Corda Pain Institute

877-740-4888

Serving South Jersey for over 30 Years

P.O. Box 8890, Turnersville, NJ 08012

Browns Mills	856-740-4888
Cherry Hill	856-616-0900
Jersey City	877-740-4888
Linwood	609-813-2113
Vineland	856-691-0361
Williamstown	856-740-4888

Please fill out this entire packet of information before you arrive.

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ SS#: _____

Marital Status: _____ Race: _____ Ethnicity: _____

Email: _____

Pharmacy Name & Number: _____

Emergency Contact Name & Number: _____

Primary Care Physician Name & Number: _____

Employer name: _____

I have been informed that Dr. Peter Corda, Dr. Jeffery Poleer and Dr. Vannette Perkins, have small investment interest in the following surgical centers: Premier Surgical Center, AlantiCare Surgical Center. Dr. Peter Corda, Dr. Jeffery Poleer have a small investment interest in Jersey Shore Medical Center. Dr. Vannette Perkins has a small investment interest in Premier Orthopedic Surgical Center.

Signature: _____ Print Name: _____ Date: _____

Attached is a packet of information, please fill out and bring with you on the day of your scheduled appointment. **MUST BRING YOUR MOST CURRENT LAB/X-RAY/MRI REPORTS (NOT JUST FILMS) WITH YOU, DO NOT FAX OR MAIL THEM TO THE OFFICE.** If your records are extensive, bring at least the notes from your doctor(s) from the last 6 months to a year. The more information you have, the better understanding the doctor has of your condition. **IF YOU DO NOT BRING IN THE PACKET, REPORTS, AND YOUR RECORDS, YOU WILL BE RESCHEDULED.**

Your also MUST present a picture ID (ex: driver's license, NJ State ID) and your insurance cards. Please remember if you have CO-PAY to bring it with you at the time of your visit.

Name: _____ Age: _____ Sex: _____

Height: _____ Weight: _____

Is your pain secondary to:

Work Injury: _____ Motor Vehicle Accident: _____ Other: _____

Date it Occurred: _____

Give short summary of how pain started: _____

_____

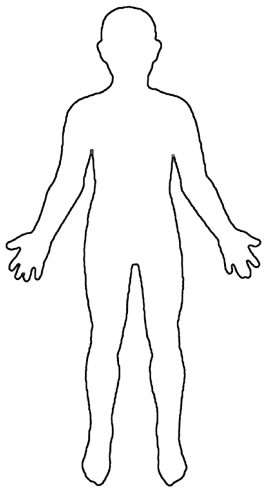
_____

What treatment have your tried? Physical Therapy: _____ TENS: _____ Surgery: _____

Chiropractic: _____ Injections: _____ Medications: _____

Present Pain (0-10): _____ Worst Pain: _____ Best Pain: _____

Where is your worst pain: _____



Occupation: _____ Currently Working: Yes _____ No: _____

Disability: No: _____ Permanent: _____ Temporary: _____

Smoker: Yes: _____ No: _____ Previous: _____ (__packs/day)

Social History: Single: _____ Married: _____ Divorced: _____ Widow: _____

Family History (ex: diabetes, heart disease, back problems: _____

_____

<u>Past Medical History:</u>

Cardiac:	Yes: _____	No: _____	Lung:	Yes: _____	No: _____
Heart Attack:	Yes: _____	No: _____	Asthma:	Yes: _____	No: _____
High Cholesterol:	Yes: _____	No: _____	Sleep Apnea:	Yes: _____	No: _____
High Blood Pressure:	Yes: _____	No: _____	COPD:	Yes: _____	No: _____
Other: _____			Other: _____		

