NEW PATIENT QUESTIONAIRE

Name_____ Date _____

DOB _____ Age _____ Referring Physician_____

Height_____ Weight_____

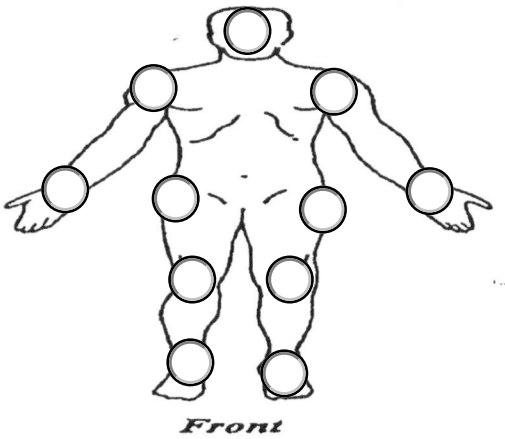
Pain Score: Please Circle

|----------|

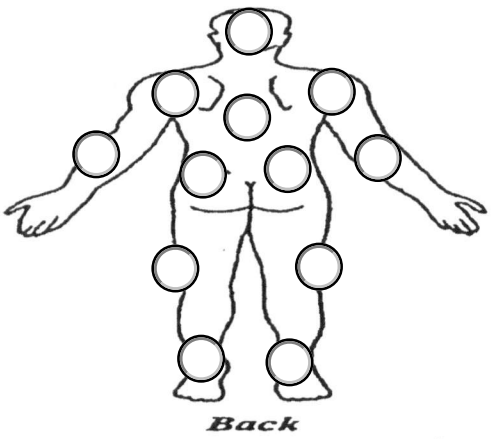
0 1 2 3 4 5 6 7 8 9 10

PAIN HISTORY

On the drawings below, shade in the areas in which you are having pain. Indicate the worst area with an X.



Front



Back

When did the pain start?_____

How long has the pain been present in this area?_____

Does the pain radiate to anywhere in particular? _____ **If so, where?**

_____

Have you received any of the following treatment(s):

Physical Therapy ○ **Chiropractics** ○ **Acupuncture** ○ **Massage** ○

Did an accident or other event precipitate your pain? If yes, please describe:

_____

_____

Describe the pain? Circle all that apply:

Burning ○ Sharp ○ Shooting ○ Throbbing ○ Aching ○ Pins/Needles ○

Numbness ○ Cutting ○ Cramps ○ Gripping ○ Electrical ○ Dull ○

How frequently do you have your pain? Circle one:

Continuously ○ Intermittently ○

What makes your pain better? _____
What makes your pain worse? _____

Were you injured on the job? ☐ Yes ☐ No If yes, date of injury _____
Are you currently involved in litigation? Yes ☐ No ☐
Are you currently working? Yes ☐ No ☐ **If no, when did you stop?** _____

PAST HISTORY

Please list ALL current medications

Medication	Dosage & Frequency
1.	
2.	
3.	
4.	
5.	

List all medical problems:

_____
_____
_____

List all surgeries:

Type of Surgery	Date
1.	
2.	
3.	

Please List Allergies

Allergies to Medications	Reaction
1.	
2.	
3.	

Could you be pregnant? Yes ○ No ○ ☐N/A ○
Do you smoke? Yes ○ No ○ packs per day _____ years _____
Do you drink alcohol? Yes ○ No ○ How much: _____ How often: _____
Do you use illicit (street drugs)? ○ Yes ○ No Name of Drug(s)_____
Last used _____

Have you treated with Pain Management in the past? Yes ○ No ○ If yes, when:_____

If yes: Physician Name:_____ Phone #_____
Were Epidural Injections performed? Yes ○ No ○
Was pain medication prescribed ? Yes ○ No ○
If yes name of medication (s):_____

Member	Alive/Deceased	Age	Diabetes	HTN	Heart Disease	Stroke	Psychiatric Illness	Cancer	Unknown
Father									
Mother									

Edward S. Rubin, M.D.
1991 Marcus Avenue Suite M217 Lake Success, NY 11042
1103 Stewart Avenue Suite 300 Garden City NY 11530
*Phone: 516-492-3100 * Fax: 516-492-3097*

Full Legal Name

Last Name:_____ First Name:_____ DOB:_____

Address:_____City_____State_____ Zip_____

Home Phone#:_____ Work#:_____ Cell#:_____

SS#:_____ Marital Status:_____

Patient Employer Info: ◯currently Employed ◯Unemployed ◯Retired ◯Legally Disabled

Employer Name:_____ Position:_____

Address:_____Phone#:_____

Nearest Relative for Emergency Contact:

Name:_____ Phone#_____

Address:_____

Referring Doctor:

Name:_____ Phone:_____

Primary Doctor:

Name:_____ Phone:_____

Primary Insurance: ***Secondary:***

Insurance Company:_____ Insurance Company:_____

Policy #:_____Group#_____ Policy #:_____Group#_____

Workers Comp Information: Only if you were injured at work & have filed a claim with your employer.

