HealthSpine & Anesthesia Institute

Please assist us in the proper handling of your claims for services provided by Dr. Prvulovic.
Please complete all fields. Thank you

Patient Name:____Male:_____Female:_____
First Middle Last

Date Of Birth:_____________________________ Social Security #: ________-______-_______

Mailing Address: ____

City, State, Zip Code: ____

Telephone: (Home) ____________________________ (Cell) ____________________________________

Email Address: ____

Employer: __________________________Employer Address/Phone: _______________________________

Emergency Contact: ______________________________ Emergency Phone: _________________________

Pharmacy Name:__________________________ Zip Code__________ Phone Number:_______________

Primary Care Physician:_________________________________Phone Number:______________________

INSURANCE INFORMATION

Charges should be billed to:

Health Insurance: ______ Workers Comp: ________ Car Insurance: _________

Responsible Party: ____________________________________ Relationship: ______________________

PRIMARY Insurance Company: ____

Policy/Claim #: _______________________________________ Phone: ___________________________

Group #:_________________________________ Date of Injury/Accident: __________________________

Medical Funds available (if car accident)__________________________

SECONDARY Insurance Company: ____

Policy ID #: ____

Address: ____

Insured's Name: ________________________________ Insured's Date of Birth: ____________________

Attorney Name and Telephone: ____

If work related injury, place of business at time of injury:

____Telephone:_________________________________

Please provide a copy of your health insurance card, front and back,
and a copy of your driver's license. Thank you

TOMI PRVULOVIC, MD

HealthSpine & Anesthesia Institute

ASSIGNMENT OF BENEFITS

I hereby assign all the medical and surgical benefits to which I am entitled and authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan to issue payment(s) directly to **Tomi Prvulovic, MD, Healthspine & Anesthesia Institute** for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

I have requested medical services from Tomi Prvulovic, MD, Healthspine & Anesthesia Institute on behalf of myself and/or my dependents and understand that by making this request, I become fully financially responsible for any/all charges incurred in the course of the treatment.

AUTHORIZATION OF RELEASE OF INFORMATION

I hereby authorize **Tomi Prvulovic, MD, Healthspine & Anesthesia Institute** to release and/all information necessary to insurance carriers, attorneys, etc. regarding my treatments and process insurance claims generated in the course of examination and/or treatment. This order will remain in effect until revoked by me in writing.

MEDICAL AUTHORIZATION FOR RECORDS RELEASE

THIS IS TO AUTHORIZE **Tomi Prvulovic, MD, Healthspine & Anesthesia institute and staff** to release information regarding my condition and care to Medicare, my insurance carrier(s) or other healthcare providers or referring physicians directly associated with my care.

____   _______________________

Patient/Responsible Party Signature   Date

HEALTHSPINE & ANESTHESIA INSTITUTE, LLC

CONDITIONAL ASSIGNMENT OF BENEFITS & AUTHORIZATION TO PURSUE APPEAL AND/OR DENIAL OF APPEAL AND/OD DENIAL OF INSURANCE BENEFITS

Patient Name: ____

Insurer: ____

Policy/Claim #: ____

Medical Provider: **Healthspine & Anesthesia Institute, LLC** EIN/TIN #271184456

In consideration of the professional services rendered by **Healthspine & Anesthesia Institute, LLC**, their shareholders, employees, contractors and agents of assigns; I hereby direct, authorize, assign and consent to the following:

1. The assignment of my rights to bill, collect, appeal/or arbitrate my claims for insurance benefits with regard to the above-captioned claims, to receive any/all communications regarding the claims, any appeals or arbitration of the denial of my claim.
2. The authorization of **Healthspine & Anesthesia Institute, LLC** to act as my agent; in fact, to all aspects regarding the above-captioned claims, to receive any and all communications regarding the claims, any appeals or arbitration of the denial of my claim.
3. The authorization of **Healthspine & Anesthesia Institute, LLC** to initial and prosecute any and all appeals and/or arbitration or legal actions on the denial of my claim, including but not limited to internal appeals with insurance.
4. The authorization of **Healthspine & Anesthesia Institute, LLC** to obtain and/or disclose any private health information as contemplated by HIPPA, limited to my claim for insurance benefits and any appeal there from. I have signed a separate HIPPA authorization for in this regard.
5. The authorization of **Healthspine & Anesthesia Institute, LLC** to file a complaint with regards to any denial of my claim(s) with the New York State Department of Health and Senior Services, the New York State Department of Banking and Insurance as well as any other government agencies with jurisdiction over my claim(s) or the Insurer.
6. The authorization for payment of any/all insurance benefits directly to **Healthspine & Anesthesia Institute, LLC** to which I might be entitled under the above claim.

