PAIN MANAGEMENT

SENSITIVITY COMPASSION TREATMENT

TIMOTHY D. GROTH, MD PC

Dear Patient,

Welcome to our office. We look forward to meeting with you, reviewing your medical history, and working together to address the causes of your pain.

Enclosed you will find a patient questionnaire. It is very important that you take the time to complete this prior to your initial visit. This information will help us understand and treat all aspects of your pain condition. Please bring this information with you at the time of your first visit. In addition, we require that you present a photo I.D. and insurance card to the Registrar upon your arrival.

Due to HIPAA (government) regulations, it is your responsibility to obtain as many records as possible that are available to you. This would include office notes and diagnostic testing (MRI, CT Scan, EMG or X-ray reports). Complete and accurate information will enable us to meet your medical and other needs appropriately. Failure to do so may result in a delay of treatment, as our review of your records are essential in determining the fastest way to relieve your pain.

The last page of this packet is an "Authorization to Obtain Health Information". Please complete and sign the bottom of this form prior to your visit. If in the future you need copies of your records from this office, we require two weeks notice to process. A signed written request must be presented to our office with specific details of the records you are requesting.

Thank you very much for your cooperation. We look forward to meeting you.

Sincerely.

*** Diagnostic test reports ARE needed at time of consult.

Timothy Groth. MD
Director, Pain Management

994 West Jericho Turnpike • Smithtown, NY 11787 • Phone: 631.543.1440 • Fax: 631.543.1930

PAIN MANAGEMENT
TIMOTHY D. GROTH, MD PC
994 West Jericho Turnpike-Suite 104
Smithtown, NY 11787
Phone 631.543.1440 Fax 631.543.1930

Dear Patient,

As a courtesy, we will bill your insurance carrier directly. Please complete this form and return it to us as soon as possible. If you are insured through a union/local, please send us a completed claim form.

CO-PAYMENTS ARE EXPECTED AT THE TIME SERVICES ARE RENDERED

Last Name: _____ First: _____ Middle: _____
Date of Birth: _____ Age: _____ SS#: _____
Street: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

Primary Insurance: _____	Secondary Ins: _____
Company: _____	Company: _____
Address: _____	Address: _____
Phone #: _____	Phone #: _____
Insured's Name: _____	Insured's Name: _____
ID #: _____	ID #: _____
Group #: _____	Group #: _____
Place of Employment: _____	Place of Employment: _____
Work Phone #: _____	Work Phone #: _____

WORKER'S COMPENSATION/NO FAULT INFORMATON (If Applicable)

Do you have a no-fault insurance? ☐Yes ☐No Date of Accident: _____
Do you have workers comp insurance? ☐Yes ☐No Date of Accident: _____
Insurance Carrier: _____
Address: _____
Claim #: _____ WCB #: _____
Employer: _____ Phone: _____
Address: _____

Your cooperation in this matter is greatly appreciated

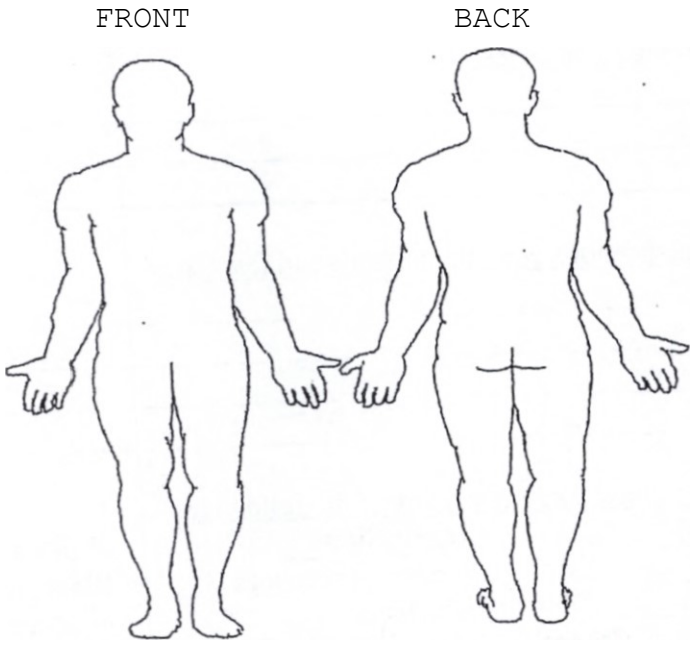
Name: _____ Date: _____

INITIAL CONSULT

Where is Your Pain Now?

