HEALTHCAREPATIENT REGISTRATION

Today's Date: _____

Referral Doctor: _____ Referral Doctor Phone#: _____

Family Doctor: _____ Family Doctor Phone#: _____

Name: _____ DOB: _____ SSN#: _____

Gender: □ *Male* □ *Female* Marital Status: □ *Married* □ *Single* □ *Divorced*

Street Address: _____City: _____ State: _____ Zip Code: _____

Mobile phone: _____ Home phone: _____ Alternate phone: _____

Email:_____

Emergency Contact: _____ Relationship: _____ Phone: _____

Current Employment Status: □ *Full time* □ *Part time* □ *Retired* □ *Student* □ *Home maker*
□ *Unemployed* □ *Disabled* □ *Self-employed*

Most Recent Occupation: _____ Employer: _____

Primary Insurance: _____Secondary Insurance: _____

Policy holder Name: _____ Policy Holder Name: _____

Policy holder DOB: _____ Policy Holder DOB: _____

Height: _____ Weight: _____

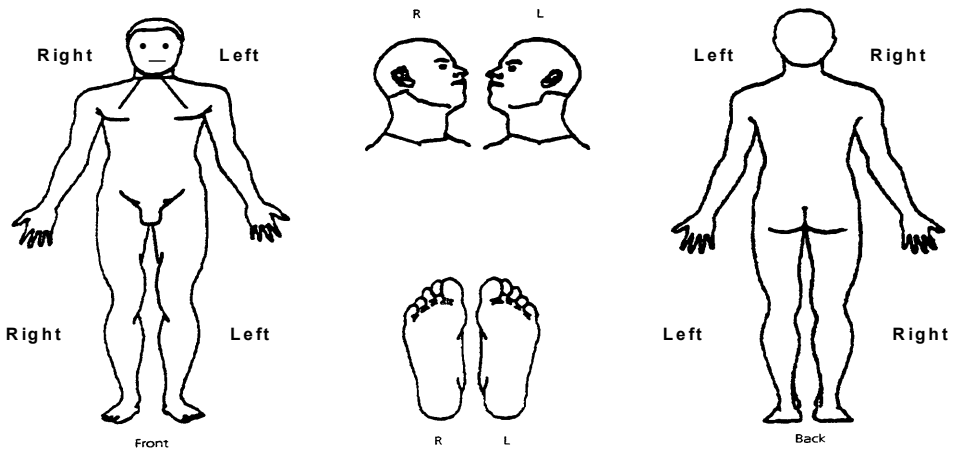
Do you smoke? □ *Yes* □ *No*If Yes, how much? _____

Do you consume alcohol? □ *Yes* □ *No*If Yes, how often? _____

Do you have any allergies (food and medicine)? □ *Yes* □ *No* If Yes, please list _____

Describe the reason for today's visit in detail:

Location of Pain: Please shade in the painful areas in the diagram below. Put "x" on areas of tingling, "o" on burning areas, and "*" on areas with no feeling at all.



Least Pain level (0 being the least amount of pain): 0 1 2 3 4 5 6 7 8 9 10

Worst Pain level (0 being the least amount of pain): 0 1 2 3 4 5 6 7 8 9 10

Which of the following make your pain feel worse? Check all that apply.

□ *Sitting* □ *Standing* □ *Walking* □ *Lying down* □ *Bending forward* □ *Bending backwards*

□ *Morning hours* □ *Evening hours* □ *Coughing, Sneezing* □ *Damp weather*

□ *Physical therapy* □ *Getting out of bed* □ *Stress*□ *Other:*_____

Which of the following make your pain feel better? Check all that apply.

