JAVERY
PAIN INSTITUTE

Dear New Patient:

Thank you for choosing the Javery Pain Institute for your pain management needs. We would like to take this opportunity to provide you with some information about what you can expect during your first visit.

Your first visit will focus on learning about your specific pain condition. You can expect to learn important information such as;

- What is causing my pain?
- Are there any other tests or diagnostic studies that need to be done to help treat my pain?
- What can be done to reduce my pain? What are the risks and benefits of these pain relieving treatments?
- Education on the various techniques that may be used as a comprehensive treatment protocol.
- Development of a customized pain treatment plan.

How can you help make your visit go smoothly?

- **Bring your completed new patient paperwork with you to your appointment.**
- **Arrive 15 minutes before your appointment to fill out necessary paperwork.** If you don't arrive early enough, we may ask you to reschedule.
- You must bring all of your insurance cards and a picture ID or your appointment will be rescheduled.
- Bring a list of all of the medication(s) that you take or bring the bottles if that is easier.
- If any imaging (X-Ray, MRI, CT) has been done due to your pain, please come with the details; what was done and where/when it was done?

Co-payments will be collected before services are rendered. Cash and credit cards are accepted for your convenience.

We take pride in our mission to provide effective pain management solutions, under the highest standards of patient safety and competent medical care in a clean, safe and comfortable environment. We hope that we can make a difference in the quality of your life! Please visit our website, www.javerypain.com, to learn more about our office.

Sincerely,

Keith B. Javery, DO

710 Kenmoor Ave SE, Suite 200 Grand Rapids, MI 49546
p 616.588.PAIN (7246) f 616.588.7086 www.javerypain.com

Javery Pain Institute, PC

Patient Information – Please Print

Name_____ Date of Birth _____ Age _____
Last First MI

Address_____ City_____ State_____ Zip_____

Home Phone ( )_____Work/Other Phone ( ) _____ **Cell Phone** ( )_____

Email _____ Social Security Number_____ Driver's License # _____

Race/Ethnicity _____ Primary Language _____

Employer _____ Marital Status_____ Male/Female _____

Referring Physician _____ Primary Care Physician _____
First Last First Last

Name of nearest relative with whom you do NOT live with and whom we may contact in case of emergency.

Name _____ Phone ( ) _____

Address _____ Relationship _____

Insurance Card Holder's Information **Relationship to Patient**_____

Name_____ Date of Birth _____ Age _____
Last First MI

Address_____ City_____ State_____ Zip_____

Home Phone ( )_____Work/Other Phone ( ) _____ Cell Phone ( ) _____

Social Security Number_____ Driver's License # _____

Employer _____ Marital Status_____ Male/Female _____

Primary Insurance Carrier _____ Insurance Card Holder _____

Policy No_____ Group No _____ Phone No (_____) _____

Secondary Insurance Carrier _____ Insurance Card Holder _____

Policy No_____ Group No _____ Phone No (_____) _____

I understand according to the State of Michigan, Department of Health, Act 488 of 1988 that if a health care professional in this practice sustains a coetaneous, mucous membrane or open wound exposure to blood or other body fluids from myself that a HIV and Hepatitis-B (HBV) blood test will be performed.

Signature_____ Date_____

I authorize payment of medical benefits by the insured directly to Javery Pain Institute, PC. I also request payment of government benefits directly to the party who accepts assignment. I understand that I am financially responsible for payment of all services or materials provided to myself and for any yearly deductible or co-payment amounts. I agree to pay all services within 30days unless a payment plan is negotiated in advance. I authorize Javery Pain Institute, PC to release any information required to process my claim. This request shall remain in effect until revoked by myself in writing.