Please use the appropriate symbols to describe your symptoms and mark the location as accurately as possible on the body drawing.

ACHING	ΛΛΛΛΛΛ
STABBING	////////
TINGLING	========
BURNING	xxxxxxxx
NUMBNESS	00000000



RIGHT LEFT LEFT RIGHT

How bad is your pain?

(No Pain) 1 2 3 4 5 6 7 8 9 10 (Worst)

List current medications for your neck/back:

_____ _____

_____ _____

DO NOT WRITE BELOW THIS LINE (FOR OFFICE USE ONLY)

Referred: _____

Pain:

When:

Better:

Worse:

P:

I:

T:

S:

BP: Pulse: BPM Height: Weight: POC:

MEDICAL HISTORY Name: _____ HEIGHT: _____
WEIGHT: _____

List all allergies and related reactions:

_____

_____

List all previous surgeries:

_____

_____

_____

List any medications you take (dosage and frequency):

_____ _____

_____ _____

_____ _____

_____ _____

Check if you have experience any of the following:

Indigestion __	Constipation __	Skin Rashes __
Diarrhea __	Swollen or sore legs __	Blackout/Dizziness __
Chest Pain __	Headaches __	Shortness of Breath __
Loss of Bowel Control __	Loss of Bladder Control __	Motion Sickness __

Family History (Please circle all that apply):

Diabetes Stroke High Blood Pressure Heart Disease Back or neck surgery

Other: _____

Social History:

Marital Status: _____ # of Children (if applicable) _____ Occupation: _____

Have you ever Smoked? NO YES How much? _____

Do you drink? NO YES How much? _____

Have you ever taken recreational drugs? (i.e. marijuana, cocaine) NO YES

Last time used: _____

Have you ever had (or still have)?

NO	YES		NO	YES		NO	YES	
__	__	Ulcer	__	__	CRPS	__	__	CAD/Angina/MI
__	__	Hiatal Hernia/Reflux	__	__	Arthritis	__	__	High Blood Pressure
__	__	Diabetes	__	__	Back Problems	__	__	Low Blood Pressure
__	__	Hepatitis	__	__	Polio/Meningitis	__	__	Stroke/TIA
__	__	Liver Problems	__	__	Jaw Problems/TMJ	__	__	Epilepsy/Seizures
__	__	Kidney Problems	__	__	Glaucoma	__	__	Lung Problems/Asthma
__	__	Thyroid Problem	__	__	Cancer	__	__	Mitral Valve Prolapse
__	__	Anemia	__	__	Blood Clots	__	__	Depression/Anxiety
__	__	Migraines	__	__	Chemotherapy/Radiation	__	__	

Name of Primary Care Physician: _____

Phone #: _____

PATIENT QUESTIONNAIRE

Today Date: _____

Your Information:

Last Name: _____ First: _____ Middle: _____

Date of Birth: ___ / ___ / _____ Age: _____ SS#: _____ - _____ - _____

Address: _____ City: _____ Zip Code: _____

Home Phone: ( )_____ Work Phone: ( )_____

Race (circle one): African-American / Asian / Caucasian / Hispanic / Native American

Emergency Contact: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Describe your pain:

Date problem started: ____ / ____ / _____

Is this injury from a motor vehicle accident? _____

Is this injury from a work-related accident? _____

Are you employed? _____

Describe your injury:

_____

_____

_____

_____

_____

_____

Which hand is dominant? Left Right

Do you experience any weakness? Left – Arm/Leg Right – Arm/Leg

Do you experience numbness/tingling? Left – Arm/Leg Right – Arm/Leg

Does pain interrupt your sleep? YES NO

Has pain changed your normal activities?