□ *Sitting* □ *Standing* □ *Walking* □ *Lying down* □ *Bending forward* □ *Bending backwards*

□ *Morning hours* □ *Evening hours* □ *Relaxation* □ *Physical therapy* □ *Acupuncture*

□ *Heat*□ *Ice pack* □ *Alcoholic*□ *Other:*_____

Please list treatment and provider you had for your pain:

□ *Over the counter Pain Killer (such as Motrin, Advil, Aspirin, Aleve, Tylenol)*

□ *Chiropractic (How long? _____ Doctor/Facility? _____)*

□ *Physical Therapy (How Long? _____ Doctor/Facility? _____)*

□ *Acupuncture (How long? _____ Doctor/Facility? _____)*

□ *Surgery (What Surgery? _____ Doctor/Facility? _____)*

□ *Pain Injections (such as epidurals, facet injections, joint injections,etc)*

□ *Other: _____*

Please check and list your past medical history: □ ***None***

□ *Hypertension(high blood pressure)* □ *Diabetes* □ *Coronary Artery Disease*
□ *Acid Reflux* □ *Chronic Low Back Pain* □ *Depression* □ *Anxiety Disorder* □ *Fibromyalgia*
□ *COPD (chronic lung disease)* □ *Asthma* □ *Osteoarthritis* □ *Rheumatoid Arthritis*
□ *Hyperthyroidism* □ *Hypothyroidism* □ *High Cholesterol* □ *Migraine Headache* □ *Cluster Headache*

_____
_____

Please check and list your past surgical history year:□ ***None***

□ *Back Surgery* □ *Neck Surgery* □ *Heart Surgery* □ *C-Section*
□ *Eye Surgery*

_____
_____
_____

Please list MEDICATIONS with dosage and frequency you are taking:□ ***None***

_____
_____
_____
_____
_____

Are you taking blood thinners?

□ *Yes (*□ *Aspirin* □ *Plavix* □ *Coumadin/Warfarin* □ *Other_____)* □ *No*
If Yes, Cardiologist _____ Phone# _____

Are you taking Benzodiazepine (i.e. valium, ativan, klonopin)?

□ *Yes* □ *No*

Have you ever had seizure?

□ *Yes* □ *No*If Yes, Neurologist _____ Phone# _____

Note To Patients: For your safety, you MUST inform our providers ANY medication changes every time you see our providers.

Signature_____ Date_____

MANDATORY SURVEY

WeCare Medical Specialty Group is participating in the U.S. Department of Health and Human Services' "Meaningful Use" Program in order to provide better patient care. This program will lead to improved electronic communications and a more complete medical record for our patients. As part of this program, we are required to collect patient information such as race, ethnicity and primary language. If you prefer not to share this information, please feel free to choose the option "I Prefer Not to Report".

Race: □ *American Indian or Alaska Native*
□ *Asian*
□ *Black or African American*
□ *Native Hawaiian or Other Pacific Islander*
□ *White*
□ *Unknown or Other*
□ *I Prefer Not to Report*

Ethnicity: □ *Hispanic or Latino*
□ *Not Hispanic or Latino*
□ *I Prefer Not to Report*

Primary Language: □ *English*
□ *Spanish*
□ *Portuguese*
□ *Polish*
□ *French*
□ *German*
□ *Italian*
□ *Other Language* _____
□ *I Prefer Not to Report*

Smoking Status: □ *Never Smoked*
□ *Former Smoker*
□ *Current Some Day Smoker*
□ *Current Every Day Smoker*

The choices of Race and Ethnicity are consistent with choices used in US Census surveys.

WeCare Medical Specialty Group will offer our patients free online access to certain portions of their personal health records through a "patient portal". In addition, patients can request electronic copy of health information. The clinical summaries for each office visit will be ready for patient to pick up within three business days.To participate, we need your email address to enroll you into the patient portal. *If you do not have an email or you do not want to give us your email, please instead write down "I do not have an email" or "I do not want to share my email."*

Patient's Email Address:_____

Preferred weekday and time for appointment reminder phone call: _____

CONSENTS AND DISCLOSURE

Patient name: _____ Date: _____

ASSIGMENT OF BENEFITS AND INSURANCE AUTHORIZATION

I hereby authorize WeCare Medical Specialty Group to furnish information to insurance carriers concerning my illness and treatments and bill insurance carriers on behalf of me using my out of network benefit. I hereby assign all payments, for medical services rendered to myself or my dependent, unconditionally to WeCare Medical Specialty Group. I do understand that I am responsible for any amount not covered by my insurance and that should my insurance company send the payment to me, I will forward the payment within 48 hours to WeCare Medical Specialty Group.

