Huntington Center for Pain Treatment

Nolan Tzou, M.D.
Diplomate American Board of Anestesiology and Pain Management

124 Main Street, Suite 10
Huntington, NY 11743
Tel: (631) 629-4770
Fax: (631) 629-4772

Mailing Address:
P.O. Box 2259
Halesite, NY 11747-0687
Email: HPaintreat@aol.com
Web: www.northshorepain.com

OFFICE COPY

*** WELCOME TO OUR PRACTICE ***

NAME:_____
APPOINTMENT DATE:_____ APPOINTMENT TIME:_____

YOU WILL BE SEEING:_____ Nolan D. Tzou, MD _____ Barbara Johnson, ANP

READ CAREFULLY: Keep the patient copy for yourself, sign the office copy and return it to us.

1. Fill out the enclosed forms prior to your visit and bring them with you. **A PHOTO ID WILL BE REQUIRED AT THE TIME OF YOUR VISIT.**
2. If you have had an MRI, CT-Scan, or X-Ray, please bring the **REPORTS** with you. If you do not have the reports, call the facility and have that facility **FAX** them to our office at **631-629-4772.**
3. You are responsible for keeping your appointment. If you need to cancel, please call our office **AT LEAST 24 HOURS IN ADVANCE.** Please be advised that there is a **$25.00 CHARGE FOR MISSED APPOINTMENTS.**
4. If your insurance company requires a **referral**, you are responsible for obtaining it. **Without it, you will not be seen.**
5. You must bring your insurance cards and any necessary worker's comp/no fault information with you.
6. Co-pays and Medicare/Medicaid balances will be collected at the time of your visit.
7. **YOU MUST CALL AT LEAST 5 DAYS IN ADVANCE FOR PRESCRIPTION REFILLS. THERE WILL BE NO REFILLS WITHOUT THIS NOTICE.**
8. **ALL SCRIPTS MUST BE PICKED UP AT OUR OFFICE. THEY WILL NOT BE PHONED INTO PHARMACIES. NO EXCEPTIONS APPLY.**
9. **NO** narcotic scripts will be given after hours on Friday, Saturday, or Sunday. If necessary, you will have to go to the Emergency Room.

_____ _____
Signature Date

_____
Print Name

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PATIENT COPY

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NAME:_____
APPOINTMENT DATE:_____ APPOINTMENT TIME:_____

YOU WILL BE SEEING:_____ Nolan D. Tzou, MD _____ Jason Urso, RPA-C

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Patient History Form

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so

Last Name _____ First Name _____ Middle _____
Social Security No. _____ Date of Birth _____ Age _____ Referred by: Self
Chief Complaint: Other _____
What is the main reason for your visit today? (Describe in detail)
_____
_____
_____

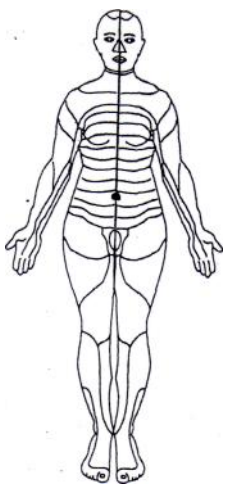
History of Present Illness

Please answer the following questions

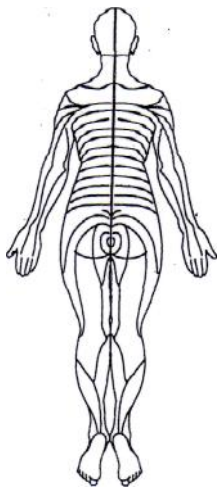
Location of the Problem:
Abdomen Back Leg Arm
Other _____
Please draw in painful area to figure on right
On scale of 0-10, with 10 being most severe, circle the number that best describes the problem:
1 2 3 4 5 6 7 8 9 10
When did you first notice the problem?
2 days ago 2 weeks ago 1 month ago
Other/Date:_____
Does anything make the pains worse?
Moving around Standing Sitting Lying on side
Other: _____
How long does the pains last? _____
Is the problem constant or variable?_____
Is there anything else occurring at the same time?
Nausea Rash Headache Numbness Tingling
Does the problem interfere with your normal functioning?
Yes___ No___ If yes explain_____