Signature_____ Date_____

How did you hear about our office? □ Doctor □ Friend/Relative □ Web Search
□ Yellow Pages □ Other_____

Javery Pain Institute, PC

Authorization For Specific Confidential Communications

I authorize my physician and/or administrative and clinical staff to disclose the following protected health information to:

Name: _____ Relationship to Patient _____
Name: _____ Relationship to Patient _____
Name: _____ Relationship to Patient _____
Name: _____ Relationship to Patient _____

Select the Protected Health Information to be used or disclosed to the above listed individual(s) from the list below:

o Medical Care / Treatment: **Yes ___ No ___ Level of Information** _____
o Billing Information **Yes ____ No ____**
o Pick up PHI: (such as prescriptions, billing statements, labs etc.) **Yes ___ No ___**
o Other (specify in detail – such as date of service, type of service, level of detail to be released, origin of information etc.) _____
_____

This authorization shall be in force and effect and does not expire until it is revoked in writing. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at: Javery Pain Institute, PC, 710 Kenmoor Ave SE, Suite 200, Grand Rapids, MI 49546. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ Date _____
Parent / Guardian Signature

I request that all communications to me (by telephone, mail, etc.) by Javery Pain Institute, PC. and/or its staff be handled in the following manner:

* For **written** communications: Address to: _____

* For **oral** communications: Call: _____ May we leave a message? YES ☐ NO ☐
(telephone number)

If the above address is not a street address or is not your home address, please provide us with a (home) street address for purposes of ensuring payment:

_____
(street number and address) City State Zip

_____ _____/_____/_____
Patient Signature Date

**Needed for alternative Written or Oral communication listed in above box only.*
For Practice Use Only: Practice: Accepts ☐ Denies ☐

Privacy Officer's Signature _____ Date: _____

JAVERY
PAIN INSTITUTE

No Show/Missed Appointment Policy
For Consult and Procedure Appointments

We , at the Javery Pain Institute (JPI), understand that sometimes you need to cancel or reschedule your appointment and there are emergencies. If you are unable to keep your appointment, please notify us as soon as possible.

To ensure that each patient is given the proper amount of time alloted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on the day and time provided. As a courtesty, an appointment reminder call to you is made/attempted 1 week and 1 to 2 days prior to your scheduled appointment. However, it is the responsibility of the patient to arrive on time and or notify us if there will be challenges in getting here .

Please Review the Following Policy and Guidelines

1. Please cancel your appointment with at least 24 hours' notice: There is a waiting list to see the providers at The Javery Pain Institute and whenever possible, we like to fill cancelled spaces to shorten waiting periods for our patients.
2. If less than 24 hour cancellation is given, this will be documented as a "No Show" appointment.
3. If you do not present to the office for your appointment, this will be documented as a "No- Show" appointment.
4. After the first "No-Show"/Missed appointment, you will receive a phone call or letter informing you that you have broken our "No-Show" policy. JPI will assist you to reschedule this appointment if needed.
5. If you have 2 "No-Show"/Missed appointments within 6 months, you will receive a warning letter from our office.
6. If you have 3 "No-Show/Missed appointment within 6 months, dismissal from the practice will be suggested. You will be notified by letter if the dismissal was approved.
7. Based on your treatment plan with the physician, "No-Show"/Missed appointments can change and or delay procedures. Please know that we will make every effort to rearrange your appointments to continue care.

I have read and understand The Javery Pain Institutes No-Show/Missed Policy and understand my responsibility to plan appointments accordingly and notify The Javery Pain Institute appropriately if I have difficult fulfilling my scheduled appointment.