Patient Signature:_____

CONSENT TO APPEAL OF DENIAL

I hereby authorize WeCare Medical Specialty Group to file appeal with my insurance carrier on behalf of me in case of denial of service and payment.

Patient Signature:_____

NO FAULT AND/OR WORKER'S COMPENSATION PATIENTS *ONLY*

I hereby authorize the release of my medical chart, bills and/or any other information related to my treatment, to my attorney _____. I further authorize WeCare Medical Specialty Group to pursue payment of my bills. I understand that all medical bills will be submitted to the responsible insurance carrier and will only be submitted to my medical insurance carrier in the event that payment is denied and/or there is remaining balance which I am responsible for. I understand that I am directly and fully responsible for all medical bills and if needed your attorney will arbitrate my bills for payment.

Patient Signature:_____

HIPPA PRIVACY ACKNOWLEDGEMENT

I acknowledge that I have been provided with a copy of WeCare Medical Specialty Group privacy notice, which is effective as of today's date.

Patient Signature:_____

DISCLOSURE OF FINANCIAL INTEREST

We wish to inform you that the doctor of WeCare Medical Specialty Group does have a financial interest in:*Pleasantdale Ambulatory Care, Middlesex Surgery Center, Surgicore Surgery Center, International Center for Minimally Invasive Spine Surgery.* You may, of course, choose to have your treatment at any of the health care facilities that we participate with.

Patient Signature:_____

CONTROLLED SUBSTANCE AGREEMENT AND INFOMED CONSENT

I acknowledge that I have been informed of WeCare Medical Specialty Group clinic policy and agreement on controlled substance and agree to abide the terms if I am placed on the controlled substances. Any violation of the clinic policy and agreement may cause termination of medication therapy at the discretion of my physician.

Patient Signature:_____

In Network/Out-of-Network Advance Patient Notice Form

You are seeking service(s) from WeCare Medical Specialty Group. Our practice will never let economics and finances impede our outstanding care or limit the opportunity for a patient to be seen irrespective of their ability to pay. Given the number of plans within various health plans, it is possible that WeCare Medical Specialty Group may be a non-preferred or an out-of-network provider for your insurance.

You have the right to receive services at a participating facility or by a participating physician or provider with your insurance company in order to obtain full benefits under your health coverage. if you have questions or would like to locate or to insure that you have in-network physician, provider or facility to provide the service or procedure, please contact your insurance customer service at the telephone number listed on your insurance identification card.

To be completed by the patient or patient's legal guardian

By placing my signature on this waiver form below, I acknowledge the following:

1. I am aware that WeCare Medical Specialty Group may not participate with my insurance discounts or write-offs. If WeCare Medical Specialty Group is not participating, my charge for today's visit will be applied toward any balances. Other procedures may require separate payment of deducible or co-insurance and I understand that WeCare Medical Specialty Group will work with me to insure the balances are not burdensome or provide financial hardship.

2. I understand that I may be responsible for additional costs for all services provided by WeCare Medical Specialty Group, as specified in my benefit contract, but that these fees can be negotiated or written off in the event they constitute a financial hardship for me.

3. I may take the opportunity to contact my insurance before obtaining services by WeCare Medical Specialty Group to confirm i) my benefits for these services, ii) to obtain prior authorization if needed, and to iii) obtain names of participating facilities and/or participating providers that can provide recommended services or procedures.

