WELCOME TO NEW YORK PAIN MANAGEMENT

The following questionnaire needs to be completed and for ease of your first apt can be faxed to 518-371-0366 or can be entered at the time of your initial evaluation.. **No injections** will be given at this visit.

Also enclosed are directions to our office and some information about the practice. Please note that many of the pages are two-sided.

ALL PATIENTS WILL NEED TO PROVIDE THE FOLLOWING BEFORE THE INITIAL EVALUATION (this includes Worker's Comp and No-Fault patients):

- Copy of medical insurance card, front and back.
- Valid photo ID
- A referral from your Primary Care Doctor if required by your health insurance policy.

WORKER' S COMP PATIENTS WILL NEED TO PROVIDE THE FOLLOWING BEFORE THE INITIAL EVALUATION:

- Insurance card and referral if required by said insurance.
- Completed Worker's Comp information form (enclosed).

NO FAULT PATIENTS WILL NEED TO PROVIDE THE FOLLOWING BEFORE THE INITIAL EVALUATION:

- Medical insurance card and referral if required by said insurance.
- Completed No Fault forms (enclosed, 2 sided).
- Copy of driver's license and car insurance.

Completed forms can be faxed or mailed to New York Pain Management. If faxing, please bring the originals with you to the appointment. If mailing, it is highly recommended that you take a copy of the completed forms before mailing them as well as bring a copy to the appointment.

If you should need to change your appointment, 48-hour notice is required, or a cancellation fee may apply. We accept cash or check only for all payments.

We look forward to seeing you.

Charles F. Gordon III

WELCOME TO NEW YORK PAIN MANAGEMENT, LLC, the office of Dr. Charles F. Gordon III specializing in Interventional Pain Management and Regenerative Medicine.

Decreasing your pain and its impact on your personal and professional life is our first and foremost concern. We deliver a complete program of unique, state-of-the-art pain control techniques to help you:

- Advance your functional ability.
- Improve your emotional well-being.
- Optimize your quality of life.

Our team always employs a caring and responsive attitude. All patients are treated with dignity and respect for privacy, and we will not release any information about you unless we have a signed release to do so. We are committed to providing you with quality pain management services and the highest standards of medical care in a cost-effective manner.

A THOROUGH APPROACH FOR THE BEST RESULTS

We work closely with your referring and primary care doctors. We continuously monitor and measure the effectiveness of your therapies and, on a regular basis, deliver telephone and written updates of your progress to your referring physician and all others that you request.

Optimum pain management begins with an accurate diagnosis of the origin of your pain. We request that referring physicians send us a complete medical history, including results of radiology and laboratory tests, and any previous approaches to pain management that have been taken. Before we can develop a comprehensive, individualized treatment plan for you, you must receive a thorough medical evaluation.

Your first visit includes:

- A detailed medical history and physical examination
- Review of all past diagnostic and treatment data Medication History
- Radiologic Tests: X-ray, CT, MRI, and Bone Scans (Bring pertinent x-rays or MRIs)
- Neurologic Tests: EMG, NCV, and QST
- Laboratory Tests Surgical Reports

TREATMENT OPTIONS

These established and innovative therapies provide a significant reduction or complete elimination of pain in most patients. Your individualized treatment plan may include one or more of the following:

- Joint, spine or nerve injections
- Regenerative therapies such as PRP
- Spinal Cord Stimulation
- SI Fusion or minimally invasive spinal stenosis treatments

We are currently not admitting new patients for medication management, but if requested, will perform a consultation for ongoing medication management by the referring doctor. Nor do we handle the implanted pumps.

APPOINTMENTS - Please bring any MRI or X-rays with you to your first appointment.
Our office hours are from **7:15 am to 3:30 PM Monday-Friday**. Appointments are scheduled from 7:30 am to 3:00 PM. When you call us at (**518)-371-0777**, we will schedule you an appointment. Every effort is made to meet with- patients on time. To speed up your first appointment you may either fax the completed paperwork to (**518)-371-0366**, or we ask that you arrive on time to fill out any necessary paperwork. Should you arrive more than 15 minutes late you may be required to reschedule your appointment.

