Liberty
Pain Center

Mariam Ghobriel, MD
800 W. Main St., Suite 111
Freehold, NJ 07728
Phone: (732) 303-0102
Fax: (732) 637-8539

Dear Patient,

Enclosed you will find a registration packet. By this time you have probably made an appointment if our office has already received all your documentation that we requested. Please read and complete all pages and information requested. If possible, please return this packet to the office 48 hours before your scheduled appointment by fax, email or in person to help expedite your appointment the day of.

Please bring with you to your first appointment:

~ This Packet Completed before your appointment. If it is not completed by your appointment time we may have to reschedule you for another day.

~ Your Insurance Card(s) and Drivers License or Photo ID

~ Any pertinent medical records such as MRI or X-Ray reports including the films or CD, EMG Reports and physician's notes from the current doctor treating you including any OP Reports from Pain Injections or Pain procedures you may have had.

~ A referral if mandated by your Insurance carrier.

Important Insurance Notice

WE STRONGLY URGE YOU TO FAMILIARIZE YOURSELF WITH THE BENEFITS AND EXCLUSIONS IN YOUR INDIVIDUAL INSURANCE COMPANIES CONTRACT. AS WE ACCEPT MANY INSURANCE CARRIERS AND EACH HAS ITS OWN INDIVIDUAL CLAUSES, OUR PRACTICE CANNOT GUARANTEE ALL SERVICES PROVIDED WILL BE COVERED. THOSE REJECTED OR NOT COVERED WILL BE BILLED TO THE PATIENT.

PLEASE KNOW YOUR OWN INSURANCE!

Should you have any questions please do not hesitate to call the office (732)303-0102.

Much Obliged,

Tania Wilcox
Office Manager

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IMPORTANT Appointment/Cancellation/No Show Policy

Appointments:

Office visits are by appointment only please call 732-303-0102. One of our staff may ask about the nature of your illness or the reason for your visit. This helps us schedule the physician's time more efficiently.

Please arrive 10-15min early for your appointment. Patients who are late for any appointment may be asked to reschedule at the physician's discretion.

Cancellation Policy/ No Show Policy for Office Appointments:
We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for your visit, due to a seemingly "full" appointment book.

If an Appointment is not cancelled at least 24 hours in advance you will be charged a forty dollar ($40) fee; this will not be covered by your insurance and is your responsibility.

Cancellation/ No Show Policy for Surgery:
Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.

If surgery is not cancelled at least 7 days in advance you will be charged a seventy five dollar ($75) fee; this will not be covered by your insurance and is your responsibility.

Repeated missed appointments may result in your physician sending a letter discharging you from the practice.

We greatly appreciate your understanding and cooperation.

I have read and understand the above Policy.

_____ _____
Signature of Patient/ Guardian Date

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Patient's Name:_____Date:_____

DOB:_____ SS#:_____

Home Phone:_____ Cell Phone:_____

StreetAddress:_____

City:_____ State:_____ Zip Code:_____

E-Mail Address:_____

Employer:_____ Job Title:_____

Emergency Contact/Relationship:_____
Emergency Contact Phone Number:_____

Referring Physician or PCP:_____ Phone:_____
Address:_____ Fax:_____

Pharmacy Name:_____ Phone:_____
Pharmacy address_____

Primary Insurance: _____
Name of primary Insured:_____
ID#:_____Group#:_____
Guarantor _____ SSN_____
Secondary Insurance:_____
ID#_____Group#:_____
Guarantor _____ SSN_____

Is this a workman's comp claim? Yes / No If Yes Date of Injury:_____

Are you receiving disability benefits? _____from what date?_____

Is this a motor vehicle accident claim? Yes / No Date of accident_____

Are you currently involved in a law suit due to your pain?_____

MEDICAL ASSESSMENT

*Name:*_____ Height:_____ Weight:_____

Please list all Current and past Medical condition:

_____

_____

_____

_____

_____

List all past surgeries:

_____

_____

_____

_____

Current Medications : (including over the counter, non prescription, herbal, vitamins and contraceptives)

Please List Blood Thinners First

Medication Dose How many times a day

_____

_____

_____

_____

_____

_____

_____

Allergies and side effects with medication: (past and present):

Are you allergic to iodine? Yes / No

_____

_____

_____

List other physicians you have seen for this condition:

_____

_____

Do you Smoke? _____ How much for how long?_____or Past Smoker?_____
Do you drink alcohol?_____How much? _____ for how long?_____

Pain Assessment: *Name:*_____

Was this pain related to an injury, accident, motor vehicle or work related, is yes please explain_____

_____

_____

_____

When did the Pain start?_____

How often do you have pain? constant / intermittent _____

Time of day: Morning ___ Afternoon ___ Evening___ Night ___

How do you describe the pain?
__ Sharp __Burning __ Shooting __ Pins and needles __ aching __ electric shock

What increases the pain _____

What decreases the pain ? _____

What treatments have you had for the pain?

__Physical therapy, When? _____ How Long? _____Did it help?_____

Name of Physical Therapy Facility: _____

__ Chiropractic, When? _____ How Long? _____Did it help?_____

__Injections: Name of Physician who performed procedures:_____
Type:_____ Date:_____ Helpful?:_____
Type:_____ Date:_____ Helpful?:_____
Type:_____ Date:_____ Helpful?:_____

__Psychological evaluation, hypnosis, relaxation therapy, acupuncture, did it help?_____

Medications that have not helped:

_____

Medications that have helped:

_____

List all testing related to your pain
Xrays_____ MRI _____ Ct scan_____ EMG_____
Facility where testing was done_____

SYSTEM REVIEW: **NAME:** _____

CONSTITUTIONAL SYMPTOMS

Recent Weight Change	Yes	No
Fever	Yes	No
Fatigue	Yes	No
Headaches	Yes	No

EYES

Eye Disease or Injury	Yes	No
Wear Glasses/ Contacts	Yes	No
Blurred or Double Vision	Yes	No

EARS/NOSE MOUTH/THROAT

Hearing Loss or Ringing	Yes	No
Earaches or Drainage	Yes	No
Chronic Sinus Problems	Yes	No
Nose Bleeds	Yes	No
Mouth Sores	Yes	No
Bleeding Gums	Yes	No
Sore Throat or Voice Change	Yes	No
Swollen Glands in Neck	Yes	No

CARDIOVASCULAR

Chest Pain/Angina Pectoris	Yes	No
Palpitations	Yes	No
Shortness of Breath with Walking or Lying Flat	Yes	No
Swelling Feet/Ankles/Hands	Yes	No

RESPIRATORY

Chronic or Frequent Cough	Yes	No
Spitting up Blood	Yes	No
Shortness of Breath	Yes	No

GASTROINTESTINAL

Loss of Appetite	Yes	No
Change in Bowel Movements	Yes	No
Nausea or Vomiting	Yes	No
Painful Bowel Movements	Yes	No
Blood in Stool	Yes	No
Abdominal Pain	Yes	No
Heartburn	Yes	No

RHEUMATOLOGIC/LYMPHATIC

Bleeding/ Bruising Tendency	Yes	No

MUSCULOSKELETAL

Joint Pain	Yes	No
Joint Stiffness/Swelling	Yes	No
Muscle Pain/Cramps	Yes	No
Difficulty in Walking	Yes	No

INTEGUMENTARY

Rash or Itching	Yes	No
Change in Skin Color	Yes	No
Change in Hair/Nails	Yes	No
Varicose Veins	Yes	No

NEUROLOGICAL

Frequent/Recurring Headaches	Yes	No
Lightheaded/Dizzy	Yes	No
Convulsions/Seizures	Yes	No
Numbness/Tingling	Yes	No
Tremors/Paralysis	Yes	No
Stroke/Head Injury	Yes	No

PSYCHIATRIC

Memory Loss/Confusion	Yes	No
Nervousness	Yes	No
Depression	Yes	No
Insomnia	Yes	No