Sleeping _____	Dressing _____	Enjoyment of life _____
Walking _____	Hobbies _____	Exercising _____
Eating _____	Relationships _____	Mood _____
Sports _____	Work/housework _____	Other _____

How has your pain changed over time? Is it worse or better and please explain why:

_____

_____

_____

Please indicate on the following what makes the pain better (B), or worse (W):

_____ Heath	_____ Cold	_____ Humidity	_____ Sitting
_____ Standing	_____ Lying down	_____ Coughing	_____ Fatigue
_____ Ice	_____ Massage	_____ Noise	_____ Anxiety/Emotions
_____ Alcohol	_____ Sneezing	_____ Stairs	_____ Bowel Movements

Using this pain scale, please describe your pain at its worse/best:

0	1	2	3	4	5	6	7	8	9	10
No pain		Mild		Discomforting		Distressing		Horrible		Excruciating

Please circle any treatments you have undergone for your pain problem. Place a (+) to those that were effective and a (-) next to those that were not:

Acupuncture	Massage	Relaxation Therapy
Bed Rest	Nerve Blocks	TENS
Chiropractor	Physical Therapy	Traction
Epidural Steroid Injection	Psychotherapy	Trigger Point Injection
Other cortisone injections	Other (Specify) _____	

Please answer the following questions: (Mark each box that applies)

1. Family History of Substance Abuse:	Alcohol	[ ]
	Illegal Drugs	[ ]
	Prescription Drugs	[ ]
2. Personal History of Substance Abuse:	Alcohol	[ ]
	Illegal Drugs	[ ]
	Prescription Drugs	[ ]
3. Age (Mark box if 16-45)		[ ]
4. History of Preadolescent Sexual Abuse:		[ ]
5. Psychological Disease:	Attention Deficit Disorder	[ ]
	Obsessive Compulsive Disorder	[ ]
	Bipolar	[ ]
	Schizophrenia	[ ]
	Depression	[ ]

PAIN MANAGEMENT

SENSITIVITY COMPASSION TREATMENT

Please Fax records to:631.670.7567

TIMOTHY D. GROTH, MD PC

Authorization to Obtain Health Information

BOX IS FOR FUTURE USE IF NECESSARY

Doctor, Hospital Facility: _____

Address: _____

Patient Name: _____

Address: _____

Phone Number: _____ Date of Birth: _____

I authorize you to disclose health information of the above-named individual to:

Timothy D. Groth, MD PC
994 West Jericho Turnpike
Suite 104
Smithtown, NY 11787

Fax Number: 631.679.7567

Please select from below any information you would like to be sent to Dr. Groth to aid in your diagnosis and treatment. Please provide dates of service where it applies.

- ☐ Operative Report
- ☐ Anesthesia Record
- ☐ Discharge Instructions
- ☐ Discharge Summary
- ☐ EKG
- ☐ History and Physical
- ☐ Laboratory Results
- ☐ Consultation Reports from _____ to _____
- ☐ Medications Sheets
- ☐ Physicians Progress Notes from _____ to _____
- ☐ Physicians Orders from _____ to _____
- ☐ X-rays, MRI from _____ to _____
- ☐ Entire medical record
- ☐ Other: Specify _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency (HIV), behavioral or mental health services, and treatment for alcohol and drug abuse. For AIDS and HIV status, the department of Health Authorization must be completed instead of this authorization.

I understand that I have a right to revoke this authorization at any time; I must do so in writing and present my written revocation to Medical records. Unless revoked, this authorization will expire on the following date, event or condition.

_____

(You may indicate "none" if you wish to indicate a specific date)

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain copies of the information to be used or disclosed, as provided in the applicable Federal and State law. If I have questions about the disclosure of my health information, I can contact the medical records department.

Signature of Patient: _____ Date: _____

Timothy D. Groth, MD. PC.
Pain Management
994 W. Jericho Turnpike Suite 104
Smithtown, NY 11787

NOTICE OF PRIVACY PRACTICES

I, _____ understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information will be used to:

**Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and indirectly.

**Obtain payment from third party payers.

**Conduct normal healthcare operations such as quality assessments and Physician certifications.

I understand that I may request in writing that Dr. Groth's office restrict how my private information is to be used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that Dr. Groth's office is not required to agree to my requested restrictions but are bound to abide by such restrictions to them.

