Northeastern Rehabilitation ASSOCIATES, P.C.

Concussion Evaluation / Patient Information Sheet

(Please Print)

Patient Name: _____ **Date of Injury:** _____ / _____ / _____
Last First Middle I

Date of Birth: _____ / _____ / _____ **Soc. Sec. # :** _____ / _____ / _____ **Sex:** ☐ M ☐ F

Race: ☐White ☐Black/African American ☐American Indian/Alaska native ☐Asian
☐Native Hawaiian/other Pacific Islander ☐Other _____

Ethnicity: ☐Not of Spanish/Hispanic descent ☐Spanish/Hispanic **Primary Language**:_____

Home #: _____ **Cell #:** _____ **Work #:**_____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Referring Physician: _____ **Phone:** _____

Primary Care Physician: _____ **Phone:** _____

Emergency Contact_____ **Phone:** _____

Person(s) we may speak with regarding your medical/financial information should the need arise:
Name: _____ **Relation:** _____

■ Primary Insurance Company: _____

Insurance ID # : _____ **Group # :** _____

Please enter the policyholder's information below. If you are the policyholder, check this box ☐ and skip to the next section.

Policyholder's Name: _____ **Date of Birth:** _____ / _____ / _____
Last First Middle I.
Relationship to Patient: _____ **Soc. Sec. #** _____ / _____ / _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone _____**Work Phone** _____

Employer: _____

■ Secondary Insurance Company: _____

Insurance ID # : _____ **Group # :** _____

Please enter the policyholder's information below. If you are the policyholder, check this box ☐ and skip to the next section.

Policyholder's Name: _____ **Date of Birth:** _____ / _____ / _____
Last First Middle I.
Relationship to Patient: _____ **Soc. Sec. #** _____ / _____ / _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone _____**Work Phone** _____

Employer: _____

Revised 11/9/18

Northeastern Rehabilitation ASSOCIATES, P.C.

IMPORTANT

It is very important that the attached Medical Record Authorization form be completed and returned to us ***before your visit.***

PLEASE DO NOT SEND THE ENTIRE PACKET BACK – JUST THE AUTHORIZATION FORM. BRING THE COMPLETED PACKET WITH YOU ON THE DAY OF YOUR APPOINTMENT.

Many medical offices will not forward your medical office notes or imaging to us without a signed authorization. If your NERA provider does not have your prior medical records at the time of your initial visit he/she will not be able to fully implement a treatment plan for you.

You may return this form to us by any of the following methods:

- **Fax:** 570-558-6361
- **Scan and email to**: MR@nerehab.com. Note: This address is only for Medical Record Authorization forms. No other communication will be addressed.
- **Mail:** to 5 Morgan Hwy- Suite 4 - Scranton PA, 18508 - Attn: Med Recs
- **Drop Off:** at our office: 5 Morgan Hwy- Suite 4 - Scranton PA, 18508

Northeastern Rehabilitation ASSOCIATES, P.C.

LIMITED PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION FORM
(Please print all information. Form must be signed and dated each year).

Patient Name: _____

SSN (last four digits): _____ **Date of Birth:** _____

Entity Requested to Release Information: _____

Purpose of request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information, about me to the individual(s) listed below.

Who will be authorized to receive information:

Northeastern Rehabilitation Associates, PC
5 Morgan Highway, Suite 4 Scranton, PA 18508

- Secure Communication – Note that regular email is not secure, and it is possible for your PHI to be compromised during transmission from our practice. Do not designate email as your preferred method of disclosure if this is of concern to you.

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; **or**, check **only** those items of the record to be disclosed:

☐ office notes
☐ lab results, pathology reports
☐ x-rays;
☐ financial history report *(previous 3 years only)*
☐ nursing home, home health, hospice, and other physician records
☐ record of HIV and communicable disease testing
☐ record of mental health or substance abuse treatment
☐ Only send the following: _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):
☐ Patient Request ☐ Other (please specify):

- This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____
Patient or Representative Signature Date

_____ _____
Patient or Representative Signature Date

_____ _____
Patient or Representative Signature Date

_____ _____
Patient or Representative Signature Date

You have the right to receive a copy of signed authorizations upon request.