____ ____________________________

Patient Signature **Date**

NORTHEASTERN ANESTHESIA INSTITUTE, LLC

Assignment of Benefits & Authorization to Pursue Appeal &/or Denial of Insurance Benefits

Patient Name: ____

Insurer: ____

Policy/Claim Number: ____

In consideration of the professional services rendered by Northeastern Anesthesia Associates, LLC (NAI), their shareholders, employees, contractors, agents of assigns, I hereby direct, authorize, assign and consent to the following:

1. The assignment of my rights to bill, collect, appeal and/or arbitrate my claims for insurance benefits with regard to the above captioned claim to NAI.
2. The authorization of NAI to act as my agent-in-fact with regard to all aspects regarding the above captioned claim and to receive any and all communications regarding the claim and any appeals or arbitration of the denial of my claim.
3. The authorization of NAI to initiate and prosecute any and all appeals and arbitration or legal actions on the denial of my claim, including but not limited to internal appeals with the insurer.
4. The authorization with NAI to obtain and disclose any private health information as contemplated by HIPAA, limited to my claim for insurance benefits and any appeal there from. I have signed a separate HIPAA authorization in this regard.
5. The authorization of NAI to file a complaint with regard to any denial of my claim(s) with the New Jersey Department of Health and Senior Services, the New Jersey Department of Banking and Insurance, as well as any other governmental agency with jurisdiction over my claim and/or the insurer.
6. The authorization for payment of any and all insurance benefits directly to NAI to which I might be entitled under the above claim.

____
(Patient Signature or Parent/Legal Guardian)

____
(Date)

TOMI PRVULOVIC, MD
HealthSpine & Anesthesia Institute
Diplomate of the American Board of Anesthesiology and Pain Medicine
Board Certified in Anesthesiology, Pain Medicine & Interventional Pain Management
Tax ID #27-1184456
NY License 3 206029 NJ License #25MA06129800

MEDICAL RECORDS RELEASE

Date: ___________________________

I, ____ HEREBY AUTHORIZE:
Print Patient Name

____
Print Name, Address, Telephone of Referring Physician's Office

TO RELEASE ANY/ALL INFORMATION INCLUDING DIAGNOSIS, RADIOLOGY RECORDS, OFFICE NOTES, MEDICATIONS, HISTORY/PHYSICAL AND ANY/ALL RECORDS OF TREATMENT/EXAMINATION RENDERED TO ME.

RELEASE RECORDS TO: **Tomi Prvulovic, MD**
70 Hatfield Lane, Suite 201
Goshen, NY 10924
Telephone (845)294-2006
Fax (845)615-1590

____

Patient Signature: _____________________________________ **Date:** __________________

TOMI PRVULOVIC, MD
HealthSpine & Anesthesia Institute

SIGNATURE ON FILE / MEDICAL RECORDS RELEASE

I authorize that payment of medical benefits be made on my behalf to **TOMI PRVULOVIC, MD** for Anesthesia and/or Pain Management services provided at St. Anthony Community Hospital, 15 Maple Avenue, Warwick, NY, 70 Hatfield Lane, Suite 201, Goshen, NY.

I authorize any holder of medical information about me to release to Medicare and and/all other insurance carriers and information needed to determine these benefits or the benefits payable for related services. I also authorize any holder of medical information about me to release any/all information including diagnosis, radiology records, hospital records, office notes and any/all records of treatment or examination rendered to me.