_____ _____ _____
Patient Name Date of Birth Todays Date

_____ _____
Patient signature or Patient Guardian Relationship to Patient

_____ _____
JPI Staff Signature Today's Date

New Patient Visit Form: Page 1 of 4

ID#_____

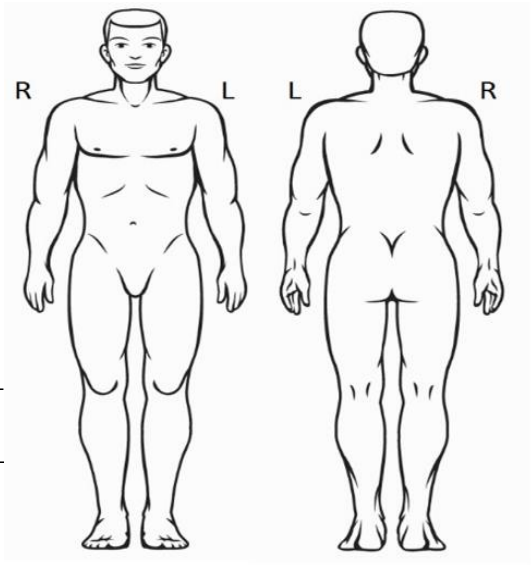
JAVERY PAIN INSTITUTE

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

Primary Care Dr._____**Referred by**_____

For Intake staff on day of appointment	BP	HR
RR T Wt Ht O2	Pain Rating	

Mark all areas of pain on the diagram



Where is your pain today?

How long have you had this problem?

Describe how your pain first began?

How often do you have pain? (Select all that apply)
□ constantly □ comes and goes □ daily □ once in a while □other_____
My pain is? (Select all that apply) □ sharp □ dull □ aching □ throbbing
□burning □shooting □ electrical □ other:_____

Do you have any of the following?

Numbness or tingling □ yes □ no **Swelling in affected area** □ yes □ no
Muscle weakness □ yes □ no **Muscle spasms or cramps** □ yes □ no

What makes your pain worse? (Select all that apply) □ sitting □ standing □ walking □ lying down □ bending
□ climbing stairs □lifting □ squatting □ other_____

What are you doing to reduce your pain? (Select all that apply) □ medication □ massage □ physical therapy □ice
□ heat □ walking □ chiropractic care □ avoiding activity □ rest more □ weight loss □ stretching
□other_____

Is your pain worse at night? □ yes □ no **New loss of bowel or bladder function?** □ no □ yes
If yes, please explain:_____

Are you on any anti-coagulants or any blood thinning medicines? □ yes □ no If yes, please list? _____

Please list Allergies:_____

PREVIOUS TREATMENTS	YES/NO	WHEN/WHERE?	HOW HELPFUL WAS THIS?
Nerve Blocks			
Surgery			
TENS Unit			
Physical Therapy			
Chiropractic			
Biofeedback/Hypnosis			
Previous Pain Doctor			
Other Treatment			

What pain medication have you tried/used, include the length of trial & when? _____

_____

_____

Please list your current medications (over the counter and prescription), vitamins, & supplements.
Include dose and how often you take them, why you take them:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

If you run out of space, write on back of this paper, or include a separate sheet of paper

Please explain how pain affects the function(s) in your life

If you are having trouble with any of the areas listed below due to your pain, please give us details on the items that only apply to you.

	List the affected area(s) in the boxes below	Include % of affect
!!!! Example Only!!!!	I am unable to enjoy my hobby of gardening due to my hip and low back pain. I miss it, and would love to enjoy gardening again. Now I have to pay someone to do it for me.	My gardening activity declined by 100%, 12 months ago
Employment: has your work been affected due to your pain		
Daily Living activities: Dressing, Bathing, meal prep, taking care of your home, etc..		
Interacting with others: such as playing with or caring for children/caring for a family member?		
Movement functions: such as standing, sitting, walking, bending		
Sleeping		
Enjoyment of Life/Quality of Life		
Hobbies		
Exercise		

 Patient Name:_____ Date of Birth_____

List any tests or surgeries you have had:

Test	Date/Place	Results	Surgery	Date/Surgeon
X-Rays				
CT Scan				
MRI				
EMG				
Bone Density				
Other				

Review of Systems/Medical History: please check any that you currently have or had in the past

Constitutional
□Recent fever/sweats
□Unexplained weight loss/gain
□Unexplained fatigue/weakness

Eye/Ear/Nose/Throat
□Vision changes
□Difficulty Hearing
□Hay fever/allergies
□Difficulty swallowing

Endocrine
□Cold/Heat intolerance
□Increased thirst/appetite
□Thyroid problems
□Diabetes
□Severe Diabetes