ENDOCRINE

Glandular/Hormone Problems	Yes	No
Thyroid Disease	Yes	No
Diabetes	Yes	No
Excessive Thirst	Yes	No
Excessive Urination	Yes	No
Heat/Cold Intolerance	Yes	No

GENITOURINARY

Frequent Urination	Yes	No
Burning/Painful Urine	Yes	No
Blood in Urine	Yes	No
Incontinence/Dribbling	Yes	No

BRIEF PAIN INVENTORY

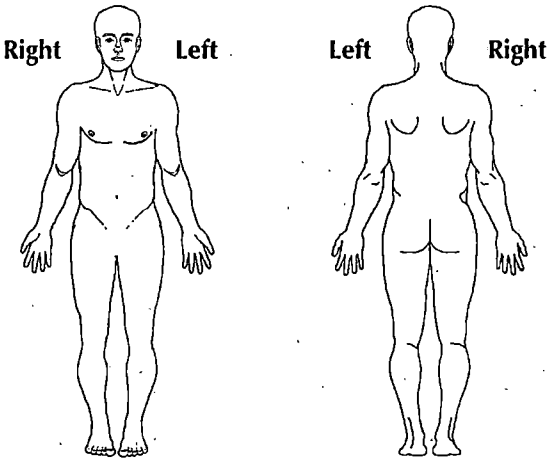
Date_____/_____/_____ Time:_____

Name:_____ _____ _____
Last First Middle Initial

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

1. Yes 2. No

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3) Please rate your pain by circling the one number that best describes your pain at its WORST in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its LEAST in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

7) What treatments or medications are you receiving for your pain?

_____

_____

8) In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that shows how much RELIEF you have received.

0% 10 20 30 40 50 60 70 80 90 100%

No relief — Complete relief

9) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General activity

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

B. Mood

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

C. Walking ability

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

D. Normal work (includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

E. Relations with other people

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

F. Sleep

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

G. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Brief Pain Inventory (Short Form). Source: Pain Research Group, Department of Neuro-Oncology, The University of Texas MD Anderson Cancer Center. Used with permission. Adapted to single page format.

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Patient Name:_____ DOB:_____

Authorization for Office to Patient Communication

Please mark boxes with the ways in which the office is able to contact you for reminder notices, changes on scheduled appointments or to discuss any ongoing treatment or results:

□ Cell Phone:_____ □ Detailed Message □ Brief Message

□ Home Phone:_____ □ Detailed Message □ Brief Message

□ Email: _____

□ Text Message (charges may apply based on your carrier)

_____ _____
Signature Date

Please Read and Sign Insurance Assignment

We accept assignment from most Insurance Companies. Your Insurance may only pay a percentage of the approved amount. It is your obligation and the law that you pay any copay, deducible and any remaining balance. If for any reason your insurance company does not pay for the office visit, consultation or procedure, it then becomes you responsibility. It is also your responsibility to know the contract between you and your insurance company. Please provide us with the necessary information including the address and phone numbers of all insurance companies pertaining to your medical care with Liberty Anesthesia and Pain Center.

I hereby read and fully understand the above.

_____ _____
Signature Date

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AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE
Patient Information

Patient Name: _____ Date of Birth _____

I hereby authorized ____Liberty Pain Center_____
Name of physician's office/medical practice disclosing information

REQUESTOR / RECIPIENT INFORMATION

Please release or discuss information related to my medical condition (including information related to my treatment plan, medication information and/or billing information) to the following named person/s:

Name:	Phone #:	Relation:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

PLEASE BE ADVISED THAT ANY PERSON NOT REFERRED TO IN THIS LIST WILL NOT BE GIVEN ANY INFORMATION RELATED TO YOUR CARE, INCLUDING BILLING INFORMATION. YOU MAY CHANGE, RESTRICT OR EXPAND THIS LISTING AT ANY TIME AND ARE NOT REQUIRED TO LIST ANY NAME IF YOU DO NOT SO CHOOSE.