Gastrointestinal: Yes: ____ No: ____

Peptic Ulcer: Yes: ____ No: ____

Gastritis: Yes: ____ No: ____

Reflux: Yes: ____ No: ____

Hepatitis: Yes: ____ No: ____

Hiatal Hernia: Yes: ____ No: ____

Irritable Bowel: Yes: ____ No: ____

Other: _____

Neurological: Yes: ____ No: ____

Seizure: Yes: ____ No: ____

Stroke: Yes: ____ No: ____

Headaches: Yes: ____ No: ____

Shingles: Yes: ____ No: ____

RSD: Yes: ____ No: ____

MS: Yes: ____ No: ____

Other: _____

Endocrinology: Yes: ____ No: ____

Diabetes: Yes: ____ No: ____

Thyroid: Yes: ____ No: ____

Sexual Dysfunction: Yes: ____ No: ____

Other: _____

Psychology: Yes: ____ No: ____

Depression: Yes: ____ No: ____

Bipolar: Yes: ____ No: ____

Schizophrenia: Yes: ____ No: ____

Other: _____

Orthopedics: Yes: ____ No: ____

Low Back Pain: Yes: ____ No: ____

Neck Pain: Yes: ____ No: ____

Knee Pain: Yes: ____ No: ____

Elbow Pain: Yes: ____ No: ____

Hip Pain: Yes: ____ No: ____

Carpal Tunnel: Yes: ____ No: ____

Rheumatoid Arthritis: Yes: ____ No: ____

Other: _____

Urology: Yes: ____ No: ____

Kidney Stones: Yes: ____ No: ____

Pelvic Pain: Yes: ____ No: ____

Headaches: Yes: ____ No: ____

Other: _____

Cancer: Yes: ____ No: ____

Type: _____

Metastic: Yes: ____ No: ____

Past Surgical History:

Orthopedics: Yes: ____ No: ____

Neck Surgery: Yes: ____ No: ____

When: _____

Knee Arthoscopy: Yes: ____ No: ____

Left: ____ Right: ____

Knee Replacement: Yes: ____ No: ____

Left: ____ Right: ____

When: _____

Back Surgery: Yes: ____ No: ____

When: _____

Hip Replacement: Yes: ____ No: ____

Left: ____ Right: ____

When: _____

Other: _____

Cardiac: Yes: ____ No: ____

By-Pass: Yes: ____ No: ____

Stent: Yes: ____ No: ____

Carotid: Yes: ____ No: ____

Other: _____

General: Yes: ____ No: ____

Appendix: Yes: ____ No: ____

Tonsil: Yes: ____ No: ____

Gall Bladder: Yes: ____ No: ____

Hernia: Yes: ____ No: ____

Other: _____

Urology: Yes: ____ No: ____

Prostate: Yes: ____ No: ____

Kidney: Yes: ____ No: ____

Hysterectomy: Yes: ____ No: ____

Tubal: Yes: ____ No: ____

Other: _____

Any Other Surgeries: _____

_____

_____

Any other system problems (Ex: fever, chills, cough, constipation, ETC):

List Medications:

Allergies:

Iodine/Dye: Yes: ____ No: ____ Latex: Yes: ____ No: ____

Other:

Past Illicit Drug Use: Alcohol:

Hepatitis: Yes: ____ No: ____ HIV/AIDS: Yes: ____ No: ____

Type:

History of Malignant Hyperthermia: Yes: ☐ No: ☐

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There is no right or wrong answer.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
How often do you have mood swings?	☐	☐	☐	☐	☐
How often have you felt a need for higher doeses of medications to treat your pain?	☐	☐	☐	☐	☐
How often have you felt impatient with your doctors?	☐	☐	☐	☐	☐
How often have you felt that things are just too overwhelming that you can't handle them?	☐	☐	☐	☐	☐
How often is there tension in your home?	☐	☐	☐	☐	☐
How often have you counted your pain pills to see how many are remaining?	☐	☐	☐	☐	☐
How often have you been concerned that people ill judge you for taking pain medication?	☐	☐	☐	☐	☐
How often do you feel bored?	☐	☐	☐	☐	☐
How often have you taken more pain medication than you were supposed to?	☐	☐	☐	☐	☐
How often have you worried about being left alone?	☐	☐	☐	☐	☐
How often have you felt a craving for medication?	☐	☐	☐	☐	☐
How often have others expressed concern over your use of medication?	☐	☐	☐	☐	☐
How often have any of your close friends had a problem with alcohol?	☐	☐	☐	☐	☐
How often have others told you that you have a bad temper?	☐	☐	☐	☐	☐
How often have you felt consumed by the need to get pain medication?	☐	☐	☐	☐	☐
How often have you run out of medication?	☐	☐	☐	☐	☐
How often have others kept you from getting what you deserve?	☐	☐	☐	☐	☐
How often, in your lifetime, have you had legal problems or been arrested?	☐	☐	☐	☐	☐
How often have you attended in AA or NA meeting?	☐	☐	☐	☐	☐
How often have you been in an argument that was so out of control that someone got hurt?	☐	☐	☐	☐	☐
How often have you been sexually abused?	☐	☐	☐	☐	☐
How often have others suggested that you have a drug or alcohol problem?	☐	☐	☐	☐	☐
How often have you had to borrow pain medications from your family or friends?	☐	☐	☐	☐	☐
How often have you been treated for an alcohol or drug problem?	☐	☐	☐	☐	☐

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, _____ , authorize release of all information including medical records, reports, test results, and any pertinent information to Corda Pain Institute (Professional Pain Management Associates.)

Mail to: PO Box 8890, Turnersville, NJ 08012
Fax to: 856-740-0558

I, _____ , authorize release of all information including medical records, reports, test results, and any pertinent information to Corda Pain Institute (Professional Pain Management Associates) to any requesting physician or attorney.

_____ _____

Patient's Signature Date

_____

Print Patients Name

Nature's RX

Professional Pain Management Associates

P.O. Box 658
Turnersville, NJ 08012
Tax ID: 223510318

ASSIGNMENT OF AND AUTHORIZATION TO PAY PHYSICIAN/MEDICAL EXPENSE BENEFITS

I, _____, employed by _____
Name of insured — Name of employer

Hereby assign, transfer and set over unto Nature's RX as interest may appear, all physician/medical expense benefits under by insurance. Policy/claim # _____, Group # _____ issued by _____, which are due or to become due my by virtue of services performed on the person _____ by Nature's RX.
Insurance Company — Name of patient

I hereby authorize said company to pay such benefits directly to Nature's RX and any and all payments so made shall constitute and be a discharge in full to said company to the extent of the benefits so paid.

It is understood and agreed that any sum of money paid under this assignment shall be credited to my account and in the event the sum is insufficient to liquidate the said account, I shall be personally liable for the unpaid balance of the account.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

Corda Pain Institute

Professional Pain Management Associates

P.O. Box 8890
Turnersville, NJ 08012
Tax ID: 223351986

ASSIGNMENT OF AND AUTHORIZATION TO PAY PHYSICIAN/MEDICAL EXPENSE BENEFITS

I, _____ , employed by _____
Name of insured Name of employer

Hereby assign, transfer and set over unto Corda Pain Institute (Professional Pain Management) as interest may appear, all physician/medical expense benefits under by insurance.

Policy/claim # _____ , Group # _____ issued by _____ , which are due or to become due my by virtue of services performed on
Insurance Company

the person _____ by Corda Pain Institute (Professional Pain Management)
Name of patient

I hereby authorize said company to pay such benefits directly to Corda Pain Institute (Professional Pain Management) and any and all payments so made shall constitute and be a discharge in full to said company tot he extent of the benefits so paid.

It is understood and agreed that any sum of money paid under this assignment shall be credited to my account and in the event the sum is insufficient to liquidate the said account, I shall be personally liable for the unpaid balance of the account.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

I understand that pain syndromes can sometimes be complex to treat. As a result, medication including narcotics which required strict guidelines for administration may be used for alleviating pain. These medications have potential to cause harmful effects used inappropriately. Consequently, these medications need to be monitored very carefully by your physician. All Narcotic medications are habit forming.

These medications not only cause physical and mental dependence, but your body will set tolerance to the medications, meaning you will need more medications to the same effect/pain relief. This may eventually give you more side effects. In addition, these medications are highly regulated by the state and federal government. Therefore, the following policies are instituted and bound by the physicians and Cord Pain institute.

