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
mandatory for worker compensation patients

Referring Physician _____ Primary Care Physician _____
First Last First Last

Emergency Contact Information:
Name _____ Phone ( ) _____

Address _____ Relationship _____

Insurance Card Holder's Information

Name_____ Relationship to Patient_____
Last First MI

Date of Birth _____ Home Phone ( )_____Cell/Work/Other Phone ( ) _____

Address_____ City_____ State_____ Zip_____

Employer _____ Employer Phone Number ( ) _____

Employer Address_____ City_____ State_____ Zip_____

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 understand this agreement authorizes Javery Pain to appeal my denied preservice request (pre-auth) on my behalf to my designated insurance carrier. 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 □Other_____

Would you like to receive our monthly Newsletter? □No □Yes – Email Address: _____

Javery Pain Institute, PC

Name: _____ Date of Birth: _____ Patient ID: _____
Last First MI

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.

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

_____ _____/_____/_____
Parent/Guardian 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: _____

New Patient Visit Form: Page 1 of 4 ID#_____

Patient Name:_____ Date of Birth_____

Primary Care Dr._____Referred by_____

JAVERY PAIN INSTITUTE

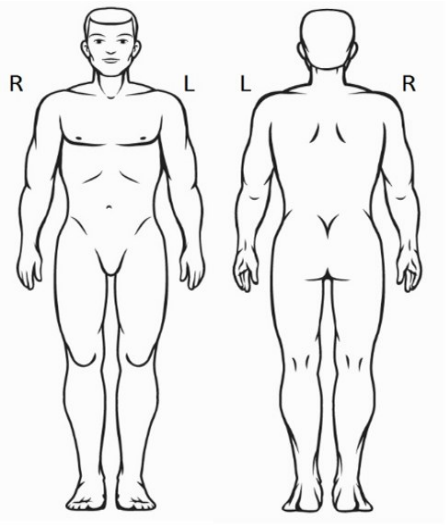
For intake staff only	BP	HR	RR	T	Wt.	Ht	O2

Where is your pain today?

How long have you had this problem?

Describe how your pain first began?

Mark all areas of pain on the diagram



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 trialed, include the length of trial & when? _____

_____

_____

Please list your current medications (Antibiotic, over the counter, Vitamins/Herbal Supplements and prescription) Include dose and how often you take them, why you take them:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____

_____

Please explain how pain affects the activities of daily living/function in your life?