ADVANCE DIRECTIVE

DO YOU HAVE AN ADVANCE DIRECTIVE/ LIVING WILL? _____ IF YES, PLEASE PROVIDE US WITH A COPY FOR OUR RECORDS.

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Description of Representative's Authority (Witness Signature Required) Witness Signature

Liberty
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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: Liberty Pain Center

Address: 800 W. Main St, Suite 111

City: Freehold State: NJ Zip Code: 07728

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES 180 DAYS AFTER IT IS SIGNED.

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Agreement for Controlled Substance Prescriptions

This is a contractual agreement between the Physicians at Liberty Pain Center and _____, intended to clarify the conditions for the use of narcotic medication to manage your chronic pain. You must be aware that there are several limitations to this type of therapy. As with all medications there is a risk of allergic reaction and other side effects including sedation, itching, urinary hesitancy, nausea, and vomiting. There are special concerns with narcotics, including tolerance, physical dependence and addiction.

Tolerance can develop to narcotics over time. This means that the initial dose of medication may become less effective over time. The amount of tolerance is not known and your doctor may adjust the medication when appropriate.

Physical Dependence develops with narcotic use. This does not mean that you are addicted to the medication. However, you cannot stop the drug abruptly or you will experience withdrawal symptoms such as nausea, vomiting, sweating and agitation. If we do decide to discontinue treatment, the medication will be tapered slowly.

Addiction refers to psycho logic dependence or craving for a drug. Most experts believe that the risk of the addiction is very low when using narcotic medication for pain.

Narcotic medication can be useful but has a high potential for misuse and is closely controlled by local, state and federal governments. Narcotic medication is intended to relieve pain and to improve function and/or ability to work, **not** simply to feel good. Because my physician is prescribing such medication for me to help manage my pain, I agree to the following conditions:

1. I will obtain narcotic prescriptions and mood altering drugs only from physicians at Liberty Pain Center. The exception to this rule is in case of trauma or surgery when the physician taking care of you can prescribe narcotics for the short-term pain that may be expected. If this does occur I will let my physician at Liberty Pain Center know what was prescribed to me. _____ **Patient Initials**

2. I am responsible for my narcotic prescriptions. Lost, misplaced or stolen Medications **will not** be replaced. I will only take my medications as prescribed and will not make any changes to the dosage unless it has been discussed with my physician at Liberty Pain Center. _____ **Patient Initials**

3. I will allow at least a 10 business day notification for my medication refill appointment and will not make this request after 12:00 p.m. on Thursdays. I am also aware that I must be seen at an appointment to receive my medications and if I do not, my prescriptions may not be ready for my due date. _____ **Patient Initials**

4. I will only fill my prescriptions at one pharmacy, unless I otherwise notify Dr. Ghobriel. _____ **Patient Initials**

5. I agree to random urine or blood testing and office pill counts to verify proper medication usage when requested. _____ **Patient Initials**

Please note that our clinical care will be inclusive of baseline and random urine testing for all patients, especially those on narcotic analgesia. Any patient receiving narcotic analgesia from a physician at Liberty Pain Center must agree to this testing if they are to continue with services from our practice.

Any patient refusing to take a baseline or random urine test will be discharged from our practice.

6. I agree to be referred for psychological testing at my physician's request. _____ **Patient Initials**

7. All recommended consultations will be obtained. _____ **Patient Initials**

8. Abstinence from all alcohol, marijuana and illegal drug use. _____ **Patient Initials**

9. I will keep scheduled office appointments and actively participate in my entire treatment plan. _____ **Patient Initials**

I have read this contract and full understand that violation of this contract is grounds for discontinuation of treatment by the physicians of Liberty Pain Center.