It is the policy of Corda Pain Institute that patients who are receiving narcotic prescriptions as a part of their treatments agree to the following terms:

___ There is a risk of addiction when using narcotic medications. Narcotic medications are to be as directed. If a patient takes more medication than directed, the will not receive additional medication. If this causes the patient to go into withdrawal it is that patient's responsibility to report to the emergency room and have themselves admitted to a drug rehabilitation program.

___ Narcotic medications will not be called in by phone

___ There are no early refills on medications. Federal lae prohibits us from writing for more than a certain number of pills.

___ There will be no replacement of lost prescriptions or misplaced medication even if a police report has been filed and documented.

___ Your concerns and questions regarding your narcotic medications must be directed to your treating physician. If a patient needs to have their narcotic medication changed or directions changed, they must make an appointment with their physicians.

___ Any patient on narcotic medications may be ordered to have a blood and urine test for liver and kidney function for quantitative analysis (amount of medication in your body) on a six month basis.

___ If a patient alters the prescription in any ay, takes medication more frequently than prescribed, shares medication or takes narcotic medications from another physician or persons, they can be discharged from the treating physician's care within thirty days.

___ You may only receive narcotic medications from your treating physician at Corda Pain Institute (Professional Pain Management)

___ Only your treating physician will prescribe and manage your narcotic therapy program

___ If you do not keep scheduled office visit appointments, therapy or any other prescribed participation in the pain management program, you will not be maintained on narcotic medications and may be discharged from the program by your treating physician.

___ Many times, non-steroid antiinflammatory medication and or blend are used to decrease the amount of narcotics taken. These medications, however, can also cause harm to the liver and kidney. Therefore, you are now informed that narcotic Tylenol and steroidal anti-inflammatory (Advil, Motrin, Bextra, Celebrex) can cause liver and kidney failure, decreased breathing/respiratory depression, coma, etc. and may result in death. You understand that he treatment for pain relief with medications is not without risk, as mentioned.

___ The patient has been advised not to drive a car or operate machinery while under the influence of opiates, benzodiazepines or muscle relaxants. The patient has been advised to check with an attorney as tot he New Jersey law regarding driving under the influence of these medications. I further suggested that the patient get a driver's evaluation with an approved company that can check reaction time behind the wheel while taking medications

___ You may be asked to participate in a narcotic group counseling session.

By signing this form, you have read, understand and agree to abide by the rules set forth in this policy. My breech of the above terms could result n my discharge from Corda Pain Institute and from all physicians associated with the group.

Patient's Signature	Print Patients Name	Date

PROTECTED HEALTH INFORMATION

Information to be Used or Disclosed
The information covered by this authorization includes:

_____ ***MEDICAL RECORDS*** _____

Persons Authorized to Use or Disclose Information
Information described above may be disclosed to:

_____ **CORDA PAIN INSTITUTE** *(PROFESSIONAL PAIN MANAGEMENT)* _____

_____
Name of Person or Organization

Expiration Date of Authorization
This authorization is effective through _____ unless revoked or terminated by the patient or the patients personal representative

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Corda Pain Institute. You should contact the Compliance Officer to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations

Medical Photography
I consent to be photographed for identification/medical record purposes. ☐ YES ☐ NO

Appointment Reminders
I authorize Corda Pain Institute to leave appointment reminders on voice mail ☐ YES ☐ NO

_____
Name of Patient (Print or Type)

_____
Signature of Patient Date

_____
Signature of Patient Representative

_____
Relationship of Patient Representative to Patient

READ THIS ARBITRATION AGREEMENT CAREFULLY. IT LIMITS CERTAIN OF YOUR RIGHTS, INCLUDING YOUR RIGHT TO MAINTAIN A COURT ACTION.

PATIENT (Called "you" or "your")	PHYSICIAN ("we" or "us") Corda Pain Institute and its agents, servants and employees.
Date	

In consideration of the mutual promises made in this agreement, you and we agree that either you or we have an absolute right to demand that any dispute be submitted to an arbitrator in accordance with this agreement. If either you or we file a lawsuit, counterclaim, or other action in a court, the other party has the absolute right to demand binding arbitration following the filing of such action.