____ __________________________
Patient/Insured Signature **Date**

____ __________________________
Relationship If Signed By other than Patient/Insured **Date**

TOMI PRVULOVIC, MD

HealthSpine & Anesthesia Institute

Date Of Visit: **Patient Name:**
Age: **Weight:**
Referring Physician: **Sex:** **Height:**

To better understand and treat your pain, please answer the following questions.

Chief Complaint: (Where is the pain?)

Duration: (How long have you had this pain?)

History of Present Illness: (Please describe the onset and course of the pain. Also list all the pain management you received in the past.)

Have you received physical therapy? ☐ yes ☐ no If so, When?______________________________
Factors aggravating the pain: (Please list all the events that make your pain worse.)

Factors easing the pain: (Please list all the events that make your pain better.)

Nature of the pain: (Please write the word or words that best describe your pain, e.g., sharp, dull, burning, throbbing, stabbing, shooting, radiating, nagging, pounding, pulling, tugging, aching, cramping, stinging, etc.)

Frequency of the pain: ☐ transient ☐ intermittent ☐ constant
Intensity of the pain: ☐ mild ☐ moderate ☐ severe ☐ excruciating
Does the pain wake you up at night? ☐ yes ☐ no

Pain Score: "0" = no pain "10" is the worst pain imaginable, on a scale of 0-10 how would you rate your pain now?
____/10 best _____/ 10 average _____/10 worst
How does the pain make you feel?

Review of Systems:

Neurological:	☐dizziness	☐tingling	☐seizures	☐tremors	☐numbness	☐weakness
	☐dysphagia	☐confusion	☐headaches	☐loss of consciousness		
Constitutional:	☐fatigue	☐fevers	☐chills	☐weight loss	☐sweating	☐weakness
Eyes:	☐eye pain	☐vision loss	☐double vision	☐photophobia	☐blurred vision	☐eye discharge &
Ears, Nose, mouth, throat:		☐nosebleed	☐sinus pain	☐hearing loss	☐tinnitus	☐ear pain
	☐congestion	☐ stridor	☐sore throat	☐ear drainage		
Respiratory:	☐cough	☐sputum	☐wheezing	☐hemoptysis	☐shortness of breath	
Cardiovascular:	☐murmur	☐chest pain	☐palpitations	☐orthopnea	☐claudication	☐leg swelling
	☐nocturnal dyspnea					
Gastrointestinal:	☐constipation	☐nausea	☐vomiting	☐heartburn	☐diarrhea	☐abdominal pain
	☐blood in stool	☐melena				
Genitourinary:	☐dysuria	☐hematuria	☐flank pain	☐urinary urgency	☐ urinary frequency	
Hematologic/lymphatic:		☐easy bruising	☐allergies	☐polydipsia		
Musculoskeletal:	☐myalgia	☐arthralgias	☐stiff joints	☐back and neck pain		
Behavior/Psych:	☐anxiety	☐depression	☐memory loss	☐suicidal thoughts	☐sleep disturbance	
	☐insomnia	☐hallucinations	☐substance abuse			

Which of the following conditions are you currently being treated or have been treated for in the past (please check)

☐ Congestive Heart Failure ☐ High Blood Pressure ☐ Carotid Artery Disease ☐ High Cholesterol ☐ Atrial Fibrillation ☐ Aortic Aneurysm	☐ Anemia ☐ Stroke ☐ Angina ☐ Heart Attack ☐ Heart Disease ☐ Heart Murmur	☐ Chronic Cough ☐ Sinusitis ☐ COPD ☐ Pulmonary Embolism ☐ Pulmonary Edema ☐ Sleep Apnea	☐ Hepatitis ☐ Ulcerative colitis ☐ Colitis ☐ Gastric Reflux ☐ Gastric Ulcer ☐ Heartburn ☐ Pancreatitis	☐ Urinary Tract Infection ☐ Kidney___________ ☐ Bladder___________
☐ Hypothyroid ☐ Hyperthyroid ☐ Diabetes	☐ Glaucoma ☐ Cataracts ☐ Macular Degeneration	☐ Memory Loss ☐ Depression ☐ PTSD ☐ Anxiety	☐ Arthritis ☐ Cancer ☐ Tremor	

