legal Guardian Date

Accelerated
Rehab and Pain Management

THE FOLLOWING QUESTIONNAIRE IS INTENDED TO HELP YOUR PHYSICIAN UNDERSTAND YOUR PAIN SO THAT HE/SHE MAY BETTER HELP YOU.

1. When and how did your pain problem start?_____

_____

_____

_____

_____

2. What is your diagnosis?_____

_____

_____

3. What doctors have you seen? When did you see them? What did they do?

Doctor's Name	Month / Year	What was done?

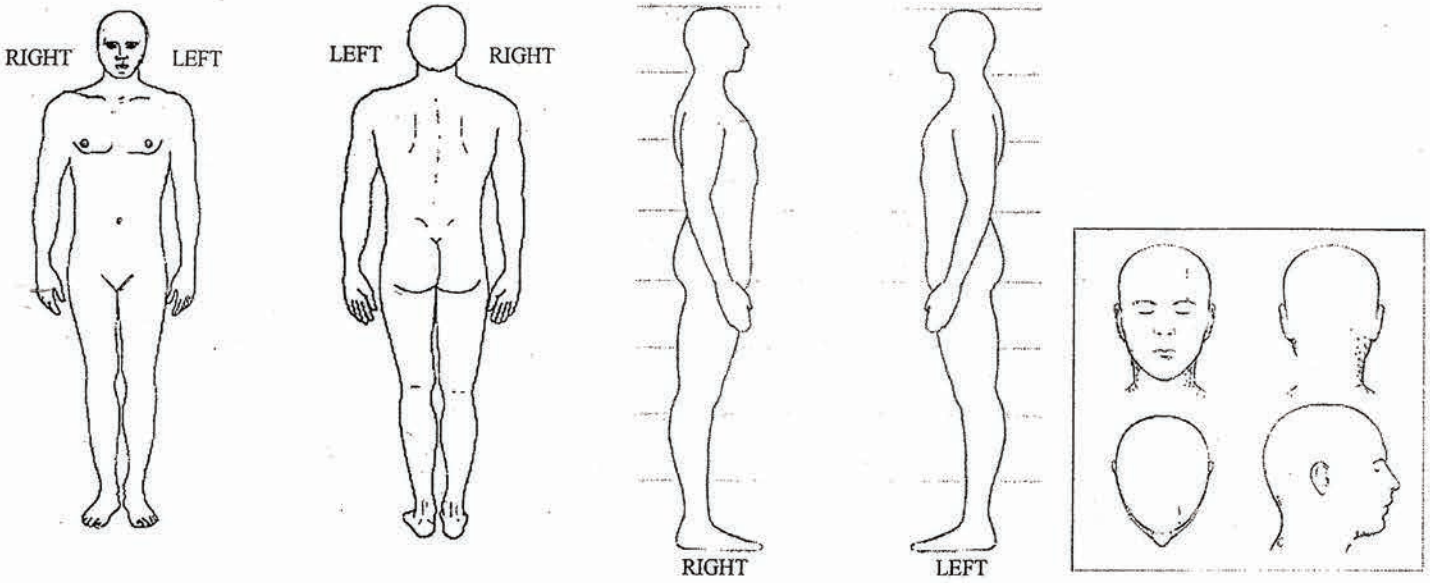
4. What test and studies have been done? (For example: X-Rays, MRI, EMG, etc.)

Test / Studies	Month / Year	Results

5. What treatments or medications are you receiving for your pain now or have received in the past?
(For example – trigger point injections, epidural injections, pain medications, physical therapy, acupuncture, chiropractic services, TENS, surgery, etc.)
Put an "X" in the box that signifies the amount of relief the treatment or medication provide(s), (d) you.

Treatment or Medication	0 No Relief	1	2	3	4	5	6	7	8	9	10 Complete Relief

6. On the diagram below shade the area where you feel the most pain with an "X".



7. Name all of the sites that you have pains: _____, _____

_____, _____, _____

8. Circle the words that describe your pain:

Aching	Sharp	Penetrating	Throbbing	Tender
Nagging Shooting	Burning	Numb	Stabbing	Unbearable
Exhausting	Miserable	Gnawing	Tiring	

9. Is it: Intermittent or Continuous (circle one)

10. Rate your pain in the past month

	0 No Pain	1	2	3	4	5	6	7	8	9	10 As bad as you can imagine
Worst Pain											
Least Pain											
Average Pain											
Right Now											

11.

What makes the pain feel better? (heat, rest, medication, etc.)	What makes the pain feel worse? (walking, standing, lifting, etc.)