ARBITRATION: Arbitration is a method of resolving disputes between parties without filing a lawsuit in court. By signing this agreement, you and we are both agreeing that if there are any disputes between you and us, either you or we may require that such dispute be submitted to an arbitrator in accordance with this agreement. If either party demands arbitration, the arbitrator's decision will be final and binding on you and us. You and we are giving up the right to continue a lawsuit, counterclaim, or other action in court, including the right to a jury trial, in the event the other party exercises the right to demand arbitration pursuant to this agreement.

DISPUTES COVERED: This agreement applies to all claims and disputes between you and us. This includes, without limitation, all claims and disputes arising out of, in connection with, or relating to:

- your purchase of any goods or services from us;
- any previous care, treatment or diagnosis from us;
- all treatment and diagnosis provided by us;
- whether the claim or dispute must be arbitrated;
- the validity and enforceability of this arbitration agreement;
- any negotiations between you and us;
- any claim or dispute based on an allegation of common law theories such as negligence, fraud or misrepresentation including but not limited to claims related to or arising out of treatment, medical care or diagnosis;
- any claim or dispute based on a federal or state statute;
- any claim or dispute based on an alleged tort including, but not limited to, medical malpractice, personal injury, emotional distress; and
- any claim or dispute based on breach of contract.

This agreement also applies to any claim or dispute, including all the kinds of disputes listed above, between you and any of our employees or agents, any of our affiliate corporations, and any of their employees or agents and any third parties related to the services provided.

RIGHT TO COUNSEL: You acknowledges that this Agreement is a legal document with binding consequences and that You have been afforded the right to consult with an attorney prior to entering into this Agreement. You are expressly encouraged to consult with an attorney before entering into this Agreement.

WAIVER OF RIGHT TO JURY TRIAL: You and we expressly waive all right to pursue any legal action to seek damages or any other remedies in a court of law, including the right to a jury trial.

_____	_____
Initials	Initials

STARTING ARBITRATION: You and We agree that arbitration shall be conducted through the JAMS or any other arbitration service or arbitrators that you and we agree upon. Either you or we can start arbitration any time a dispute arises between you and us. If either party brings a lawsuit, counterclaim, or other action in a court against the other party, the other party can within a reasonable time after service of the lawsuit, counterclaim, or other action (but in no event after a judgment is entered) demand arbitration of the entire dispute. If arbitration is demanded, you and we agree that the entire dispute must be arbitrated in accordance with this agreement and that any lawsuit, counterclaim, or other action must be discontinued. The arbitration will be conducted under the applicable rules of the service provider. For example, if through JAMS then the JAMS Policy then in place on Consumer Arbitrations Pursuant to Pre-Dispute Clauses Minimum Standards of Procedural Fairness or any other applicable rules will apply.

COSTS OF ARBITRATION: If you start arbitration, you agree to pay the initial filing fee required by JAMS or any other arbitration service that you and we agree upon. If we start arbitration, we will pay the filing fee and all required deposits.

LOCATION OF ARBITRATION: The arbitration will take place in the State of New Jersey in either Atlantic, Burlington, Camden or Gloucester Counties unless you and we both agreed to another location.

OTHER IMPORTANT AGREEMENTS:

1. The Federal Arbitration Act applies to and governs this agreement.
2. If either you or we should need to file a lawsuit to enforce this agreement, the suit may be brought in any court with jurisdiction.
3. You and we agree that this agreement applies to all of your, and all of our, assigns and heirs.
4. If any term of this agreement is unenforceable, the remaining terms of this agreement are severable and enforceable to the fullest extent permitted by law.
5. This agreement supersedes any prior arbitration agreement that there may be between you and us.
6. This agreement is fully binding in the event a class action is filed in which you would be a class representative or member. You and we agree that arbitrations pursuant to this agreement which involve you and us and/or us and any other person cannot be consolidated unless we consent to a consolidation. You and we further agree that there shall be no class action arbitration or class action lawsuits in court pursuant to this agreement.
7. You and we agree to only use in the arbitration experts with the same board certifications as the medical provider against whom the claim is brought.
7. For more information about the arbitration process, or to obtain a copy of JAMS Arbitration Rules, contact the JAMS at 1-800-352-5267, or log on to their website at http://www.jamsadr.org.