Genitourinary
□Painful/bloody urination
□Night-time urination
□Discharge: penis or vagina
□Unusual vaginal bleeding
□Kidney problems
□Concern with sexual function

Other
□Implantable Device

Gastrointestinal
□Stomach/intestinal problems
□Nausea/Vomiting/diarrhea
□Changes in bowel movement
□Blood in stool

Respiratory
□Emphysema/COPD
□Asthma
□Coughing/wheezing
□Coughing up blood
□Communicable disease-TB

Psych/behavioral
□Anxiety/stress
□Depression
□Substance abuse/addiction
□Sleep problems
□Sleep problems

Neurological
□Headaches
□Numbness
□Tremors
□Poor balance
□Epilepsy
□Stroke
□ Loss of balance

Blood/Lymphatic
□Unexplained lumps
□Easy bruising/bleeding
□Cancer
□Communicable disease (HIV,AIDS, Hep B or C)

Musculoskeletal
□Arthritis
□Muscle/Joint Pain
□Recent back pain
□Muscle weakness
□Osteopenia
□Osteoporosis

Cardiovascular
□Chest pain/discomfort
□Shortness of breath
□Heart attack
□High blood pressure
□Palpitations/irregular heart
□Pacemaker/defibrillator

Skin
□Sores
□Psoriasis
□Eczema
□Rash
□Communicable Disease-MRSA

Please give further details on selections above?

 Patient Name:_____ Date of Birth_____

How often do you drink alcohol? □ yes □ no □Never □Monthly # of drinks_____ □Weekly # of drinks_____

□Daily # of drinks _____ □Other:_____

Have you felt you ought to cut down on your drinking?

Have people annoyed you by criticizing your drinking?

Have you felt bad or guilty about your drinking?

Have you ever had a drink first thing in the morning to steady your nerves, get rid of a hangover, or as an eye opener?

Have you been an inpatient in the hospital for any reason in the last 30 days? □ yes □ no
If Yes, When/Where and Why?

If you are a tobacco user, are you interested in Tobacco Cessation information? □ yes □ no

Tobacco use: □ never □ quit in _____ □currently # _____/day for _____years

If aged 65 or older, have you fallen twice in the last year, or had one fall that resulted in an injury? □ yes □ no
If yes, please explain?

Recent Flu shot? □ yes □ no **If yes, when?**

Oral Antibiotic in past 3 months? □ yes □ no **IV antibiotic in past 12 months?** □yes □ no

If yes, to either antibiotic questions, please explain?

What are your goals for life, when/if you receive relief from your pain?

Patient Signature_____**Date**_____

Javery Pain Institute Patient Policies

Short-Notice Cancellation

We understand that a patient may, on occasion, need to cancel or reschedule due to unforeseen circumstances. However, patients who chronically cancel or reschedule appointments *less than 48 hours prior* to their appointment time may be charged a fee and/or may be denied future appointments with the practice. If a patient cancels or reschedules their appointment *less than 48 hours prior* to their appointment time twice, they may be charged a $25 fee on the second occurrence and every occurrence thereafter, and their status of care at the our practice will be reviewed for possible dismissal. In the event there is a charge due to short-notice cancellation, the fee will not be submitted to any insurance carrier and is payable prior to scheduling further non-urgent appointments within our practice. JPI reserves the right to deny appointments to those who chronically give short-notice cancellations. The decision will be made on a case by case basis.

Prescription Renewal Policy

Prescriptions are renewed during normal office hours, which are 8:30 AM to 5:00 PM, Monday – Friday. Refills generally take between 24 - 48 hours to be processed. If you have questions about how to take your prescription, please do not hesitate to call the office and leave **ONE** message on the prescription line. One of our staff members will call you back within 24-48 hours, or if necessary, talk with the physician and get back to you as soon as possible. R**enewal requests will not be processed outside of normal business hours.**

If at any time you are in need of a new medication, please contact our office during regular business hours and leave **ONE** message on the prescription line or send a request through the Patient Portal. Please note that when you call our office for your refill, because of the volume of calls we receive daily, we will not call to notify you that your prescription is ready, unless there is a problem. **You must give us 48 hours to process your request**.