Date of Injury:_____

Ins Carrier:_____ Phone#_____

WC Claim#_____ WCB#_____

Adjuster:_____ Phone#_____

Employer at time of Accident:_____

Address:_____City_____State_____Zip_____

Job Title:_____ Job Description:_____

Description of Accident:_____

_____.

Injured Body Part(s) filed on Workers Compensation Claim with your employer:

_____

No Fault Ins. Information: (Only if you were involved in a motor vehicle accident)

Date of Injury:_____ NF Claim#_____

Ins Carrier:_____ Phone#_____

Adjuster:_____ Phone#_____

Description of Accident:_____

_____.

Injured Body Part(s) reported with your Auto Insurance Company:

_____

Circle One

Y ☐ N ☐ **INSURANCE AUTHORIZATION**
I hereby authorize Dr. Edward S. Rubin/Nassau Pain Associates to furnish information to my insurance carriers concerning my illness and treatment.

Y ☐ N ☐ **ASSIGNMENT OF BENEFITS**
I hereby assign Dr. Edward S. Rubin/Nassau Pain Associates all payments for medical services rendered to my dependents of myself. I understand that I am responsible for any amount not covered by insurance.

Y ☐ N ☐ **TREATMENT AUTHORIZATION**
I hereby authorize Dr. Edward S. Rubin/Nassau Pain Associates to render health care to me during my visit.

Y ☐ N ☐ **PRIVACY NOTICE**
I have received a notice from Dr. Edward S. Rubin/Nassau Pain Associates that explains how my personal health information will be used.

If your insurance carrier requires you to have a referral generated by your PCP, to see a specialist, it is your responsibility to provide the referral to Dr. Rubin's office the day of your initial visit as well as follow-up visits. Please be advised if a referral is not provided you will be responsible for full payment of services rendered. Copayments are due at the time of service or a $25.00 fee will be charged.

I _____ hereby acknowledge the above statement and agree to adhere to the referral guidelines or accept responsibility for payment.

Signature_____ Date_____

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HIPAA PRIVACY

Our Duties:

Our office is required by law to maintain the privacy of your health information and to provide you with this notice of our duties to maintain standard privacy practices. We are required to abide by the terms set forth by the Department of Health and Human Services (https://www.hhs.gov/hipaa). These guidelines and this notice may be amended from time to time. We reserve the right to change the terms of this notice and to make a new notice of provisions effective for all protected health information that we maintain. If the office changes notices, we will provide a copy of the revised notice via regular mail or in person or in another secured fashion.

- ***Sharing your information with other health care providers:***

The Privacy Rule allows covered health care providers like physicians and laboratories to share protected health information for treatment purposes without patient authorization, as long as they use reasonable safeguards when doing so. These treatment communications may occur orally or in writing, by phone, fax, e-mail, or otherwise.

- ***HIPAA Right of Access***

If you would like an individual (spouse, partner, child, or friend) to have access to your records provide the name and relationship below:

I request that my protected health information be released to: (PUT "N/A" if no individual is designated)
Name_____ Relationship_____ Patient Initial _____

- ***Complaints:***

You have the right to express complaints to the office and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the Office by contacting the Office's Privacy Officer verbally or in writing, using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. The office, all staff members and physicians will not treat you any differently or retaliate in any manner should you file a complaint.

- ***Contact Person:*** **The office's contact person for all issues regarding patient privacy and your rights under the Federal privacy standards is the Privacy Officer. Information regarding matters covered by this notice can be requested by contacting the Privacy Officer. Complaints against the office can be mailed to the Privacy Officer at:**

Edward S. Rubin, M.D.
1991 Marcus Avenue Suite M217 Lake Success, NY 11042
1103 Stewart Avenue Suite 300 Garden City NY 11530
*Phone: 516-492-3100 * Fax: 516-492-3097*

This notice is revised as of 10/1/2021

I acknowledge that I have received our Notice of Privacy Practices.

The office may contact me by text or email or call to leave voice messages.