PLEASE COMPLETE THIS SECTION IF THIS IS A WORK RELATED INJURY OR AUTO ACCIDENT
(IF NEITHER, SKIP TO NEXT PAGE)

Patient Name: _____

■ Work Related Injuries

Date of Injury: _____ / _____ / _____ **Claim #:** _____

Employer: _____ **County located in:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____

Contact Name: _____ **Phone:** _____

Address where Injury Occurred- if different than address above:

City: _____ **State:** _____ **Zip:** _____

Job Title: _____ **Usual Job Duties:** _____

■ Auto Accident

Date of Injury: _____ / _____ / _____ **Claim #:** _____

State where Injury Occurred: _____

Auto Insurance Carrier: _____

Insurance ID # : _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____

Contact Name: _____ **Phone:** _____

■ Attorney Information - if Applicable

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____

Patient Name: _____Date of Injury: _____ / _____ / _____

Describe how the injury occurred:

_____

_____

_____

_____

Were you Hospitalized for this Injury ☐ No ☐ Yes- If yes- What Hospital? _____

If injury occurred at school/school event, what school do you attend? _____

_____

Athletic Trainer Name: _____

Do you have memory of the injury? ☐ Yes ☐ No

Symptoms at the time of the concussion:

☐ Unconscious Episode ☐ Dizziness ☐ Headache

☐ Fogginess ☐ Disorientation

☐ Other: _____

Symptoms after concussion / or at this time:

☐ Balance Impairment ☐ Memory Issues ☐ Vision Problems

☐ Movement Problems ☐ Nausea / Vomiting ☐ Disturbed Sleep

☐ Other: _____

Have you had any treatment for this recent injury? ☐ No ☐ Yes, please describe:

_____

_____

_____

Patient Name: _____

Past Medical History:

Do you or have you had any problems with the following: (Check all that apply)

☐ Alcohol Abuse	☐ Diabetes	☐ Kidney Disease
☐ Arthritis (Osteoarthritis)	☐ Fibromyalgia	☐ Liver Disease
☐ Arthritis (Rheumatoid)	☐ GERD (Reflux)	☐ Stroke/ TIA
☐ Asthma	☐ Heart Disease	☐ Thyroid
☐ Cancer	☐ Hepatitis	☐ Anxiety
☐ Cholesterol	☐ HIV/AIDS	☐ Depression
☐ Drug Abuse	☐ Hypertension	

Past Concussion History: ☐ No ☐ Yes, please describe:

_____

_____

_____

Family History: Please check any diseases/disorders that run in your family. **Do not include yourself**.

	Relative		**Relative**		**Relative**
☐ Motion Sickness	_____	☐ Heart disease	_____	☐ Arthritis	_____
☐ Migraine	_____	☐ Hypertension	_____	☐ Alcohol Abuse	_____
☐ Concussion	_____	☐ Diabetes	_____	☐ Drug Abuse	_____
☐ Cancer	_____	☐ Other	_____		

Social History: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

1. Do you Smoke? ☐ No ☐Yes If yes: Packs/Day____ How many years?_____ / ☐ Quit When?_____
2. Do you drink alcoholic beverages? ☐ No ☐Yes If yes, how much per day?_____ Per week?_____
3. Do you use or have you used street drugs? ☐ No ☐Yes
   If yes, what kind and when? _____

Patient Name: _____

MEDICATION INTAKE SHEET

Please list **ALL** medications taken on a daily basis, including **vitamins, herbals and over-the-counter medications**. Please list all **medication allergies.**

Medication Name	Dose/Strength	Times taken per Day	Who Prescribes

Please list any Medications you have tried in the past for this current problem:

Medication: _____ Who Prescribed: _____

Medication: _____ Who Prescribed: _____

Medication: _____ Who Prescribed: _____

Medication: _____ Who Prescribed: _____

Medication: _____ Who Prescribed**:** _____

ALLERGIES: _____

_____

Pharmacy Name _____ **Phone Number**_____

NERA Medication Agreement/Refill Policy

Your treatment plan with NERA may include diagnostic and/ or therapeutic interventions, behavioral medicine, alternative therapies, physical therapy and use of prescription medications. Medications can have serious side effects if they are not managed properly. Your health and safety are very important to us. This agreement is an essential factor in maintaining the trust and confidence necessary in a physician/patient relationship. You will receive information from your NERA physician regarding the risks and potential benefits of these medications and you should address any concerns regarding your medication regimen with your NERA physician.

