Spine Institute
MARC A. COHEN, M.D.

**Marc A. Cohen, MD, FAAOS, FACS**
*Diplomate American Board of Spinal Surgery*
*Fellow American College of Spinal Surgery*

221 Madison Ave • Morristown, New Jersey 07960 • (973) 538 -4444 •Fax (973) 538 -0420

## PATIENT INFORMATION

Date _____
Patient SS# _____
Last Name _____
First Name _____Middle Initial ___
Address _____
City _____
State _____ Zip _____
E-mail _____
Sex □ M □ F Age _____
Birth Date _____
□ Married □ Widowed □ Single □ Minor
□ Separated □ Divorced □ Partnered
Spouse/Parent's Name_____
Spouse/Parent's Birth Date _____

## PHONE NUMBERS

Home Phone (____) _____
Cell Phone (____) _____
Work Phone (____) _____

## IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____
Home Phone (____) _____
Cell Phone (____) _____

## EMPLOYER INFORMATION

Occupation _____
Employer Name: _____
Employer Address _____
_____

## INSURANCE

Primary Insurance: □ Health □ MVA □ Work Comp.
Insurance Co _____
Insured's Name _____
Insured's Date of Birth _____
Relationship to Patient _____
Member ID #: _____
Group #: _____

## PLEASE FILL OUT IF MVA OR WORK COMP.

Date of Accident _____
Claim#: _____
Adjuster's Name _____
Adjuster's Phone Number: _____

Are you covered by additional insurance? □ Yes □ No

Secondary Insurance: □ Health □ MVA □ Work Comp.
Insurance Co _____
Insured's Name _____
Insured's Date of Birth _____
Relationship to Patient _____
Group #: _____
Member ID #: _____

All professional services rendered are charged to patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees. Regardless of insurance coverage, it is customary to pay for services when rendered unless other arrangements have been made in advance.

I irrevocably assign to *The Spine Institute of Dr. Marc A. Cohen* all my rights and benefits under any insurance contracts for payment for services rendered to me by *The Spine Institute of Dr. Marc A. Cohen*. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by *The Spine Institute of Dr. Marc A. Cohen* to be released to *The Spine Institute of Dr. Marc A. Cohen*. I irrevocably authorize *The Spine Institute of Dr. Marc A. Cohen* to act on my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities. Their assignment of benefits has been explained to my full satisfaction and I understand its nature and effect.

**Patient Signature:** _____ Date:_____

**Minor may not sign – guardian only**

**(PLEASE COMPLETE MEDICAL INFORMATION ON OTHER DOCUMENTS AS SPECIFIED)**

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## ***OUT OF NETWORK****

**This Letter is to inform you that our office is out of network with all insurances. By reading and signing below you have acknowledged and have read the following statement:**

**I understand that The Spine Institute/Northern NJ Orthopedic Specialists is a non-participating provider and out of network with all insurance companies, which means that I may be responsible for my deductible/co-insurance.**

**I understand that if other services are required such as any surgical procedures, The Spine Institute/Northern NJ Orthopedic Specialists will provide me with additional information to make me aware of what the billed charges are and/or what my responsibility will be if any.**

**I understand that The Spine Institute/Northern NJ Orthopedic Specialists offers payment plans if I am unable to pay in full that will be acceptable to my needs and financial expenses. Please contact the billing department at 973-538-4444.**

**I understand that reimbursement for my medical procedures may be sent to me. In the event that I receive direct payment of any amounts due for the services rendered by my carrier, I agree to forward immediately to The Spine Institute/Northern NJ Orthopedic Specialists any checks made payable to me from services rendered by your office. I also agree to endorse the check received or send a personal check and a copy of the explanation of benefits received regarding payment details.**

The undersigned had read and understands the above terms.