READ THIS ARBITRATION AGREEMENT CAREFULLY. IT LIMITS CERTAIN OF YOUR RIGHTS, INCLUDING YOUR RIGHT TO MAINTAIN A COURT ACTION.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE AMONG OTHER ISSUES, ANY ISSUE OF ALLEGED MEDICAL NEGLIGENCE OR BREACH OF CONTRACT BETWEEN YOU AND YOUR PHYSICIAN DECIDED BY A BINDING ARBITRATION PROCESS IN WHICH BOTH PARTIES ARE GIVING UP THEIR RIGHT TO A TRIAL BY JURY, OR A TRIAL BY JUDGE.

You and we have entered into this agreement as of the "Date" written above.

PATIENT

By:

PHYSICIAN

By: Dr. Corda, D.O.

I, THE UNDERSIGNED HEREBY ACKNOWLEDGE THAT ALL DOCUMENTS THAT I SIGNED WERE FULLY COMPLETED AND EXPLAINED TO ME PRIOR TO MY AFFIXING MY SIGNATURE ON THE DOCUMENT AND I RECEIVED A COPY OF THE DOCUMENT I SIGNED WHEN I SIGNED IT AND I FULLY UNDERSTAND THE CONTENTS OF ALL DOCUMENTS THAT I HAVE SIGNED.

PATIENT

By: _____

DISCLOSURE OF INSURANCE PARTICIPATION STATUS AND FEES

The laws of the State of New Jersey and New Jersey Department of Health require that a health care professional inform patients of the health care plans in which the professional participates in and the facilities with which the professional is affiliated with. In compliance with these laws, the undersigned patient is hereby notified, in writing, that:

Health Plans Health Care Professional Participates With:
Aetna-exlcudes Medicaid plans
Amerihealth Administrators
Amerihealth NJ PPO/HMO
Blue Cross Blue Shield of NJ-PPO/HMO/Blue Card Plans -Excludes Medicaid Plans
ChampVA
Clover
Coventry
Highmark IBC
Humana Military
Medicare
Medicare Railroad
Oxford
Qualcare
Tri-Care for Life
Tri West
UMR
United Healthcare-Excludes Medicaid Plans

Facilities Physician Is Associated with and Address:

Advanced Surgical Institute (ASI)-556 Egg Harbor road, Sewell NJ 08080
Access Surgical Center-3205 Fire Road, Egg Harbor Township NJ 08234
Atlantic Care Hospital System and Ambulatory Surgical Center-2500 English Creek Ave, Egg Harbor NJ 08234
Virtua Hospital Systems-200 Bowman Drive, Voorhees NJ 08043
Jefferson Hospital Systems-435 Hurfville Cross Keys Road Washington Twp NJ 08080
Premier Orthopedic Associates Ambulatory Surgical Center-352 S. Delsea Drive, Suite C, Vineland NJ 08360
Millenium Surgical Center-2090 Springdale Road, Suite A Cherry Hill NJ 08003
Jersey Shore Ambulatory Surgical Center-405 Bethel Road, Somers Point NJ 08244

If the patient's health plan is not listed above they are out of network. The physician and/or facilities providing services does not participate with the patient's health plan. In order to proceed with any health care services, the patient hereby acknowledges and agrees:

Anesthesia, Radiology, Laboratory, Pathology Services and Neuromonitoring Services:

Outside service providers may be contracted to perform services on the patient based upon the treatment plan and needs of the patient.. The patient is hereby notified and understands that any such assistants, anesthesia, radiology, laboratory and/or pathology services may not participate with any health insurance plans and may be "out-of-network" providers subject to the following disclosures. Patient should inquire with each provider to determine their participation status and/or contact patient's health plan or administrator for further consultation on costs associated with these services.