Please read each statement and sign below. If you have any questions regarding this information or practice policy regarding the prescribing of controlled substances, please request clarification from your NERA physician. If you would like a copy of this Agreement for your records, please ask the staff to provide you with a copy during your visit.

You acknowledge that you:

1. Understand the main goal is to improve your ability to function /work and to reduce pain. You agree to comply with the treatment plan as prescribed by your NERA physician. In addition to utilizing pain medications, other medical treatments, following better health habits such as exercise, weight control and avoiding the use of nicotine and alcohol, may be part of your treatment plan. You understand that it may not be possible to completely eliminate all of your pain.

2. Understand that your medication regimen may be continued for a definitive time period as determined by your NERA physician. Your treatment plan will be reviewed periodically. If there is no significant evidence of improvement or progress being made to improve your functioning or quality of life, the regimen may be tapered or possibly discontinued and your care referred back to your primary care physician.

3. Understand you must inform your NERA provider of **all** medications you are taking, including over-the-counter, herbals, and vitamins, as controlled substances can interact with other medications.

4. Understand that you must notify your NERA physician if you have a history of alcohol and/or drug misuse/addiction, as treatment with controlled substances may increase the possibility of relapse.

5. Understand that there are potential side effects and interactions involved with taking any medication, including the risk of addiction. Possible complications include but are not limited to: constipation, difficulty with urination, fatigue, drowsiness, nausea, itching, stomach cramps, loss of appetite, confusion, sweating, flushing, depressed respiration and reduced sexual function. You may develop a tolerance, and become physically dependent on the medication. You must notify your NERA physician if you experience any adverse effects with your prescribed medications.

6. Understand that opioid medications can cause physical dependence within a few weeks of taking these medicines. If you suddenly stop or decrease the medication, you could experience withdrawal symptoms (including nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24- 48 hour of the last dose. Do not stop these medications without consulting your NERA physician.

7. Understand that the use of alcohol while taking controlled substances is contraindicated.

8. Agree to take the medications only and **exactly** as prescribed by your NERA physician.

9. (Female patients only) Understand that if you plan to get pregnant or believe that you have become pregnant while taking these medications, you will immediately call your Obstetric and NERA physicians to inform them. Understand that many medications could harm the fetus or cause birth defects.

10. Understand that you must exercise extreme caution when taking these medications and driving or operating heavy machinery. The use of these medications may induce drowsiness or change your mental abilities, making it unsafe to drive or operate heavy machinery. If there is any question of your ability to safely perform these activities, you will not attempt to perform the activity until the side effects have had time to resolve.

11. Agree to use only <u>one</u> pharmacy for your pain-related medications. In the event that circumstances require the use of another pharmacy, you will notify NERA of this immediately and provide all pertinent contact information.

12. Understand that NERA does not replace lost or stolen prescriptions or medications or those destroyed by fire, flood, etc. The safekeeping of your medication and prescriptions is your responsibility. This includes keeping medications out of reach of children. You will not share, sell, exchange or otherwise permit others to have access to these medications for any reason.

13. Agree that you will not seek or accept any pain medications other than those prescribed by my NERA physician. This includes prescriptions for pain medications from other physicians, medication borrowed or accepted from family or friends and any illicit or street drugs. If you are in an emergent situation, have surgery, a dental procedure, etc., and are given a controlled substance by another physician, you must notify your NERA physician as soon as possible. You consent to the disclosure of all personal health information related to this matter.

14. Agree that you will not use any illegal substance, (cocaine, heroin, marijuana, etc) while being treated with controlled substances. Using illegal substances will result in a change to your treatment plan, including the safe discontinuation of controlled substances when applicable or may result in the termination of the doctor/patient relationship. * If you are being prescribed *medical* marijuana, you must provide your NERA physician with verification before any controlled substances will be prescribed. Understand that medical marijuana is only legal at the state level and not at the federal level. Physician DEA licenses are registered at the federal level and may choose NOT to prescribe opiates to patients with positive marijuana screens despite PA law.