Patient Name (Please Print): _____

Patient Signature: _____

Date: _____

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# ASSIGNMENT OF BENEFITS

**Date: _____**

**Patient Name: _____** **Date of Birth: _____**

**Patient Address: _____**

**Date of accident (If applicable): _____** **Insurance Company: _____**

**Identification # and/ or Claim#: _____**

1. I, the undersigned, hereafter referred to as "the patient" do hereby assign all of my rights and interests to **NNJOS/ The Spine Institute,** hereafter referred to as "the medical provider" to pursue and obtain payment on my behalf. This assignment shall include but is not limited to, all rights available to me pursuant to the Personal Injury Protection Statues of the State of New Jersey.
2. I, assign, to the medical provider, all my rights and benefits under the insurance contract for payment for services rendered to me. If it is determined that more than one insurance company is responsible for payment of my medical bills I hereby authorize and give the medical provider power of attorney to sign any documents on my behalf to pursue a claim for personal injury protection benefits. However, upon consent of both parties, same shall be revocable.
3. I, the patient, do hereby understand and acknowledge that if I willfully refuse to comply with reasonable requests of the insurance carrier, payment of my medical bills may be denied and I will be held responsible for same.
4. I, the patient authorize my bodily injury attorney to pay directly to the medical provider any monies due on my account, or, have same deducted from any settlement made on my behalf.
5. I, the patient, do hereby direct my health insurance carrier and/or other insurance carrier to issue payment on my behalf directly to the medical provider. The check should be made payable to the medical provider. Further, in the event that the health carrier and/or other insurance carrier fails to forward the check to the medical provider, I will endorse and sign the check to the medical provider within (5) days of receipt of the same. **Initial _____**
6. I, the patient, do hereby acknowledge that I will not file suit and/or arbitration for the payment of the above provider's medical bills unless I am requested to do so by the medical provider. I understand that the above referenced medical provider has an attorney and will collect payment on my behalf from the insurance carrier.

Patient Signature: _____

Patient's Name: _____

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# Authorization Form to Release Protected Health Information (PHI) To Spouse / Significant Other

This Authorization grants permission to my Spouse / Significant Other /Party Named Below to: make or confirm appointments; have access to radiology, laboratory, or test findings; have access to telephone communication and answering machine messages as well as other common means of communication; pick up medications; be made aware of my diagnosis, prognosis, and treatment plans; and have access to my financial health information.

I hereby authorize Northern NJ Orthopedics/ The Spine Institute to use and disclose my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that once this information is disclosed to my spouse / significant other, or the party named below, the released information may no longer be protected by federal privacy regulations.

**PATIENT NAME:** _____
**Date of Birth:** _____
**Spouse / Significant Other / Other:**_____
**Relationship to Patient:** _____
**Address:** _____
**Phone:** _____
**If address or phone number is different from Patient's, please provide information:**
_____

The patient must read and initial the following statements:

1. I understand that this authorization will (Please check one)
o Expire 1 year from the date signed by the patient
o Be effective for the lifetime of the patient unless revoked (see # 2 below)
Patient's Initials: _____

2. I understand that I may revoke this authorization at any time by notifying Northern NJ Orthopedics/The Spine Institute in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken Northern NJ Orthopedics/The Spine Institute prior to their receipt of the revocation.
Patient's Initials: _____

3. I understand that my treatment cannot be conditioned on whether I sign this authorization.
Patient's Initials: _____

(Form must be completed before signing or will not be valid)

**Patient's Signature**: _____
**Date**: _____

** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION *

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**Opiate and Pain Management Agreement**

The purpose of this agreement is to improve communication and prevent any misunderstandings about the medications you are taking to treat your chronic pain. The medications you are currently taking require close monitoring. They should be taken as directed by your doctor. You should also follow any other directions your doctor has given you about managing your pain. It is your responsibility to accurately report your use of the medications and how they affect you. It is your provider's responsibility to provide options that will improve your pain level.

Pharmacy_____ Telephone #_____

Address: _____

By signing this agreement, you understand that you have a right to comprehensive pain management and you wish to enter a treatment agreement to prevent possible chemical dependency. You further understand that failure to follow any of these agreed to statements may result in Dr. Cohen not providing ongoing care for you. Therefore, by way of this foregoing pain contract, you will be referred back to your pain management doctor.

1. You understand that opiate analgesics are strong medications for pain relief and have been informed of the risks and side effects involved and taking them.
2. In particular, you understand that opiate analgesics could cause physical dependence. If you suddenly stop or decrease the medication with the knowledge or permission of Dr. Cohen, you could have withdrawal symptoms (flu-like symptoms such as nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24-48 hours of the last dose. You understand that opiate withdrawal is quite uncomfortable, and may be life-threatening.
3. You understand some patients develop tolerance to pain medications, and may need to increase their dose over time or change to a different narcotic to achieve the same pain relieving effect. You also understand that if you are pregnant or become pregnant while taking these medications, your child would be physically dependent on the opiates and withdrawal con be life-threatening for a baby. Furthermore, you understand that many medications, including opiates, may harm a developing fetus.
4. Overdose on this medication may cause death by stopping your breathing; this can be reversed by emergency medical personnel if they know you have taken narcotic pain-killers. It is suggested that you wear a medical alert bracelet or necklace that contains this information.
5. If the medication causes drowsiness, sedation, or dizziness, you understand that you must not drive a motor vehicle or operate machinery that could put your life or someone else's life in jeopardy.
6. You understand it is your responsibility to inform the doctor of any and all side affects you have from this medication.
7. You agree to take this medication as prescribed and not to change the amount or frequency of the medication without discussing it with Dr. Cohen. Running out early, needing early refills, escalating doses without permission and losing prescriptions may be signs of misuse of the medication and may be reasons for the doctor to discontinue prescribing to you.
8. You agree that the opiates will be prescribed by only one doctor, and you agree to fill your prescriptions at only one pharmacy. You further agree not to take any pain medication or mind-altering medication prescribed by any other physician without first discussing it with Dr. Cohen. Also, you give permission for the doctor to verify that you are not seeing other doctors for opiate medication or going to other pharmacies.