PAIN LOCATION DRAWINGS

Please indicate the primary location of your pain on the drawing below



R Front L



L Back R

Past Medical & Social History

Your past Medical History/Illnesses	Past Surgeries	All Mediations	List all Family Illnesses
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies to medications _____ Smoke? Y N if yes how much? _____
Are you currently working? Y N What do you do? _____ Drink alcohol? Y N if yes how much? _____

Physician use only (comments/notes):

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Review of Systems

Do you know or have you had any problems related to the following systems?
Circle YES or NO. Please explain any YES answers in the space provided

Constitutional Symptoms:

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other _____		

Eyes:

Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N
Other _____		

Allergic / Immunologic:

Hay Fever	Y	N
Drug Allergies	Y	N
Other _____		

Neurological:

Tremors	Y	N
Dizzy Spells	Y	N
Numbness/Tingling	Y	N
Other _____		

Endocrine:

Excessive Thirst	Y	N
Too Hot/Cold	Y	N
Tired/Sluggish	Y	N
Other _____		

Gastrointestinal:

Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Indigestion/Heartburn	Y	N
Other _____		

Cardiovascular:

Chest Pain	Y	N
Varicose Veins	Y	N
High Blood Pressure	Y	N
Other _____		

Integumentary:

Skin Rash	Y	N
Boils	Y	N
Persistent Itch	Y	N
Other _____		

Muscoloskeletal:

Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N
Other _____		

Ear / Nose / Throat / Mouth:

Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problem	Y	N
Other _____		

Genitourinary:

Urine Retention	Y	N
Painful Urination	Y	N
Urinary Frequency	Y	N
Other _____		

Respiratory:

Wheezing	Y	N
Frequent Cough	Y	N
Shortness of Breath	Y	N
Other _____		

Hematologic / Lymphatic:

Swollen Glands	Y	N
Blood Clotting Problems	Y	N
Other _____		

Psychologic:

Are you satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N
Other _____		

Physician use only (comments/notes)

Physician _____ Date_____

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Previous Test and Treatments

NAME: _____

Please list (as well as you can remember tests such as MRI, Ct, EMRG, X-Ray, Scans, Discograms, Nerve Blocks and others that you underwent for this condition:

TEST	DATE	RESULSTS

Have you received any of the following treatments for this condition, and was this treatment beneficial to you?

Treatment		Duration of Treatment	Beneficial Effect
Acupuncture	yes/no	_____	good/none/limited
Psychological	yes/no	_____	good/none/limited
Biofeedback	yes/no	_____	good/none/limited
Chiropractic	yes/no	_____	good/none/limited
Physical therapy	yes/no	_____	good/none/limited
TENS treatment	yes/no	_____	good/none/limited

Other (describe below)

_____

_____

List all MEDICATIONS that you have tried and that were NOT EFFECTIVE:

_____ _____ _____

_____ _____ _____

_____ _____ _____

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Medical Background Information

Name _____ Age _____

Please name the professional that you have seen for this condition:

NAME	SPECIALTY	TOWN	PHONE #

Who is your primary care doctor and which other physicians have you seen in the past 12 months?

NAME	SPECIALTY	TOWN	PHONE #

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Dear Patient,

RE: FORMS

Please be advised that as of September 2005, there will be a $10.00 fee for all medical forms that need to be completed by the physician. This fee is due that day that the forms are dropped off.* If you are mailing in your forms, please include your payment payable to Huntington Center for Pain Treatment.

Please not that if your payment is not received with the forms, they will not be mailed out.

* There is usually a two (2) week turn around time for forms to be completed.

RE: YOUR INSURANCE COVERAGE

Please be advised that it is your responsibility to familiarize yourselves with your insurance company as to what benefits are covered under your plan (i.e. what they pay for and how many visits you are entitled to each year).

Our office has medically set guidelines for scheduled visits that we abide by for your health, but we have no way of knowing what your individual insurance plans will or will not pay. Unfortunately, some plans cover a certain number of visits, even if your physician recommends it.