Please describe any current or past medical treatment not listed above

____

____

____

Please list your past surgeries

____

____

____

Allergies

Are you allergic to penicillin or any other drugs? ☐ Yes ☐ No

Please List: ____

Medications

Social and Preventive History

Do you currently smoke or chew tobacco? ☐ Yes ☐ No If no, have you in the past? ☐ Yes ☐ No

How many packs per day? ____________________________

Do you drink alcohol, beer or wine? ☐ Yes ☐ No If no, have you in the past? ☐ Yes ☐ No

How many drinks per week? __________________________

Family History

Has any member of your family (including children and parents) had any of the following illnesses:

Illness:	Which family member?
Anemia or Blood disease	______________________
Cancer	______________________
Diabetes	______________________
Glaucoma	______________________
Heart disease	______________________
High blood pressure	______________________
HIV disease / AIDS	______________________
Mental illness / Depression	______________________
Stroke	______________________
Other serious illness	______________________

Psychosocial History: (For those questions you don't feel comfortable with you can leave them blank.)

Are you currently disabled? □ yes □ no

If "yes" since when have you been disabled?

If "no" what is your current occupation?

Are you currently suing anyone for your pain and suffering? □ yes □ no

Have you ever thought of committing suicide? □ yes □ no

Do you have a history of substance abuse? □ yes □ no

Were you physically abused in the past? □ yes □ no

Were you sexually abused in the past? □ yes □ no

Marital status: □ single □ married □ widowed □ divorced □ separated

If married, how do you describe the relationship with your spouse?

□ poor □ fair □ good □ excellent

Goal of pain management: (What is your expectation of this pain management? Please check one or more from the following.)

□ Pain relief □ Functional recovery □ Returning to work

How long can you perform the following before you need to change position (minutes/hours)?

Sitting ____________________________ Standing __________________________ Walking ___________________

Lifting ___________________________ Pushing ___________________________ Pulling ___________________________

Stairs ____________________________

Are you able to drive? Yes or No

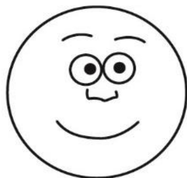
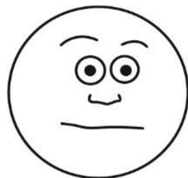
If no who drove you to your appointment?

If you take narcotic medication, are you aware it is against the law in New York and New Jersey to drive while taking narcotics? Yes or No

Do you use an assisted device to walk, stand etc. (walker cane etc.) ___________________________________

Do you need assistance with hygiene dressing activities of daily living? Yes or No

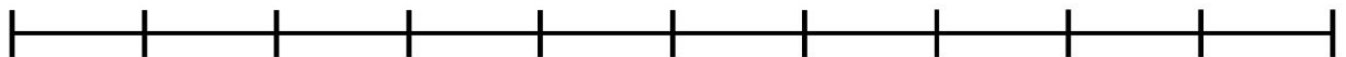
Faces Pain Scale

Very happy, No Hurt	Hurts just a little bit	Hurts a little more	Hurts even more	Hurts a whole lot	Hurts as much as you can imagine (don't have to be crying to feel this much pain)

NUMERICAL PAIN SCALE

0 1 2 3 4 5 6 7 8 9 10



No Pain — Moderate Pain — Severe Pain

SOAPP-R

The following are some questions given to patients who are on or are being considered for medication for their pain. Please answer each question as honestly as possible. There is no right or wrong answer.