Patient Name_____ Patient Signature: _____

Date:_____

Additional Authorizations Required for Treatment

INSURANCE AUTHORIZATION
I hereby authorize Dr. Edward S. Rubin and/or Nassau Pain Associates to furnish information to my insurance carriers concerning my illness and treatment.

Initial _____

ASSIGNMENT OF BENEFITS
I hereby assign Dr. Edward S. Rubin and/or Nassau Pain Associates all payments for medical services rendered to my dependents of myself. I understand that I am responsible for any amount not covered by insurance.

Initial _____

TREATMENT AUTHORIZATION
I hereby authorize Dr. Edward S. Rubin/Nassau Pain Associates to render health care to me during my visit.

Initial_____

REFERRALS TO OUR PRACTICE

- If your insurance carrier requires you to have a referral generated by your PCP, to see a specialist, it is your responsibility to provide the referral to the office the day of your initial visit as well as follow-up visits.
- Please be advised if a referral is not provided you will be responsible for full payment of services rendered.
- Copayments are due at the time of service or a $25.00 billing fee will be charged.

I _____ hereby acknowledge the above statements

Signature_____

Date_____

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HIPAA Right of Access Form

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: Relationship:

_____ _____

Contact information: _____

_____

Health Information to be disclosed upon the request of the person named above –
(Check either A or B):

- ☐ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
- ☐ B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify): _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event: _____ unless I revoke it.
  (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____

Name of the Individual Giving this Authorization Date of birth

_____ _____

Signature of the Individual Giving this Authorization Date

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524

Edward S. Rubin, M.D.

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Request for Narcotic Therapy

I, _____, am requesting treatment with narcotic pain medication(s) because other therapies, treatments, and/or medication(s) that I have previously received had not provided me with adequate relief of pain. I understand that it is unlikely that any medication(s) will completely remove nor eliminate my pain. I further understand that the narcotic pain medication(s) will be prescribed for me for humane reasons ***as long as my pain continues,*** provided that I follow all terms of this agreement.

Potential Complications

My physician, Edward Rubin, M.D., has discussed potential long-term narcotic therapy with me in detail and I understand some of the possible complications that may occur are:

- Chemical/physical dependence and addiction
- Severe constipation which could require medical treatment difficulty with urination
- Drowsiness
- Nausea
- Itching
- Slowed breathing or respirations
- Reduced or absent sexual desire and/or function

I also understand that if I take more medication that my physician has prescribed serious and life-threatening complication may occur. Serious complications include but are not limited to:

- Coma
- Organ damage or failure death

I further understand that if I take all my medication(s) sooner than prescribed or if I suddenly stop taking my medication(s) that I could have narcotic withdrawal symptoms that can be very painful and life threatening.

(Female patients only) I understand that there are both known and unknown hazards/risks to an unborn infant if the mother takes narcotic medication(s). The risks/hazards include but are not limited to narcotic addiction of the infant with narcotic withdrawal after birth. I assume full responsibility for notifying my physician if I suspect or confirm that I am pregnant. I further understand that a different plan of treatment, without the use of narcotics, will be tried during pregnancy.

Terms/Agreements

This narcotic agreement is contingent on compliance with ALL of the following patient and physician terms:

1. I agree to receive narcotic medications prescriptions ONLY from physician(s) or physician extenders at our center
2. I agree to complete a baseline urine test at my initial new patient visit if I am seeking narcotic medication
3. In order to obtain a refill for narcotic medication(s), I understand that an appointment must be scheduled with the physician or physician extender (Physician's Assistant or Nurse Practitioner). I further understand that is my responsibility to assure that I have enough medication to last through the weekend, holiday, and/or after hours (5pm-8am).
4. I understand that Dr. Rubin's policy is to see patients every 3-4 months in office if telemedicine is utilized.