One or more of the following may be an outside service provider providing services to the patient in conjunction with Professional Pain Management Associates:

Natures Rx Anesthesia Services-2007 Black Horse Pike, Williamstown NJ 08094

Med Arbor Laboratories: 3430 Progress Drive, Suite H Bensalem PA 19020

Mandatory Disclosures:

1) I understand that the health care professional that I am seeking healthcare services from is "out-of-network" with and does not participate with my health insurance plan;

Patient initials:_____

2) I understand that the amount or estimated amount the health care professional will bill the covered person for the services is available upon request;

Patient initials:_____

3) I may request from the provider an estimated charge for the services proposed and the Current Procedural Terminology (CPT) codes associated with that service, and the health care professional shall disclose to me, the patient, in writing, the

amount or estimated amount that the health care professional will bill the covered person for the service, and the CPT codes associated with that service, absent unforeseen medical circumstances that may arise when the health care service is provided;

Patient initials: _____

4) I understand that I will have a financial responsibility applicable to health care services provided by an out-of-network professional, which may be in excess of my in-network copayment, deductible, or coinsurance, and that I may be responsible for any costs in excess of those allowed by my health benefits plan; and

Patient initials _____

5) I have been advised that I should contact my health insurance plan or administrator for further consultation on those costs.

Patient initials: _____

The health care provider and patient both acknowledge and agree that receipt or acknowledgement by patient of these disclosures shall not waive or otherwise affect any protection under existing statutes or regulations regarding in-network health benefits plan coverage available to the patient under the law.

The in-network status of Professional Pain Management Associates may change in between the time the patient has signed these documents and the procedure. The patient should check the practice's website prior to the procedure to make sure that there have been no updates which affects the patient.

I, the undersigned patient, acknowledge receipt of this disclosure form from my health care provider, and have read it and understand the contents. I have discussed my option to obtain treatment with other health care providers, service providers, or at alternative health care facilities that may participate with my health plan and I waive the right to do so and wish to obtain my treatment at this office with full notice of these disclosures and potential cost sharing consequences. I certify that I am at least 18 years of age, competent, not under the influence of any drug, alcohol or other substance that would impair my ability to understand these disclosures

By: _____ Date: _____

Print Name: _____

Corda Pain Institute

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P.O. Box 8890, Turnersville, NJ 08012

Williamstown | 856-740-4888 Linwood | 609-813-2113
Vineland | 856-691-0361 Cherry Hill | 856-616-0900

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Professional Pain Management Associates, (PPMA) as your healthcare provider. We are honored by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for his/her treatment and care.
- We are pleased to assist you by billing for our contracted insurers. However, the patient is required to provide us with the most correct and updated information about their insurance and will be responsible for any charges incurred if the information provided is not correct or updated.
- Patients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Patient accounts must remain in good standing. Patient accounts not in good standing will be denied future appointments until the account is brought up to date. Payment is due at the time of service, and for your convenience, we accept cash, check, and most major credit cards at our office.

Patients may incur and are responsible for the payment of additional charges at the discretion of PPMA. These charges may include (but are not limited to):

- Charge for returned checks.
- Charge for missed appointments without 24 hours advance notice
- Charge for extensive phone consultations and/or after-hours phone calls requiring diagnosis, treatment, or prescriptions.
- Charge for the copying and distribution of patient medical records.
- Charge for extensive forms completion.
- Any costs associated with collection of patient balances.

Patient Authorization

- By my signature below, I hereby authorize PPMA and the physicians, staff associated with PPMA to release medical and other information acquired during my examination and/or treatment to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.

- By my signature below, I hereby authorize assignment of financial benefits directly to PPMA and any associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

- By my signature below, I authorize PPMA's personnel to communication by mail, answering machine message, text and/or email according to the information I have provided in my patient registration information.

Patient Name (print): _____ Date: ____/____/____

Patient signature: _____