4. I understand that absent special circumstances (e.g., financial hardship), the non-participating facility/provider is prohibited from waiving co-payments, deductibles, coinsurance or other member cost sharing amounts.

5. I am voluntarily choosing on behalf of myself or my child/legal guardian to obtain the services or procedures from WeCare Medical Specialty Group.

6. I will immediately within 4 days of receipt forward any payments made to me in relation to the services performed by WeCare Medical Specialty Group unless expressly discussed with WeCare Medical Specialty Group.

Patient Signature:_____ Date: _____

PATIENT AUTHORIZATION FORM

Patient Name: _____ DOB: _____

I hereby request and authorize my health care provider _____to release my health record to WeCare Medical Specialty Group. The information includes but is not limited to:

I hereby also request and authorize my healthcare carrier, my treating physician and doctor, and lab to disclose, make available and furnish to WeCare Medical Specialty Group all information including: healthcare insurance, medical records, X-rays, MRI report, IME report and/or copies thereof related to my examination, confinement of treatment and to permit WeCare Medical Specialty Group to inspect and make copies, or abstracts thereof.

Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

Please send the records by fax, mail or email to:

2040 Millburn Ave #201, Maplewood, NJ 07040

Phone: 973-996-2990 Fax: 908-242-3911

Email: officemanager@wecaremedical.us

I understand that after the custodian of records discloses my health information it may no longer be protected by Federal privacy laws. I further understand this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Patient Signature: _____ Date: _____

Controlled Substance Agreement and Informed Consent Form
(please sign with your initial on each page)

The following agreement relates to my use of controlled substances including but not limited to "narcotics/opioids," to treat chronic pain. I will be provided with prescriptions only if I understand and agree to the following:

1. I understand that, depending on the drug and dose, I can become physically dependent on the medication and can develop withdrawal symptoms if the medication is stopped suddenly or the dose reduced rapidly. Although the risk is small there is a chance of developing an addiction to controlled substances if I am placed on them to help control my pain.

2. Controlled substances can cause sedation, confusion, or other changes in mental state and thinking abilities. I understand that the decision to drive while I am taking controlled substances is my own decision, and I agree not to be involved in any activity that may be dangerous to me or someone else such as driving or operating any dangerous equipment, working in unprotected heights or being responsible for another individual who is unable to care for himself or herself if I am in any way sedated, feel drowsy or a not thinking clearly.

3. I will not use any illegal controlled substances including, but not limited to, marijuana and cocaine. I will not drive while intoxicated with alcohol.

4. The WeCare Medical Specialty Group policy regarding the dispensing of controlled substances requires that I be seen regularly and I agree to make and keep my appointments. I will advise my doctor of all other medicines and treatments that I am receiving.

5. If the medication requires adjustment, an appointment must be made to see the doctor. No adjustments will be made over the telephone. My careful planning is required. I understand that medication refills and adjustments are done during office appointments except under very unusual circumstances. I must stay with the prescribed dosing so that I do not run out of medication early. The medication is expected to last until the date that is found on the bottom of the prescription. I understand that the WeCare Medical Specialty Group policy is not to prescribe early. I agree that I will use my medication exactly as prescribed and that if I run out early, I may go without medication until the next prescription is due, possibly resulting in withdrawal symptoms.

6. I understand that the prescriptions are my responsibility once they are placed in my hand and that if anything happens to my prescription (lost, stolen, accidentally destroyed), I may not receive a replacement from my physician. WeCare Medical Specialty Group expects me to file a police report if my medication is stolen. I will be prepared to bring in a copy at my next office visit.

7. My physician will prescribe whatever medication he/she is comfortable with and thinks best; he/she is not under any obligation to prescribe any specific medication.

8. I am aware of the possible risks and benefits of other types of treatments that do not involve the use of opioids. The other treatments discussed included: injections, therapy, and surgery (if indicated).