When unexpected events prevent you from keeping an appointment, we ask that you give us **48** hours advance notice. If you forget to cancel within the 48-hour period and do not show up for an evaluation appointment, **there is a $50 charge** which must be paid prior to your next appointment. Should the appointment be for a procedure, **the charge is $100**. If you forget to cancel or do not arrive for your appointment on three occasions, we reserve the privilege of excusing you from the practice with a 30-day notice and a referral to other practitioners in the area.

MESSAGE CENTER
For medical emergencies we advise you to go the nearest emergency room or to call 911. For non- emergency questions, clinical information, or prescription refills, please call us during office hours. Urgent messages will be relayed to the physician on call**.** ***As a reminder, there are no medication refills after office hours or on Fridays.***

PRESCRIPTION REFILLS
We are currently not accepting new patients for medication management.

FINANCIAL INFORMATION
An "initial registration" phone call will provide information that allows us to verify your coverage and benefits with your insurance carrier. On the day of your appointment and at each visit that follows we require that you bring your insurance card and referral document if required**. Co-payments, Deductibles and/or Co-insurance amounts are due at the time of check-in. We accept cash and check. A $10 billing fee applies if Co-payments are not paid prior to your visit.** ***Note that checks that are returned due to insufficient funds will be subject to *a $15 charge, plus any bank charges, and all subsequent visits will be on a cash only basis.*

REFERRALS
Many insurance companies require Referrals from your Primary Care Doctor. We will attempt to track your referrals, but they are ultimately your responsibility. Regarding referrals, any charge not paid by your insurance company due to an outdated referral, a lack of referral, or visits above the number allowed on your referral, is your responsibility.

NEW YORK PAIN MANAGEMENT
DIRECTIONS TO OUR LOCATIONS

9 OLD PLANK ROAD, SUITE 100, CLIFTON PARK, NY 12065

COMING FROM THE NORTH (Allow least 15 minutes extra driving time due to heavy traffic in the morning): Take I- 87 Southbound, merge on to NY-146 E via EXIT 9E toward Halfmoon. You are now on Rte. 146 heading eastbound. At the next light turn LEFT on to Fire Road.

COMING FROM THE SOUTH: Take I-87 Northbound, merge on to Rte. 146 via Exit 9. At the end of the ramp stay straight through the light. You are now on Fire Road.

COMING FROM THE EAST: Take Route 146 Westbound. Pass thru the intersection of Rte. 146 and Rte. 9. At the next light turn right on to Fire Road.

COMING FROM THE WEST: Take Route 146 Eastbound. Pass UNDER THE NORTHWAY. At the next light turn LEFT on to Fire Road.

****FOR ALL DIRECTIONS**: ****
Once on Fire Road, stay straight and you will pass a Red Roof Inn on your left-hand side; take the first left onto **Clifton Park Village Road**. Continue to veer to your left before the Church. This will put you on **OLD PLANK ROAD**. The green building on the left is G6 Medical & New York Pain Management.

375 BAY ROAD STE 103, BLDG. "B", QUEENSBURY, NY 12804

FROM THE NORTH: 87 South to exit 19 for NY-254 toward Glens Falls/Hudson Falls, continue NY-254 E. Turn Right onto NY-254 E, turn left onto Glenwood Ave. Turn left onto Bay Rd, 375 is on the left. Office is in the back; entrance is labeled with a large "B."

FROM THE SOUTH: I-87 N to NY-254 W/Aviation Rd in Queensbury. Take exit 19 for NY-254 toward Glens Falls, turn right onto NY-254 W/Aviation Rd, turn left onto Glenwood Ave.
Turn left onto Bay Rd. 375 is on the left. Office is in the back; entrance is labeled with a large "B."