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Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consents for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about your treatment, payment, or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under the law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time, you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our Health Insurance Portability and Accountability Act Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name	Signature	Date

Effective 4/14/03

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Financial and Medical Record Policy

I, _____ (print name) authorize payment directly to Huntington Center for Pain Treatment of all benefits otherwise payable to me, but not exceed the total charges for the services rendered in my complete medical and billing record to:

1. My insurance company or its representatives.
2. Other persons or entities financially responsible for my care of treatment.
3. Medicare or Medicaid programs and their fiscal intermediaries, if applicable, or otherwise required or permitted by laws and/or regulations.
4. Federal or state agencies, as required or permitted by laws and/or regulations.
5. My referring, primary care or other treating physicians, and my attorney.
6. Other providers that we may refer you to at your request to participate in your care.

I understand that I am financial responsible to the Huntington Center for Pain Treatment for all charges for services rendered to me. If you have insurance, we will assist you in receiving maximum benefits. We will fill out insurance claims as a courtesy to you. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, pre-existing conditions, etc., other than to supply factual information as necessary. For major surgery or office visits, we may accept your insurance if we obtain approval from your insurance company prior to the date of service. CO-PAY AND DEDUCTIBLE PAYMENTS ARE DUE AT THE TIME OF SERVICE OR THERE IS A $15.00 SURCHARGE.

NO FAULT/WORKER'S COMPENSATION: We will first bill your carrier as long as your account is open. We will accept the no-fault/worker's compensation reduced fee schedule if you are eligible.

Please be aware WE DO NOT PARTICIPATE IN MEDICAID. IF MEDICAID IS YOUR SECONDARY INSURANCE, YOU WILL BE RESPONSIBLE FOR ANY AND ALL BALANCES DUE.

Thank you for understanding our policy. Please let us know if you have any questions or concerns.

_____ _____

Patient's Signature Date

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Patient Information/Insurance Information

Today's Date _____

Last Name _____ First Name _____ MI_____

Address _____

_____ Zip Code _____

Home Phone # _____ Work Phone # _____

Cell Phone # _____ Social Security # _____

Date of Birth _____ Gender (circle) M / F

Height _____ Weight _____

Primary Care Physician _____ Phone # _____

Primary Insurance _____

ID # _____ Group # _____

Co-Pay Amt. $ _____ Policy Holder Name _____

Policy Holder SS# _____ Policy Holder DOB _____

Relationship to Patient (circle) Self Spouse Child Other

Secondary Insurance _____

ID # _____ Group # _____

Co-Pay Amt. $ _____ Policy Holder Name _____

Policy Holder SS# _____ Policy Holder DOB _____

Relationship to Patient (circle) Self Spouse Child Other

Name/Phone # of relative not living with you _____

_____

FOR OFFICE USE ONLY

PATIENT SIGNED IN BY: _____

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Authorization for the release of Medical Information

TO: _____

_____

_____

I, _____, authorize the release of my medical records to include history and physical examination, progress notes, laboratory, x-ray, EKG, MRI studies, etc., as well as the insurance and demographic information to:

Huntington Center for Pain Treatment
124 Main Street, Suite 10
Huntington, NY 11743
(631) 629-4770
(631) 629-4772

Signed: _____ Date: _____

Witness: _____ Date: _____

Patient Name: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ (insert patient's name) acknowledge receipt this day from **Nolan D. Tzou, MD** of a copy of the NOTICE OF PRIVACY PRACTICES of **THE HUNTINGTON CENTER FOR PAIN TREATMENT.**

Date:_____ _____
(Patient Signature)

Do we have permission to? :

Leave a message on your answering machine at home/on cell? YES____ NO____

Discuss your medical condition with a member of your household? YES___ NO___

If so, whom:_____ Relationship_____

Patient Name: (please print)_____

Patient Signature:_____ Date:_____

THIS COMPLETED FORM IS TO BE PLACED IN THE PATIENT'S MEDICAL RECORD

Received By:

_____
(Signature of Staff Member)