9. I agree to come to the WeCare Medical Specialty Group with my medication on the same day that I am called and submit to a pill count, and/or urine or blood screening to detect illegal substances or confirm proper use of prescribed medicine. The call to come to the WeCare Medical Specialty Group can be made either randomly, or if a concern arises. I may be required to bring my unused medication routinely to each office visit. If I do not have insurance or my insurance denies testing, I will be responsible for the cost of the test.

10. I give permission to the WeCare Medical Specialty Group staff to call any pharmacy or another health care provider at any time, without my being informed, to discuss my past or present use of controlled or illegal substances.

11. I will not use my pain medication in higher than prescribed amounts for new problems that arise (toothache, surgery, etc.) unless authorized to do so. I will inform my other doctor(s) of my use of medication for

chronic pain, and I will inform the WeCare Medical Specialty Group staff if another physician prescribes controlled substances for the acute problem. My doctor at WeCare Medical Specialty Group is my primary doctor with regard to my pain medications. If there is a medical emergency (e.g. broken leg, surgery requiring post-op pain medication, dental procedures, etc.), another doctor may prescribe pain medication to me, but I will advise the prescribing doctor of my care at WeCare Medical Specialty Group, authorize the doctor to disclose information to WeCare Medical Specialty Group, and I will also notify my doctor at WeCare Medical Specialty Group of the medication and dosage.

12. (Females only) Because of the risks of certain medications to unborn children, I will inform all physicians, obstetrician/gynecologist and WeCare Medical Specialty Group, immediately if I become pregnant or decide to try to become pregnant. I am aware that should I carry a baby to delivery while taking these medicines, the baby will be physically dependent upon opioids. I am aware the use of opioids is not generally associated with risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

13. (Males only) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

14. My physician can wean me off of controlled substances at any time if he/she feels that it is in my best interest. The weaning process can result in withdrawal symptoms. If I am weaned off, the WeCare Medical Specialty Group staff may inform my other health care providers as to the reasons for the weaning.

15. Abstinence Syndrome (Withdrawal Syndrome): Stopping my opioid, antiseizure or antidepressant medication abruptly may result in withdrawal symptoms (flu-like symptoms, GI distress, diarrhea, sweating, heart palpitations, and rarely seizures or death). I should wean from my medications rather than stopping them abruptly. If I find myself without medication, I will use the emergency line to notify my doctor.

16. I understand that in general I may be weaned off of my medication or my drug therapy may be terminated at the discretion of my physician if any of the following occur:a)It is the opinion of my physician that controlled substances are not very effective for my pain and/or my functional activity is not improved.b)I misuse the medication.c)I develop rapid tolerance or loss of effect from this treatment.d)I develop side effects that are significant and detrimental to me.e)I obtain controlled substances from sources other than my WeCare Medical Specialty Group physician without informing him or her.f)Pill counts or test results indicate the improper use of the prescribed medication or the use of other drugs, and/or I fail to submit to such counts/tests on the day that I am called.g)I am arrested and/or convicted for a controlled or illicit drug violation including drunk driving.h)Any violation of this agreement.

17. I further understand that my drug therapy will be terminated or detoxification in a controlled environment will be required if I give away, sell, distribute and/or transport with the intent to sell or dispense my medication.

18. I choose to use _____ Pharmacy, located at _____, for all of my pain medication prescriptions. I will not fill partial prescriptions, if my pharmacy does not stock the full quantity of medication. If I change my pharmacy for any reason, I agree to notify my pain physician.

I have read the above Agreement, understand the Agreement, have had all my questions concerning this Agreement answered to my satisfaction, and I agree to abide by the terms of this Agreement if I am placed on controlled substances (including, but not limited to narcotic analgesics). I have received a copy of the Agreement. By signing this form voluntarily, I give my consent for the treatment of my pain with narcotic/opioid pain medicines.

_____ _____

Patient Date

_____ _____

Physician Date