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9. You agree to keep your medication in a safe and secure place. Lost, stolen or damaged medication will not be replaced.
10. You agree not to sell, lend, or in any way give your medication to any other person.
11. You agree not to drink alcohol or take other mood-altering drugs while you are taking opiate analgesic medication. If you agree to submit a urine specimen at any time that Dr. Cohen requests, and you agree for it to be tested for alcohol and drugs. Taking opiates with alcohol, sleeping medication, sedatives, barbiturates or anti-anxiety medications can be lethal. You will consult Dr. Cohen before taking any of these types of medications or chemicals with your pain medication.
12. Prescriptions for controlled substances are issued only during appointments which must occur at least monthly. You will not receive new prescriptions if you do not keep your appointments.
13. You understand that Dr. Cohen's office hours are: Monday – Friday, 9:00am – 5:00pm.

    ***The doctor may be reached at other times for emergencies only. You will not request medications after hours. You are to schedule your appointment well before your medications run out.***

14. The following are grounds for discharge from Dr. Cohen's practice:
    i. Altering or forgoing a prescription. This is a felony and will be reported.
    ii. Lying to Dr. Cohen or his staff about anything concerning your medical care.
    iii. Multiple missed appointments, late cancellations, or late appearances.
    iv. Repeated violations of this agreement
    v. Failure to appear or to produce urine for a random drug screening.
    vi. Persistent non-compliance with your pain treatment plane.
    vii. Use of illegal drugs or substances.
    viii. Disruptive, threatening or violent behavior.
15. You authorize a copy of this agreement to be sent to your pharmacy.
16. You agree that you will attend all required follow-up visits with the doctor to monitor your medication, and you understand that failure to do so may result in discontinuation of this treatment. You also agree to participate in other chronic pain treatment modalities recommended by the doctor.
17. You understand that there is a risk that opiate addiction could occur. This means that you might become psychologically dependent on the medication, especially if you begin to use it to change your mood or get high. People with past history of alcohol or drug abuse problems are more susceptible to addiction. If this occurs, the medication will be discontinued. And you will be referred to a drug treatment program for help with this problem.

    Please be aware that your treatment plan may change based on the outcome of therapy especially if pain medications are ineffective. Such medications will be discontinued.

    I understand that Dr. Cohen believes in the following "Pain Patients' Bill of Right."

You have the right to:

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a. Have your pain prevented or controlled adequately.
b. Have your pain and medication history taken.
c. Have your pain questions answered.
d. Know what medication, treatment or anesthesia will be given.
e. Know the risks, benefits and side effects of treatment
f. Know what alternative pain treatments may be available.
g. Ask for changes in treatments if your pain persists.
h. Receive compassionate and sympathetic care.
i. Receive pain medication on a timely basis.
j. Refuse treatment without prejudice from your physician.
k. Include your family in decision-making.

You acknowledge that the doctor may terminate this agreement at any time if he has cause to believe that you are not complying with the terms of this agreement or if he believes that or your compliance with the terms of this agreement you have made a misrepresentation of false statement concerning your pain.

You also understand that you may terminate this agreement at any time.

If the agreement is terminated, you understand that you will not be a patient of Dr. Cohen and you will likely be referred for chemical dependency treatment if clinically indicated.

Furthermore, you understand that medication is unlikely to completely eliminate your pain, but medication is expected to reduce it enough that you may become more functional and experience improvement in your quality of life.

By signing this agreement you confirm that any questions and concerns you have regarding treatment have been adequately answered and that a copy of this document has been given to you.

---

This agreement is entered on this day of _____, 20__.