Date:_____

Patient's Signature:_____

Doctor's Signature:_____

Witness Signature:_____

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Oral Opioid (Narcotic) Consent Form

This agreement between the undersigned (patient) and Mariam Ghobriel, M.D. and/ or covering physicians of liberty anesthesia and pain center is to establish clear conditions for the prescription and use of controlled substances and pain medication prescribed by the doctor for the patient. Doctor and patient agree that this agreement is an essential factor in maintaining the trust and confidence necessary in a doctor-patient relationship. The patient agrees to and accepts the following conditions for the management of pain medication prescribed by the doctor for the patient:

1. I will not share, sell, or trade my medication for money, goods, or services.

2. I will not undergo any pain management procedures or injections without the preceding consent of Dr. Ghobriel. Patients are free to transfer their interventional care at any time; we would expect those physicians to assume continued prescribing of all controlled substances.

3. I understand that an important part of my pain management program may include non-drug treatment. If I fail to follow-through with my doctor's treatment program, I understand and agree that opioids may be withdrawn.

4. I understand that reduction in the intensity of my pain as well as improvement in my quality of life and function-ability are the desired goals of treatment. Should it become evident to my doctor that these objectives are not being met with the use of opioids, I agree to weaning and discontinuation of narcotic medication.

5. I will tell my doctor about all other medicines and treatments that I am receiving.

I understand that the long-term advantages and disadvantages of chronic opioid have yet to scientifically determined and that treatment may change throughout my time as a patient. I understand, accept, and agree that there may be unknown risks associated with the long-term use of controlled substances and my doctor will advise me as knowledge and training advance and will make appropriate treatment changes.

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I understand that all medications have potential side effects. I have been fully informed by the doctor of the potential side effects including, but not limited to: Physical dependence, pseudo-addiction, chemical dependence, addiction, constipation which may be severe enough to require medical treatment, difficulty with urination, drowsiness, cognitive impairment, nausea, itching, depressed respiration, reduced sexual function and adverse effects or injury to organs.

A distinct clinical syndrome, "Hyperalgesia Syndrome", has been described in the literature and can result in increased pain from continual and escalated doses of opioid medication. If I take more medication than prescribed, a dangerous situation could result such as coma, organ damage, or even my death.

I am aware that the development of addiction has been reported rarely in medical journals and is much more common in a person who has a family or personal history of addiction. I agree to tell my doctor my complete and honest personal drug history and that of my family to the best of my knowledge.

I realize that it is my responsibility to keep others and myself from harm, including the safety of my driving. If there is any question of impairment in my ability to safely perform any activity, I agree not to attempt to perform such activity until my abilities have been properly evaluated and/or my medications have been held for four days.

I agree to waive any applicable privileges or right of privacy or confidentiality with respect to prescription medication and I authorize one of the above staff and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency in the investigation of any possible misuse, sale, or other diversion of my pain medication.

(Females only): Narcotics are felt to have minimal risk for development of birth defects. However, if I continue to take these medications throughout pregnancy, my child will be born drug-dependent and need specialized care. I therefore agree that if I plan to become pregnant, or believe I have become pregnant while on these medications, I will immediately notify my obstetrician and Dr. Ghobriel. Doctor and patient agree that this agreement is essential to the doctor's ability to treat the patient's pain effectively and that failure of the patient to abide by the

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terms of this agreement may result in the withdrawal of all prescribed medication by the doctor and the termination of the doctor-patient relationship.

I am aware that certain other medicines such as nalbuphine, pentazocine, buprenorphine, and butorphanol , may reverse the action of the medicine I am using for pain control. Taking any of these other medicines while I am taking my pain medicines can cause symptoms like a bad flu, called a withdrawal syndrome. I agree not to take any of these medicines and to tell any other doctors that I am taking an opioid as my pain medicine and cannot take any of the medicines listed above until discussed with my pain physician.

Acknowledgement

I have read or have had the above form read to me and understand all of it. I have had a chance to have all my questions answered to my satisfaction. By signing this form voluntarily, I give my consent for treatment of my painful condition with opioid medications.

Patient Signature: _____

Doctor Signature: _____

Date: _____

Witness (receipt of copy of agreement):_____