5. I understand that Edward Rubin, MD does not accept telephone requests for narcotic prescriptions and I must be seen at my regularly scheduled appointment with the physician to receive a narcotic prescription.
6. Physician(s) on-call after hours, on holidays, and on weekends will **NOT** refill my medication. It has been explained to me that they do not have charts available for review to make decisions regarding medications.
7. I agree to be under the care of a primary care physician. I will inform Edward Rubin, MD if I change my primary care physician.
8. I agree to keep my referring provider updated on my diagnoses and treatment.
9. I hereby authorize a release of my information that allows the physician(s) and/or staff to communicate and collaborate with any other health care provider(s) currently involved in my care, as well as those previously involved in my care.
10. I understand that at Edward S. Rubin, MD PC there are many different professionals on staff who work together with a team approach to treatment. I further understand that the team will meet and discuss my treatment plan & progress, and give permission for the team to discuss my plan and progress.
11. I will notify Edward Rubin, MD about medication side effects.
12. I understand that if a serious issue effect occurs while the office is closed after hours, on a holiday, or during the weekend, that I should immediately seek Emergency assistance from the nearest hospital or dial 911.
13. Prescription dosage(s) have been thoroughly explained to me by my physician and I understand that **I SHALL NOT** change dosage amounts or alter the time schedule of the prescribed medication without directions to do so by my physician. **I understand that I am to take prescriptions as prescribed.**
14. I understand that narcotic medication(s) should be kept in a safe place at all times and that I am responsible for the security of my medications. It has been thoroughly explained to me that the policy does not allow for replacement of misplaced, spilled, inaccessible, or lost narcotic medication(s) or prescription(s). I understand that if my medication(s) or prescription(s) are stolen that I must deliver a police report to my physician and they will contact the police department for verification of the report. A second event such as above may lead to termination of this contract.
15. I understand that narcotic medication(s) should be kept away from children as well as animals.
16. I must keep all appointments as recommended by my physician.
17. I understand the benefits of narcotic medications will be evaluated regularly using the following criteria:
    a. Increase in general level of functioning
    b. Increase in life activities
    c. Decrease in the intensity of pain
    d. Absence of unacceptable or intolerable adverse effects
    e. Improvement in mood
18. I agree to participate in psychotherapy sessions and psychological testing as deemed appropriate by my physician and/or the team of health care provider(s) if recommended.
19. I agree to submit to random urine and/or blood screens for other medications and drugs at the time of my appointment or at the randomized request of Dr. Rubin. I understand that these toxicology screenings are randomized and mandatory, and failure to comply may result in a delay of my medication. I understand that Dr. Rubin utilizes in-house testing for samples.
20. I have been given information about the use of narcotic medication, including possible risks and adverse side effects such as the development of tolerance, dependence, addiction, and withdrawal and after thoroughly reviewing the information; I believe the benefits will be greater than the risks.
21. I will not hoard narcotic medication nor will I share my medication with others
22. I will not drink alcohol within 24-48 hours of taking narcotic medication(s).
23. I understand that violations to this agreement may result in the termination of controlled substances as part of my treatment plan.
24. I agree to allow Edward Rubin, MD to contact other pharmacies to discuss my medications.
25. I understand Edward Rubin, MD and his healthcare team has an obligation to check my name in the NYS database (Istop / PMP) with each opioid prescription.
26. I understand the use of benzodiazepines with opioids may have a potential for overdose and death. I will not take sleeping pills or other sedative medications with my opioids

Narcotic Treatment Monitoring

During this period, I understand that I might have my narcotic medication discontinued at any time for any reason, per a decision by my physician and the health care team. If notified of such discontinuance, I will be provided with a 30 day supply of an appropriate medication(s). I further understand that during this period I could be referred to an addiction specialist or to a drug detoxification program if warranted. In cases requiring admission to an inpatient detoxification program, NO further medication will be provided.

I attest to the following **(initial below)**:

____ I agree to only use my medication as prescribed

____ I am not undergoing treatment for substance (drugs or alcohol) dependence or abuse.

____ I have never been involved in the sale, illegal possession, or transport of illegal substances.

____ I will keep my medication in a safe place not accessible to children or family members or others

____ I have read this document or had it read to me and, I understand the possible side effects and complications of opioid therapy.

FEMALES ONLY

____ I am not pregnant. I will inform the medical staff if I become pregnant or intend to become pregnant. I understand that there may be harmful effects on an unborn infant if I take narcotic medication(s).

Release

I release my physician, the team of health care providers, and Edward Rubin, MD, from liability for any social consequences related to narcotic medication(s) therapy and/or discontinuance of narcotic medication(s). This includes but is not limited to job related issues, legal issues, DMV action and relationship issues.

Laboratory Testing

I have been advised that, Edward Rubin, MD, may perform toxicology testing and bill for such testing through a physician owned lab at 1103 Stewart Ave Ste 300 Garden City NY 11530

Acknowledgement/Agreement

I hereby acknowledge that the content of this contract has been explained to me. I was offered an opportunity to ask questions and discuss any unclear aspects of this contract. I acknowledge that I fully understand that my failure to comply with any term(s) set forth within this agreement will result in termination of this contract and of my care and medications at our center.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____