Patient Name: _____

Patient Signature: _____

PHYSICIAN SIGNATURE _____

Dr. Marc A. Cohen M. D., FAAOS, FAC

Witness Signature: _____

Printed Name: _____

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## NEW PATIENT INFORMATION

**Date** _____

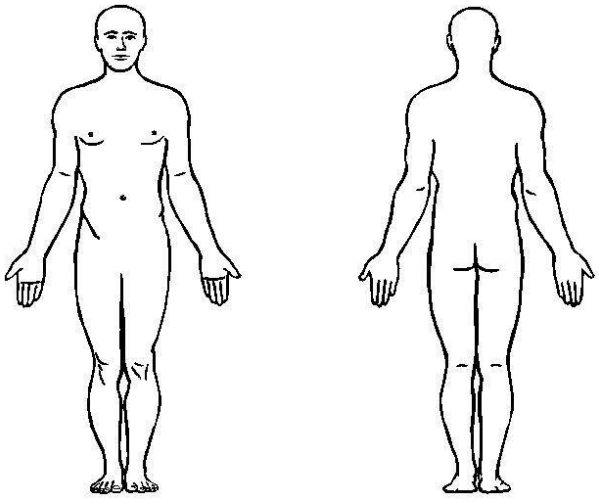
**Last Name** _____ **First Name** _____ **MI** _____

**DOB** _____ **Age** _____ **Sex** _____ **Weight** _____ **Height** _____

## ACCIDENT INFORMATION

**Is condition due to an accident? □ Yes □ No**
**Accident Date** _____
**Type of Accident: □ Auto □ Work □ Home □ Other**

**Work Status:**
**□ Full Duty □ Light Duty □ Off Duty per Physician**
**□ Unemployed □ Retired**
**If you're NOT working on full duty,**
**how long have you been off work?** _____



**Using the symbols below,**
**please indicate your symptoms on the picture to the right ➢**
**X=pain I=aching O=numbness *=pins & needles**

**Briefly describe your main problem/complaint. Also, describe the injury that caused these symptoms, if applicable.**

_____

_____

**When did your symptoms appear?** _____
**Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)** _____
**How long can you STAND with no or minimal pain? ___ minutes**
**WALKING DISTANCE with no or minimal pain?**
**□ 0-50 ft □ 50-200 ft □ 200-500 ft □ 500+ft □ ½ mile+**
**Do you need SUPPORT to help you walk? □ Yes □ No If yes, what kind?** _____
**Do you wear a back or neck BRACE? □ Yes □ No If yes, what kind?** _____

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**What position/activity makes the pain worse/better?**

| | Worse | Better | Comments |
|---|---|---|---|
| Bending | | | |
| Bowel Movement | | | |
| Coughing | | | |
| General Activity | | | |
| Home Remedies | | | |
| Lying Down | | | |
| Sitting | | | |
| Standing | | | |
| Walking | | | |

List below the **PREVIOUS PHYSICIANS** (MD, DO, Chiropractor) you have seen for your main complaint /problem.

| Physician | Specialty | Dates | Treatment |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Past **MEDICAL HISTORY** Check yes or no if you have had any of the following.

□ Yes □ No Bowel Disorder
□ Yes □ No Cancer (where? _____)
□ Yes □ No Depression
□ Yes □ No Diabetes
□ Yes □ No Heart Disease
□ Yes □ No High Blood Pressure
Other _____

□ Yes □ No Kidney Disease
□ Yes □ No Lung Disease
□ Yes □ No Pacemaker
□ Yes □ No Seizures
□ Yes □ No Stroke
□ Yes □ No Thyroid

List any **MAJOR SURGERIES** you've had.

| **Type** | **Date** | **Outcome** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**TOBACCO USE**

Do you currently use Tobacco products? Yes _____ No _____ Started Age/Year _____ Stopped _____
If yes, indicate the quantity per day:
Cigarettes_____ Cigars_____ Chewing Tobacco (snuff) _____

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**DRUG ALLERGIES**

| Drug | | | | Type of Reaction |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

List **ALL CURRENT MEDICATIONS** as follows

| Name | Dose (milligrams, grams) | | | | How Often (how many times a day) | How Long |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**ALCOHOL USE**

Do you currently consume alcoholic beverages? Yes_____ No _____

If yes, indicate the quantity per day:

Beer _____ Wine_____ Distilled Spirits _____

Have you ever been treated for drug of alcohol addiction? Yes _____ No _____

**PATIENT SIGNATURE_____ DATE _____**