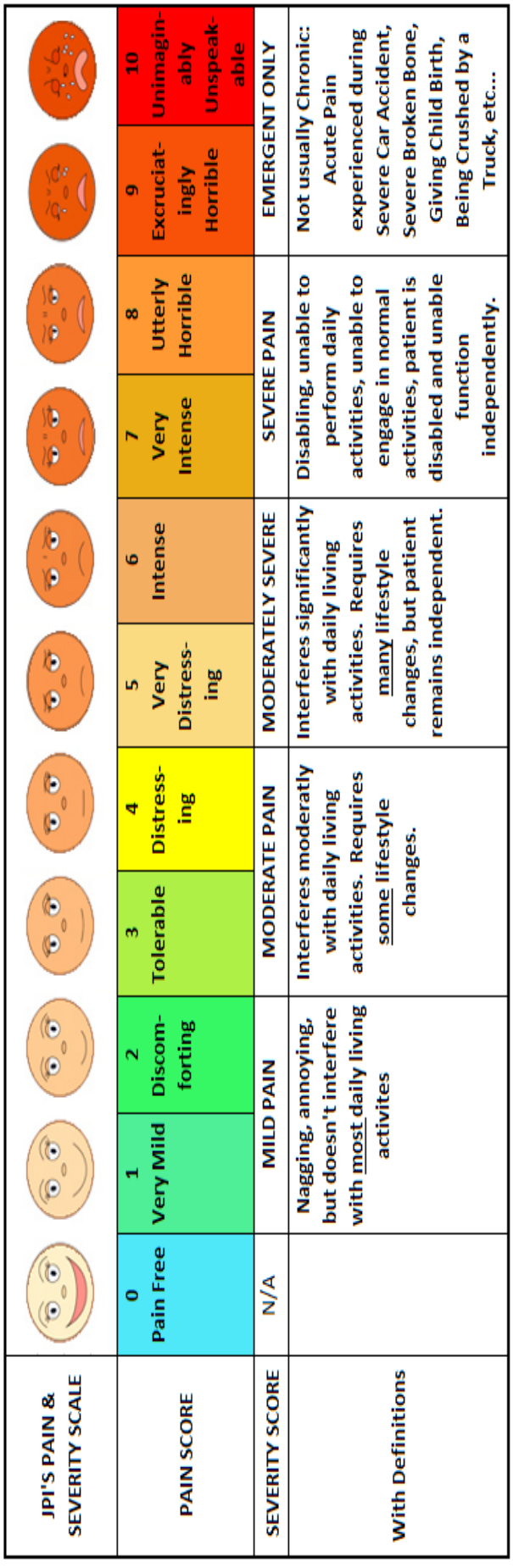
If you are going to be treated for more than one area, please document separately	Pain Area 1 (Example: low back pain)	Pain Area 2 (Example: neck pain)
List Pain Area Here? →		
What is your pain TODAY on a scale of 1 out of 10 (see pain scale/severity scale for reference on page 3??	/10	/10
What is your current severity of pain (see pain scale/ severity scale for reference on page 3)?	□ Mild □ Moderate □ Moderately Severe □ Severe	□ Mild □ Moderate □ Moderately Severe □ Severe
What is your current activities of daily living that you have difficulty with? (select all that apply)	□ sitting □ standing □ walking □ lifting □ bending □ twisting □ self-care □ sleeping □ job activities □ school activities □ exercise □ recreational activities □ none	□ sitting □ standing □ walking □ lifting □ bending □ twisting □ self-care □ sleeping □ job activities □ school activities □ exercise □ recreational activities □ none
What is your current severity of difficulty with activities of daily living (see pain scale/severity scale)? →	□ Mild □ Moderate □ Moderately Severe □ Severe	□ Mild □ Moderate □ Moderately Severe □ Severe

What activities/hobbies not listed above would you like to start doing again, once you are feeling better?

_____

_____

 Patient Name:_____ Date of Birth_____



List any tests/imaging you have had done?

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

Please list any surgeries you have had?

Surgery	Date/Surgeon

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

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

Other
- □Implantable Device

Review of Systems Continued

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

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

Blood /Lymbphatic
- □Unexplained lumps
- □Easy bruising/bleeding
- □Cancer
- □Communicable disease (HIV,AIDS, Hep B or C)
- □Other:_____

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

Psych/Behavioral
- □Anxiety/stress
- □Depression
- □Substance abuse/addiction
- □Sleep problems
- □Other:_____

Neurological
- □Headaches
- □Numbness
- □Tremors
- □Poor balance
- □Epilepsy

Neurological (continued)
- □Stroke
- □Loss of balance
- □Other:_____

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

Please give further detail on selection listed above?_____

_____

_____

How often do you drink alcohol? □ 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?

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.

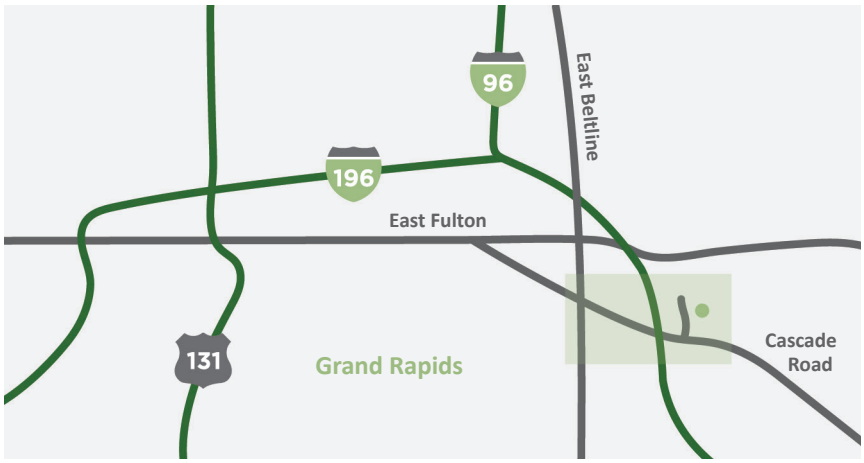
JAVERY
PAIN INSTITUTE

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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