New Patient Information

FULL LEGAL NAME

Last Name: _____ First Name: _____Middle: _____
Address:_____City:_____State:___Zip: _____
Home Telephone: ( )_____ Date of Birth:_____ Sex:___ Age: _____
Marital status: Single _____ Married ____ Divorced _____ Widowed_____
E-Mail Address: _____

Race:
_____ White _____ American Indian _____ Black/African American
_____ Alaska Native_____ Asian Native Hawaiian_____ Other Pacific Islander
_____ Not Provided _____ Other

Ethnicity:
_____ Hispanic/Latino _____ Non-Hispanic/Latino
_____ African American _____ Other Not Provided

Language:
_____ English _____ French _____ German _____ Japanese
_____ Mandarin _____ Russian _____ Spanish _____ Other

PATIENT EMPLOYER INFORMATION

[__] Currently employed [__] Unemployed [__] Retired [__] Legally disabled

Company Name: _____
Company Address: _____
City:_____ State:_____ Zip:_____
Work Telephone: (_____) _____

IF MARRIED, PLEASE LIST SPOUSE'S EMPLOYMENT INFORMATION

Spouse's Name: _____
Spouse's Date of Birth: _____
Spouse's Employer: _____

PRIMARY CARE PHYSICIAN

Name: _____ Telephone #: (__) _____
Address: _____

REFERRING PHYSICIAN

Name: _____ Telephone #: (___) _____
Address: _____

PRIMARY CARDHOLDER INFORMATION (If different from patient)

Name:_____
Relationship: _____
Date of Birth:_____
Cardholder's Employer: _____

PRIMARY INSURANCE

Insurance Company: _____ Cardholder's Name: _____
Policy #: _____ Group #: _____

SECONDARY INSURANCE COMPANY

Insurance Company: _____ Cardholder's Name: _____
Policy #: _____ Group #: _____

WORKER'S COMPENSATION, NO FAULT INFORMATION AS APPLICABLE

Date of Injury: _____ Last 4 of SS # _____

WCB #: _____

Workers Compensation Carrier Name and Case Number: _____

Telephone #: ( )_____ Adjuster:_____

Employer at time of injury: _____ Telephone #: ( )_____

Employers Address:_____

_____

Job title: _____

Job duties: _____

_____

_____

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____

I authorize the use or disclosure of the above-named individual's health information from/to my referring physician and other specialists involved in my care. The following additional individual or organization is authorized to make/receive the disclosure i.e., Lawyer, Spouse, etc.:

_____

The type and amount of information to be used or disclosed is the entire medical chart including medical records, office notes, hospital records, pharmaceutical records, laboratory records, X-ray and MRI films, CAT scans, any other radiological films, and medical bills.

I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, treatment for alcohol and drug abuse, pregnancy, and/or family planning.

This information may be disclosed to and used by the following individual or organization for medical evaluation and treatment:

New York Pain Management, LLC
9 Old Plank Road, Suite 100
Clifton Park, NY 12065

I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the person or entity I authorized to release my information. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization shall be in full force and effect until such time as the medical provider no longer maintains the health insurance.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re- disclosure, and the information may not be protected by federal confidentiality rules.

A photocopy of this authorization shall be considered as effective and valid as the original.

WRITE *YES* OR *NO* IN SPACE PROVIDED.

_____ INSURANCE AUTHORIZATION - I hereby authorize New York Pain Management, LLC, to furnish information to my insurance carriers concerning my illness and treatment.

_____ ASSIGNMENT OF BENEFITS - I hereby assign to New York Pain Management, LLC, all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance.

_____ OUT OF NETWORK- I understand it is my responsibility to know my insurance plan benefits and whether a provider is in my network. I agree that I am fully responsible for any costs incurred.

_____ TREATMENT AUTHORIZATION - I hereby authorize New York Pain Management, LLC, to render health care to me during my visit.

_____ APPOINTMENT AUTHORIZATION – I hereby authorize New York Pain Management, LLC, to communicate with me regarding my appointments using my answering machine, other Voice Mail, and authorized persons. AUTHORIZED PERSONS:

_____

SIGNATURE DATE

_____

WITNESS NAME DATE

PAIN QUESTIONNAIRE

Complete and return this form before your arrival for your first appointment. Your answers will help us to understand your pain. Our records are strictly confidential. No outsider is permitted to see your case record without your written permission unless we are required to do so by law (e.g., Worker's Compensation Claims).

Last Name _____ First Name _____ MI _____ Age _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Referring Physician _____

PRIOR PAIN PROCEDURES:

Have you previously had any pain procedures, blocks, or injections? **YES** **NO**

If your answer is YES please specify: _____

Why are you seeking treatment? _____

Have you seen another pain doctor? Who? _____

PAIN DURATION: How long have you had your current pain? _____ YEARS _____ MONTHS

ONSET OF PAIN: How did your current pain start?