13. If "10" is the worst pain you could imagine, what number do you think you could function with?

Circle the number 0 1 2 3 4 5 6 7 8 9 10

12. Put an "X" in the box that describes how during the past week pain has interfered with:

	0 Does Not Interfere	1	2	3	4	5	6	7	8	9	10 Completely Interferes
General Activity											
Mood											
Walking Distance											
Normal Work											
Relations with other people											
Sleep											
Enjoyment of life											
Ability to Concentrate											
Appetite											

14. Are you presently involved in a law suit? Yes ____ No ____
If Yes, please explain:

15. Past Medical History: (such as heart attacks, diabetes, hypertension, as well as accidents, etc.)

16. Past Surgical History: (***Unrelated*** to Pain)

17. Past Surgical History: (***Related*** to Pain)

18. Allergies: (Medications and Food)

19. Medications: (Include Vitamins and Birth Control)

20. Social History:

A. With whom, do you live? _____

B. What chores did you used to do around the house? _____

C. Because of you pain, what chores are you unable to do now? _____

D. What is your highest level of education? _____

E. Are you working outside of your home? Yes ____ No ____

If Yes, what do you do? _____

If No, what was your last job? _____

Why and when did you leave? _____

F. What is your work history?

Job Title	Years Worked	Why did you leave?

G. I am able to:

	0 With No Difficulty	1	2	3	4	5	6	7	8	9	10 Unable
Dress and bathe myself											
Walk around											
Climb up stairs											

H. What drugs or substances have you used in the past? (Circle all that apply)

Alcohol Barbiturates Cocaine Amphetamines Heroin Marijuana

I .What drugs or substances are you presently using? Put an "X" in the box that applies.

	Occasionally	Frequently	Continuously
Alcohol			
Cocaine			
Marijuana			
Barbiturates			
Amphetamines			
Heroin			

J. Do you smoke cigarettes now? Yes ____ No ____ Did you ever smoke? Yes ____ No ____
How many packs do (did) you smoke a day? _____ How many years? _____

K. Have you ever taken pain medication that was prescribed by your doctor in a way other than that was prescribed.....amount, frequency or route) Yes ____ No ____
If Yes, please describe:

_____

_____

_____

L. Do you have any of the following? (Circle all that apply)

Chest Pain	Urinary Problems	Rashes	Shortness of Breath
Nausea	Swollen Joints	Constipation	Vision Problems
Diarrhea	Stomach Pain	Vomiting	Hearing Problems

ACCELERATED REHAB & PAIN MANAGEMENT, PA

IRFAN A. ALLADIN, M.D.

HIPAA PATIENT CONSENT FORM

Our notice of privacy practices provider's information about how we may use and disclose protected health information about you. The notice also contains a patient rights section describing your patient rights under the law. You have a right to review this notice before signing the consent. The forms of the notice may change and if this should occur, you may receive a revised copy by contacting this office. You have the right to restrict how protected health information about you is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, or healthcare operations. You have a right to revoke this consent in writing, signed by you.

However, such a revocation shall not affect any disclosures we have already made in relation to you on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

1. Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
2. The practice has a Notice of privacy practices and the patient has the opportunity to review this notice.
3. The practice reserves the right to charge the notice of privacy practices.
4. The patient has the right to request restricted use of their information, but the practice does not have to agree to those restrictions.
5. The patient may revoke this consent in writing at any time and all future disclosures will then cease.

_____

Printed Name (Patient name or Representative)

_____

Signature

_____

Date

ACCELERATED REHAB & PAIN MANAGEMENT, PA

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MEDICATION MANAGEMENT AGREEMENT

The treatment of chronic pain may involve the use of many different modalities such as nerve block, exercise, surgery, psychology technique's and pain medications. Some of the medications prescribed by your doctor may include substances such as Ibuprofen (Motrin & Advil), Amitripylene (Elavil, an anti-depressant drug that may decrease pain) and Carbamazepine (Tegretol, an anti-seizure drug that may decrease pain). Your doctor may also decide to do trial with an Opioid Analgesic such as Morphine to assess its efficiency in treating your pain.

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 **sudation** 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 pain syndromes. Your doctor has no way of knowing what side effects you may experience or how much pain relief you experience.

Furthermore, these medicines may cause unintended psychological effects, some as a false sense of well being and improved ability to cope with problems. Sometimes patients, who experience these psychological effects, may be using these medicines in a way other than prescribed.

There exists significant misunderstanding regarding the use of Opioid Analgesics. The following definitions are important for you to understand.

1. ***Physical dependence*** is a pharmacological property of certain drugs. Such as caffeine and opioids, they cause biochemical changes in the body such that abruptly stopping these drugs will result in a withdrawal response.
2. ***Addiction*** is a psychological and behavioral syndrome in which there is drug craving and drug seeking behavior. For purposes other than that intended by your physician. For example addiction behavior would include increasing your usual dose of opioid benefit (without prior discussion with your doctor) for psychological benefit to self medicates during a stressful situation.
3. ***Tolerance*** is a pharmacological property it contain drugs defined by the need for increasing doses to maintain effort.