No Show Policy

We understand that a patient may, on occasion, need to reschedule their appointment time due to unforeseen circumstances. However, patients who do not call the office *at least 24 hours prior to their appointment time* to reschedule/cancel *and* do not present to the office at their appointed time may not be rescheduled unless the patient's referring physician calls to speak with our New Patient Referral Coordinator. JPI continues to reserve the right to deny an appointment even after talking with the referring physician. The decision will be made on a case by case basis.

Designated Driver Policy

In order to make our patients more comfortable during procedures, we offer sedation. In order for a patient to receive sedation, a designated driver must be present during the patient's entire appointment**. Under no circumstances will we allow this policy to vary.**

Payment Policy

As a courtesy to our patients, the office will submit the charge(s) to the patient's insurance carrier for payment, however, payment is expected at the time of a patient's visit in the office. If however, the physician participates with the patient's insurance policy, and the visit is a covered benefit under the policy, our office will submit the charge to their insurance carrier for payment. Any co-pay and/or deductible amount will be collected prior to your appointment.

No Children In The Exam Rooms

For many reasons we have had to make it a policy that children cannot enter beyond the clinic doors. Due to the sometimes considerable amount of time spent waiting, the Javery Pain Institute is not very enjoyable for young children. If there is no other alternative and you must bring your children with you to your appointment, please make arrangements to have your adult driver watch your children in the waiting room. If a patient comes to an appointment, and does not have an adult with them to supervise his/her children, they will have to reschedule their appointment. No exceptions can be made. We are sorry for any inconveniences this may cause.

Lost/Stolen Property

JPI is not responsible for lost or stolen items and we recommend that valuable items be left at home or with your adult driver.

Abusive or Violent Behavior

JPI's mission is to provide a safe environment for care in our office. We have a **Zero Tolerance Policy** for abusive or violent behavior towards our staff, patients or visitors.

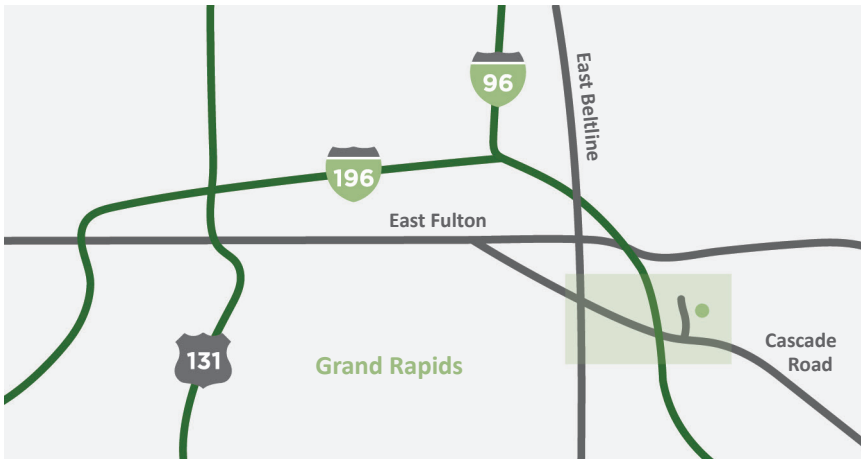
JAVERY
PAIN INSTITUTE

From I-96

- Exit 40 Cascade Road, head East
- Turn Left (North) at the first traffic light onto Kenmoor Avenue
- Proceed North on Kenmoor to Javery on the Right (East) side of Kenmoor Avenue

From East Belt Line

- Turn East on Cascade
- Follow Cascade over I-96
- Turn Left (North) at the first traffic light onto Kenmoor Avenue
- Proceed North on Kenmoor to Javery on the Right (East) side of Kenmoor Avenue



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