	NEVER	SELDOM	SOMETIMES	OFTEN	VERY OFTEN
1. How often do you have mood swings?	O	O	O	O	O
2. How often have you felt a need for higher doses of medication to treat your pain?	O	O	O	O	O
3. How often have you felt impatient with your doctors?	O	O	O	O	O
4. How often is there tension in the home?	O	O	O	O	O
5. How often have you counted pain pills to see how many are remaining?	O	O	O	O	O
6. How often do you feel bored?	O	O	O	O	O
7. How often have you taken more pain medication than you were supposed to?	O	O	O	O	O
8. How often have you worried about being left alone?	O	O	O	O	O
9. How often have you felt a craving for medication?	O	O	O	O	O
10. How often have others expressed concern over your use of medication?	O	O	O	O	O
11. How often have any of your close friends had a problem with alcohol or drugs?	O	O	O	O	O
12. How often have others told you that you had a bad temper?	O	O	O	O	O
13. How often have you felt consumed by the need to get pain medication?	O	O	O	O	O
14. How often have you run out of pain medication early?	O	O	O	O	O
15. How often have others kept you from getting what you deserve?	O	O	O	O	O
16. How often, in your lifetime, have you had legal problems or been arrested?	O	O	O	O	O
17. How often have you attended an AA or NA meeting?	O	O	O	O	O
18. How often have you been sexually abused?	O	O	O	O	O
19. How often have others suggested that you have a drug or alcohol problem?	O	O	O	O	O
20. How often have you had to borrow pain medications from your family or friends?	O	O	O	O	O
21. How often have you been in an argument that was so out of control that someone got hurt?	O	O	O	O	O
22. How often have you been concerned that people will judge you for taking pain medication?	O	O	O	O	O
23. How often have you felt that things are just too overwhelming that you can't handle them?	O	O	O	O	O

Please include any additional information you wish about the above answers. Thank you.

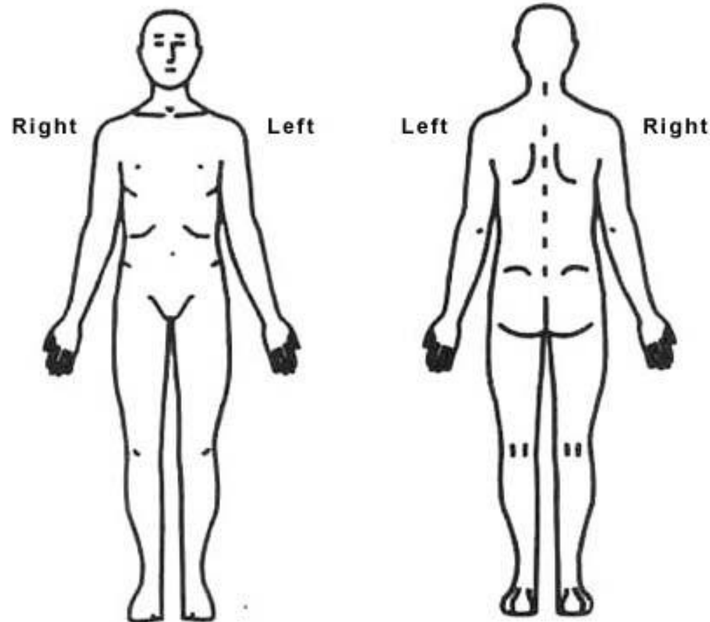
Brief Pain Inventory (Short Form)

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

0% No Relief	10%	20%	30%	40%	50%	60%	70%	80%	90%	100% Complete relief

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

0 Does not interfere	1	2	3	4	5	6	7	8	9	10 Completely interferes

B. Mood:

0 Does not interfere	1	2	3	4	5	6	7	8	9	10 Completely interferes

C. Walking ability:

0 Does not interfere	1	2	3	4	5	6	7	8	9	10 Completely interferes

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

0 Does not interfere	1	2	3	4	5	6	7	8	9	10 Completely interferes

E. Relations with other people:

0 Does not interfere	1	2	3	4	5	6	7	8	9	10 Completely interferes

F. Sleep:

0 Does not interfere	1	2	3	4	5	6	7	8	9	10 Completely interferes

G. Enjoyment of life:

0 Does not interfere	1	2	3	4	5	6	7	8	9	10 Completely interferes

---

What is your present work status?

_____Employed _____Unemployed _____Disabled

If you are employed, are you _____Part-time _____Full-time

If you are not presently employed, what is the last day that you worked?

Briefly describe your job/responsibilities:

Have you returned to work since the date of your last office visit/procedure?
_____Yes _____No

If "Yes", date you returned to work: ________________________

What are your work restrictions/limitations: (Please **circle** appropriate answers)

Walking, Bending, Pushing, Pulling, Reaching, Standing, Stairs, Squatting, Stretching, Other: ____

What pain management treatments, medications, procedures, surgeries, and therapies have you had prior to your visit today? Please also indicate if they did help your pain or did not help your pain.