The risk of addiction in patients who do not have a prior addiction history (to any substance) is extremely low. The risk of addictive behavior is much higher in patients who have a prior history of addiction. If you develop an addiction problem your doctor may 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 and addiction disorder, however I also understand that this is extremely rare in patients who have no prior addiction history. 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. I will not obtain opioid analgesics from any other health care professional unless I first discuss this with my doctor. If I require treatment in an emergency room which necessitates opioids I will inform the ER physician of the present medication regimen and ask him/her to call my doctor. I will not share or sell my medication and if my medication is stolen or lost I will report this to my local police department and obtain a stolen/missing police report. Please bring all discharge/medical records from hospitalizations/ER visits/Dentist visits on next visit to this office. I will not take another persons medications.

Date: _____

Patient Name: _____ Signature: _____

Witness Name: _____ Signature: _____

Phone #: _____

Address: _____

IRFAN A. ALLADIN, M.D.

Diplomat, American Board of Physical Medicine and Rehabilitation
Diplomat, American Board of Pain Management, Diplomat, American Board of Pain Medicine

Morris County: **1279Route 46 East, Parsippany, NJ 07054 P: (973)794-4704 F: (973) 794-4707**
Passaic County: 680 Broadway, Paterson, NJ 07514 P: (973) 225-0732 F: (973) 225-0723
Queens County: 22A North Service Road/ JFK , Jamaica, NY 11413 P: (718) 244-1644 F: (718) 244-1622
Middlesex County: 1520 route 130, suite 205, New Brunswick, NJ 08902 P: (732) 658-1630 F: (732) 658-1631
Monmouth County: 1910 Route 35 south, Oakhurst, NJ 07755 P: (732) 531-0100 P: (732) 531-0144

DISCLOSURE FORM

I, _____ , fully understand that Accelerated Surgical Center of North Jersey, 680 Broadway, Paterson NJ is an ambulatory surgical center and Dr. Irfan Alladin has ownership rights to this facility.

Patient's name: _____

Patient's Signature: _____

Sincerely,

Management
Accelerated Rehab & Pain Management
1279 Route 46
Parsippany, NJ 07054

(973) 794-4704

IRFAN A. ALLADIN, M.D.

Diplomat, American Board of Physical Medicine and Rehabilitation
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DISCLOSURE FORM

I, _____ , fully understand that Accelerated Specialty Surgical Center of Middletown, 1270 Route 35, Middletown NJ is an ambulatory surgical center and Dr. Irfan Alladin has ownership rights to this facility.

Patient's name: _____

Patient's Signature: _____

Sincerely,

Management
Accelerated Rehab & Pain Management
1279 Route 46
Parsippany, NJ 07054

(973) 794-4704

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DISCLOSURE FORM

I, _____ , fully understand that North Brunswick Surgical Center, 1520 Route 130, North Brunswick, NJ is an ambulatory surgical center and Dr. Irfan Alladin has ownership rights to this facility.

Patient's name: _____

Patient's Signature: _____

Sincerely,

Management
Accelerated Rehab & Pain Management
1279 Route 46
Parsippany, NJ 07054

(973) 794-4704

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DISCLOSURE FORM

I, _____, fully understand that Advanced Surgical Center 1117 Route 46, Clifton, NJ is an ambulatory surgical center and Dr. Irfan Alladin has ownership rights to this facility.

Patient's name: _____

Patient's Signature: _____

Sincerely,

Management
Accelerated Rehab & Pain Management
1279 Route 46
Parsippany, NJ 07054

(973) 794-4704

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PAIN MANAGEMENT SAFETY AGREEMENT

I, _____, promise to keep my medications and prescriptions in a locked box, so that they will not be stolen or misplaced. I will be responsible for any future loss of the above items.

_____
Printed Name

_____
Signature

_____
Date

_____
Irfan A. Alladin

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General Medical Records Release and Authorizations for Use or Disclosure of Protected Health Information

Patient Name:_____ Date of Birth: _____

Address: _____ Social Security: _____

_____ Phone: _____

I, _____request the release of my medical records from the office of:

Name of Office: _____

Address: _____

_____

To:

Name: _____

Address: _____

_____

NOTE: **Medical records are faxed in cases of medical necessity only.**

I understand that:

- ***My right to healthcare treatment is not conditional on this authorization***
- ***It the person or facility receiving this information is not a healthcare or medical insurance provider by privacy regulations the information stated above could be re disclosed***
- ***There may be a charge for the requested records***

_____ _____

Patient Signature **Date**