15. Agree to keep all scheduled appointments. Most patients taking controlled substances will need to be seen at least every one to three months. You understand that no medication prescriptions/refills will be given for canceled or no-show appointments. You understand that if you are 15 minutes late for an appointment time, you will be rescheduled for another appointment and no prescriptions/refills will be given. Scheduled appointments are required for all office visits. NERA physicians do not see “walk-in” patients.

16. Understand that each prescription is for a specific number of pills, designed to last a certain amount of time. Early refills will not be given. It is not our practice to make changes to your prescriptions by telephone. New prescriptions, changes to prescriptions or medication refills will not be addressed after office hours, on weekends, or on holidays. If you are experiencing concerns with your medications, you will be scheduled for an office appointment. Medical Assistants phone triage hours are from 9AM- 4:00PM, Monday through Friday for refill requests and questions. Medical Assistants are assisting the doctors during the day and may not be able to speak with you directly at the time of your call. Please leave detailed information and you will receive a call back before the end of the business day.

17. Understand that your NERA Provider is required to check your prescription history via the state database, *PA Aware*, every time you are prescribed a controlled substance and with medication refills.

18. Understand that you may be asked to bring any or all of your prescribed medicines to the office at a random time or at your office appointment, for a prescription compliance check (Pill Count). Understand that failure to

comply with or discrepancy with pill counts may result in the discontinuation of medication prescriptions and you may be discharged from the practice immediately.

19. Understand that you will undergo random urine drug screens as long as your treatment plan utilizes controlled substances. You accept responsibility for the cost of the urine drug test in the event that your healthcare coverage will not cover the cost of this test. If the results of the urine drug screen do not reflect medicine prescribed by your physician, or you test positive for illegal substances, you understand this may result in the discontinuation of medication prescriptions and you may be discharged from the practice immediately.

20. Understand that altering a prescription in ***any*** way is against the law. Report of forged, falsified, or altered prescriptions will result in your immediate discharge from NERA. NERA cooperates fully with law enforcement agencies in regards to infractions involving prescription medications. Understand that if the responsible, legal authorities have questions regarding your treatment, all confidentiality is waived and these authorities may be given full access to our records of controlled substance administration.

21. Understand that inappropriate, abusive behavior or harassment of any NERA staff member will not be tolerated.

22. Understand that NERA physicians may discontinue any prescriptions, and discharge you from the practice if any of the following occurs:
    - You give, sell, or misuse your pain medication, including but not limited to: taking more medication than prescribed, running out of medication early, obtaining medications at more than one pharmacy,
    - You fail to keep follow- up appointments,
    - You attempt to obtain pain medication after office hours, on the weekend, on holidays, from any other physician, or any other source,
    - You do not cooperate with requested Pill Counts or Urine Drug screens, or there is any discrepancy with results of Pill Counts and/or Urine Drug Screens.
    - You are released from the practice for any reason,
    - Any aggressive behavior toward NERA staff or physicians,
    - Any allegations, suspicious information or an investigation is initiated by anyone regarding potential violations of this agreement, is brought to the attention of your NERA physician.

By signing this document you acknowledge that:

- You have thoroughly read, understand and accept all the above statements.
- You have received and understand the NERA Prescription Refill Policy.
- You agree to adhere to the terms of this Medication Agreement and the NERA Prescription Refill Policy, knowing that failure to do so may result in termination of treatment with all NERA providers.
- This agreement is in effect for the duration of your treatment.
- Your NERA physician may provide a copy of this agreement to your pharmacy, referring physician and all other physicians involved in your care.

Patient Signature _____ Date _____/_____/_____

Patient Name _____ Date of Birth _____/_____/_____
(Please Print)

Pharmacy Name: _____ **Phone#** _____ / _____ / _____

If you change your pharmacy for any reason, you agree to notify this office at the time you receive a prescription.

Reviewed by Physician/Staff Signature _____ Date____/____/____