☐ Injury at work ☐ Motor vehicle accident

☐ Undetermined ☐ Illness, non-injury

Other _____

TIMING OF PAIN: How often do you have your pain? (Please check one)

☐ Constantly (100% of the time) ☐ Intermittently (30% to 60% of the time)

☐ Nearly constantly (60% to 95% of the time) ☐ Occasionally (less than 30% of the time)

PAIN QUALITY: How would you describe the pain?

☐ Burning ☐ Cramping ☐ Pins & Needles ☐ Sharp

☐ Numbness ☐ Shooting ☐ Aching ☐ Throbbing

☐ Pressing ☐ Other _____

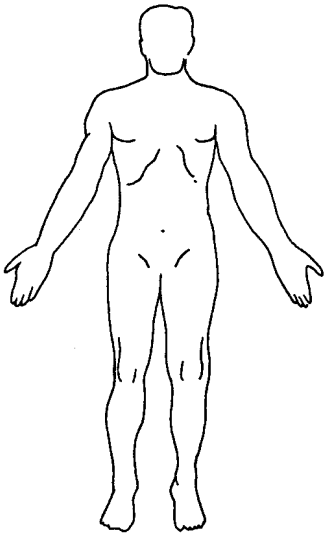
PAIN LEVEL:

CHOOSE THE FACE THAT BEST DESCRIBES HOW YOU FEEL

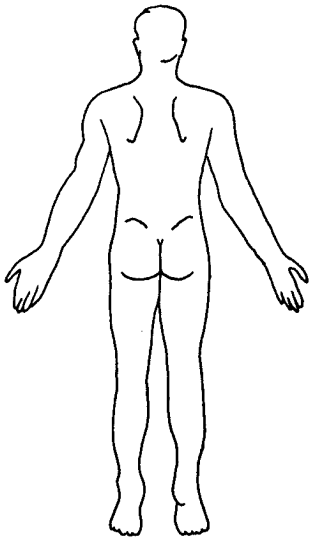
0 1 2 3 4 5 6 7 8 9 10

MILD **MODERATE** **EXTREME**

Patients Name : _____



Front



Back

PAIN LOCATION: Please describe the location(s) of your pain: _____

RELIEVING AND AGGREVATING FACTORS:

How do the following affect your pain? Please check one for each item

	INCREASED	NO CHANGE	DECREASED
Lying down	☐	☐	☐
Standing	☐	☐	☐
Sitting	☐	☐	☐
Walking	☐	☐	☐
Medications	☐	☐	☐
Relaxation	☐	☐	☐
Coughing/Sneezing	☐	☐	☐

How long can you walk before having to stop due to pain? _____ Minutes _____ Hours

How long can you sit before having to get up? _____ Minutes _____ Hours

How long can you stand before you have to sit down? _____ Minutes _____ Hours

Patients Name : _____

PAIN TREATMENTS:

Check all of the treatments you have tried and then indicate the amount of relief if any

	DATE (approx)	No Relief	Moderate Relief	Excellent Relief
Traction		☐	☐	☐
Acupuncture		☐	☐	☐
TENS Unite		☐	☐	☐
Physical Therapy		☐	☐	☐
Heat Treatment		☐	☐	☐
Chiropractic		☐	☐	☐
Exercise		☐	☐	☐

PSYCHOLOGICAL TREATMENT:

Have you ever had psychiatric, psychological, or social work evaluations or treatments for any problem, including your current pain? If yes, when? _____ YES NO

Have you ever considered suicide? _____ YES NO

EDUCATION: Your highest educational level achieved: _____

EMPLOYMENT: Current employment status (please check all that apply):

☐ Employed full-time ☐ Employed part-time ☐ Unemployed ☐ Unemployed because of the pain

☐ Homemaker ☐ Retired ☐ Student

If you are currently unemployed, indicate how long you have been off work:

☐ 1 - 3 weeks ☐ 4 - 7 months ☐ 12 - 18 months ☐ 25 or more months

☐ 1 - 3 months ☐ 8 - 11 months ☐ 19 - 24 months

LEGAL ISSUES: Indicate any of the following you have filed related to your pain:

☐ Workers' compensation ☐ Social Security Disability Insurance (SSDI)

☐ Personal injury/liability (Unrelated to work) ☐ Other insurance ☐ None

Patients Name : _____

SOCIAL HISTORY:

Marital Status: _____ Lives with _____ Number of children _____

Occupation: _____

Exercise:	YES	NO	Type of exercise		
Tobacco use:	YES	NO	Caffeine use:	YES	NO
Alcohol use:	YES	NO	Contraception?	YES	NO

Ever felt the need to cut down alcohol use?	YES	NO
Ever been angry when criticized about your alcohol use?	YES	NO
Ever felt guilty about something that happened while drinking?	YES	NO
Ever needed an “Eye Opener” in the morning?	YES	NO
Illegal drug use?	YES	NO

SUBSTANCE ABUSE:

Do you have a history of alcoholism?	YES	NO
Have you ever been in a detoxification program for drug abuse?	YES	NO
Alcoholics Anonymous?	YES	NO

FAMILY HISTORY:

Alcoholism	YES	NO	Headaches	YES	NO
Asthma	YES	NO	Heart disease	YES	NO
Bleeding disorders	YES	NO	Hepatitis	YES	NO
CAD/Coronary Disease	YES	NO	Hyperlipidemia	YES	NO
Cancer	YES	NO	Hypertension	YES	NO
COPD /Emphysema	YES	NO	Liver disease	YES	NO
CVA/Stroke	YES	NO	Pain	YES	NO
Diabetes	YES	NO	Pancreatitis	YES	NO
Gout	YES	NO	Pneumonia	YES	NO

ARE YOU CURRENTLY PREGNANT?	YES	NO
ARE YOU TRYING TO BECOME PREGNANT?	YES	NO

YOUR PRIOR MEDICAL HISTORY Patients Name : _____

Infectious disease	YES	NO	Describe		
Alcoholism	YES	NO	Heart attack	YES	NO
Anemia	YES	NO	Heart disease	YES	NO
Anxiety	YES	NO	Heart murmur	YES	NO
Arthritis	YES	NO	Hemorrhage	YES	NO
Asthma	YES	NO	Hepatitis	YES	NO
Back pain	YES	NO	HIV	YES	NO
Bleed easily	YES	NO	Hyperlipidemia	YES	NO
Blood clots	YES	NO	Hypertension (HTN)	YES	NO
Coronary Disease	YES	NO	IBS/Irritable Bowel	YES	NO
Cancer/tumor	YES	NO	Insomnia	YES	NO
Carotid stenosis	YES	NO	Kidney disease	YES	NO
Carpal Tunnel Syndrome	YES	NO	Liver disease	YES	NO
COPD/Emphysema	YES	NO	Lung disease	YES	NO
Crohn's Disease	YES	NO	Mitral valve regurg	YES	NO
CVA/Stroke	YES	NO	Narcotic addiction	YES	NO
Depression	YES	NO	Nicotine addiction	YES	NO
Diabetes	YES	NO	Pancreatitis	YES	NO
Diverticulitis	YES	NO	Plantar Fasciitis	YES	NO
Edema	YES	NO	Pneumonia	YES	NO
Endometriosis	YES	NO	PVD/Vascular Disease	YES	NO
Epilepsy/seizures	YES	NO	Scoliosis	YES	NO
Fibromyalgia	YES	NO	Shingles	YES	NO
Fracture	YES	NO	Sleep apnea	YES	NO
Gallbladder problems	YES	NO	Thyroid disease	YES	NO
Gastro-intestinal disease	YES	NO	Ulcer	YES	NO
Glaucoma	YES	NO	Urinary Tract Infection	YES	NO
Gout	YES	NO	Yellow Jaundice	YES	NO
Headaches	YES	NO			

Other _____

SURGERIES:

DATE	HOSPITAL	TYPE OF OPERATION

Patients Name : _____

MEDICATIONS: List all current medications, including any over the counter and dietary supplements.

MEDICATION	DOSE	FREQUENCY

ALLERGIES: I am allergic to dye put into my body _____ YES NO

Other Allergies : _____

_____