List below any friend or family member(s) you give the authority to pick up information concerning your treatment if you are unable to come to the office.

I have read and/ or received a copy of the HIPAA Notice of Privacy Practice.

Name	Relationship to patient
Name	Relationship to patient
Name	Relationship to patient
Patient Signature	Date

NOTICE OF DISCLOSURE OF OWNERSHIP INTEREST

Corporations, including local physicians own the North Shore Surgi-Center and Suffolk Surgery Center, one of whom is Timothy D. Groth, MD. These physicians have become owners as a result of their commitment to quality healthcare and services to their patients.

The North shore Surgi-Center and Suffolk Surgery Center may have a financial relationship with your physician as indicated above. You have the right to choose where to receive services, including and entity in which your physician may have a financial relationship.

St. Catherine of Siena Medical Center
50 Route 25A
Smithtown, NY 11787
(631) 862-3000

Peconic Bay Medical Center
1300 Roanoke Ave.
Riverhead, NY 1 901
(631) 548-6000

PLEASE INITIAL HERE _____

PAIN MANAGEMENT RISKS AND COMPLICATIONS

CORTISONE INJECTIONS may have the following side effects: increased appetite, facial flushing, fluid retention, feeling your heart racing and feeling energized. Frequent repetitive cortisone injections can increase bone loss and contribute to osteoporosis. Therefore, we recommend that you take Calcium and Vitamin D.

INTERVENTIONAL PAIN MANAGEMENT injections are safe and have a long track record with complications occurring rarely. However, the complication rate is not 0%. The most common complication is a post dural puncture headache (Spinal Headache), which occurs in the approximately 1% of cases.

EXTREMELY RARE COMPLICATIONS including bleeding, infection or adverse reaction to medication, which can result in death, paralysis, loss of bowel or bladder control, increased pain or weakness or the need to emergency surgery.

I have been informed of the risk of developing tolerance, or an addiction to opioids, and also of the risk of addiction to any newborn children of female patients taking opioids while pregnant.

I give permission of the prescribing physician to contact my pharmacy directly, at the physician's discretion, to review and evaluate data. My signature below grants permission to release such requested information.

I, _____, understand all of the above and will comply.

Patient Signature: _____ Date: _____

PAIN MANAGEMENT AGREEMENT

TIMOTHY D. GROTH, MD
GULLE N. AWAN, DO and LISANNE CRUZ, DO

Please initial each item:

____ I will not request any controlled substance or medications or prescriptions from another physician or practice while I am receiving such medications from Dr. Groth and Dr. Awan unless discussed with Dr. Groth or Dr. Awan previously. You must notify this office if additional medications are prescribed by another healthcare provider (e.g., a hospital or an emergency room).

____ Refill prescriptions for controlled maintenance medications will be re-written every 30 days. It is your responsibility to schedule a monthly office visit. Be sure to make your appointment AT LEASET 2 weeks in advance.

____ A single pharmacy will provide the medication. At the beginning of this agreement you must designate the name of that pharmacy. The name and address of the pharmacy are as follows:

_____

_____

____ Lost medications or pain medication prescriptions will not be replaced.

____ You will be subject to urine testing upon request, which will test for the presence of any drugs in your system.

____ Any breach of agreement will result in permanent discharge from the practice.

____ I understand that my medication may make me drowsy and that my reflexes and reactions may be slowed. I agree that such things like operating heavy machinery or equipment, a motor vehicle or working in unprotected conditions may result in harming others or myself. I understand I must be responsible for my actions while taking any controlled substances.

____ I AGREE NOT TO DRINK ANY ALCOHOL BEVERAGES WHILE I AM TAKING MEDICATIONS PRESCRIBED BY THIS OFFICE.

Pharmacy Name: _____ Pharmacy Number: _____

Pharmacy Address: _____

_____ _____
Patient Signature Date

PATIENT INFORMED CONCENT FOR OPIOID TREATMENT FORM

PATIENT INFORMED CONSENT FOR OPIOID TREATMENT FORM

Patient Name: _____ WCB Claim #: _____

Doctor Name:

I plan to take a pain medicine called OPIOIDS. This pain medicine may help improve my pain but it may also cause some serious problems. The problems may be worse if I mix the pain medicine with alcohol or other drugs.

I understand that the pain medicine I will be taking may cause serious problems including:

- ⇨ Confusion
- ⇨ Poor Judgment.
- ⇨ Nausea (a stomach ache).
- ⇨ Vomiting.
- ⇨ Constipation (hard stools that may be painful to push out).
- ⇨ Sleepy or drowsy feeling.
- ⇨ Poor coordination and balance (such as feeling unsteady, tripping, and falling).
- ⇨ Slow reaction time.
- ⇨ Slow breathing or I can stop breathing – which could cause me to die.
- ⇨ More depression (such as feeling sad, hopeless, or unable to do anything)
- ⇨ Dry mouth.
- ⇨ Increased feeling of pain (hyperalgesia).
- ⇨ Addiction (it may be very hard to stop taking the pain medicine when I'm ready to quit).
- ⇨ For men: the pain medicine may lead to less interest in sex and poor sexual performance.
- ⇨ For pregnant women: the pain medicine may hurt my unborn child and may cause my child to be born addicted to the pain medicine.

I will tell my doctor if I have any of the problems listed here.
I understand there may be other problems caused by the pain medicine, in addition to the problems listed here.

I understand that these problems may get better when I stop taking the pain medicine.
My doctor has reviewed the serious problems that this pain medicine may cause. My doctor has answered all questions that I have about this pain medicine and the serious problems it may cause.

Patient Signature: Date:

I attest that this form was reviewed by me with the patient and all questions were answered.

Doctor Signature: *Timothy Groth* Date:

PATIENT UNDERSTANDING FOR OPIOID TREATMENT FORM

PATIENT INFORMED CONSENT FOR OPIOID TREATMENT FORM

Patient Name: _____ WCB Claim #: _____

Doctor Name:

I am taking a pain medicine called OPIOIDS to help improve my pain.

I agree (the patient must initial each box to show agreement):

- ☐ I will take my pain medicine exactly the way my doctor tells me to. That means I will take the right amount of pain medicine at the right time.
- ☐ I will tell my doctor about any new medical problems.
- ☐ I will tell my doctor about all medicine I take, and will tell my doctor if I am given any new medicines.
- ☐ I will tell my doctor if I see another doctor, or if I go to the Emergency Room
- ☐ I will only get my pain medicine prescription form this doctor. My doctor's name is listed on the top of this page.
- ☐ If my doctor is away, I will only get medicine from the doctor who is in charge while my doctor is away.
- ☐ I will only get my pain medicine from one pharmacy (drug store).
- ☐ I will follow my doctor's directions about therapy, exercises and physical things to do so I can learn to live with my pain.
- ☐ I will do what I can to get back to work.
- ☐ I will not drink alcohol or use any other drugs unless I am told to do it by my doctor.
- ☐ When I am asked, I will get lab tests to see if I am taking my medicines the right way.
- ☐ If the lab tests show that I am not taking the medicines the way I should, my doctor may cut downs or stop my medicine or send me to a specialist or special program to help care for me.
- ☐ I will store my pain medicine in a safe place where other people cannot take it.
- ☐ I will keep my scheduled appointments. If I must miss an appointment, I will call my doctor to cancel at least 24 hours before the appointment.
- ☐ My doctor may stop giving me pain medicine if:
  - I do not follow this agreement.
  - The pain medicine is not helping me.
  - I'm not meeting my goals in active therapy.
  - My pain or my functions do not improve.
  - I have bad side effects from the pain medicine.
  - I become addicted to the pain medicine.
  - I give or sell the pain medicine to someone else.
- ☐ I am not pregnant and I will call my doctor as soon as possible if I think I may be pregnant.

Patient Signature: _____ Date: _____

I attest that this form was reviewed by me with the patient and all questions were answered.