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Northeast Rehab

Spine • Sports • Neuro • Pain

Thank you for choosing Northeastern Rehabilitation Associates

-www.nerehab.com-

To ensure we are providing quality care, we need information from you and need to provide you with information about our practice policies. Our ***New Patient Brochure*** *is enclosed and it outlines our services and practice policies. Please review prior to your visit.*

Please complete the attached ***New Patient Packet*** *in its entirety* ***prior to arriving*** *for your appointment. This information is important for your physician to review with you during your initial visit and if not completed, it may delay your appointment time.*

At NERA, we have a team approach to concussion therapy. Our team will work with you to create an effective treatment plan. The goal with concussion therapy is to provoke some of the symptoms while avoiding overstimulating the brain in the hopes these activities will become easier and easier, in essence, retraining the brain. Patient Health Questionnaires are tools used to assist in creating your treatment plan. Please complete the enclosed ***SOAPP-14*** *questionnaire and bring with you to your first visit. You may be asked to update this information annually or more often as your treatment plan changes over time.*

To provide you with secure electronic access to our physicians and staff, Northeastern Rehabilitation Associates utilizes a ***Patient Portal****. Instructions for access are included in this packet. You can request appointments, update your medical history, medications, allergies, and send a note to your provider. Your provider may send forms for you to complete as part of your treatment plan via the Portal as well.*

We encourage you to sign up for the Patient Portal before your first visit.

Patient Information

Patient Name: _____

Date of Birth: _____ Social Security #_____ 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:_____

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

Address: _____

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 Information

Name of Insurance Company_____

Policy Number_____ Group Number _____

Policyholder Information - If you are the policyholder, check this box ☐ and skip to the next section.

Name of Policy Holder:_____ Relationship to Patient: _____

Date of Birth: _____ Social Security #_____ Phone: _____

Address: _____

Employer: _____

Secondary Insurance Information

Name of Insurance Company_____

Policy Number_____ Group Number _____

Policyholder Information - If you are the policyholder, check this box ☐ and skip to the next section.

Name of Policy Holder:_____ Relationship to Patient: _____

Date of Birth: _____ Social Security #_____ Phone: _____

Address: _____

Employer: _____

Work / Auto Related Injury

Is this the result of an accident: ☐Auto ☐Work Date of Injury/Accident: _____

Insurance Carrier:_____ Contact Name/Phone:_____

Address:_____

Claim Number:_____ Insurance ID Number_____

If Auto Accident, State where injury occurred: _____

If Work Injury, Employer Name:_____

Employer Address: _____

County: _____ Contact Name/Phone: _____

Address where injury occurred: _____

Job Title: _____ Job Duties: _____

Adjuster Handling Claim (Name/Phone): _____

Attorney Handling Claim (Name/Phone): _____

Patient Name: _____ **DOB:**_____

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: _____ **DOB:**_____

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: _____ **DOB:**_____

Medication Intake Sheet

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

Medication Name	Dose / Strength	Times taken per Day	Prescribing Doctor	Reason for Taking Medication

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**:** _____

Please list ALL Medication Allergies:

_____

_____

Pharmacy Name _____ **Phone Number**_____

Pharmacy Address (if known): _____

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Screener and Opioid Assessment for Patients with Pain- SOAPP V1- 14Q

As part of your treatment plan with your Northeastern Rehabilitation Associates (NERA) physician, you may receive a prescription for a controlled substance medication. In addition to medication agreements and random drug screen protocols, NERA requires a medication screening form to be completed by all patients receiving these medications. **Your health insurance may also require a pre authorization of this medication before it can be filled by your pharmacy. The pre authorization process also requires the completion of this form.**

Print Name: _____ DOB: _____ Today's Date: _____

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

Please answer the questions below using the following scale: (Circle answer)

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1.	How often do you have mood swings?	**0 1 2 3 4**
2.	How often do you smoke a cigarette within an hour after you wake up?	**0 1 2 3 4**
3.	How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	**0 1 2 3 4**
4.	How often have any of your close friends suggested that you have a drug or alcohol problem?	**0 1 2 3 4**
5.	How often is there tension in the home?	**0 1 2 3 4**
6.	How often have you attended an AA or NA meeting?	**0 1 2 3 4**
7.	How often have you taken medication other than the way it was prescribed?	**0 1 2 3 4**
8.	How often have you been treated for an alcohol or drug problem?	**0 1 2 3 4**
9.	How often have your medications been lost or stolen?	**0 1 2 3 4**
10.	How often have others expressed concern over your use of medication?	**0 1 2 3 4**
11.	How often have you felt a craving for medication?	**0 1 2 3 4**
12.	How often have you been asked to give a urine screen for substance abuse?	**0 1 2 3 4**
13.	How often have you used illegal drugs (example marijuana, cocaine, etc) in the past five years?	**0 1 2 3 4**
14.	How often, in your lifetime, have you had legal problems or been arrested?	**0 1 2 3 4**

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

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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.
    - **Refills requests must be made at least two business days before your medication runs out**. **Requests made after this time frame will not be expedited.**
    - 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 are assisting the providers 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 within 48 hours. If you are experiencing an emergency, please call 911 or go to an Emergency Room.
- Please review *Medication Refill Policy* posted in all office locations for further details.

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**____/____/____

* If above is unsigned, this is a blank copy for patient to keep after e-signature was obtained during office visit.

6/04,/7/05,7/10,9/17, 4/21

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MEDICATION REFILL POLICY

****Refills requests must be made at least two business days before your medication is due. Requests made after this time will not be expedited. ****

When using your NERA Patient Portal or leaving a message in our Prescription Refill Voice Mail system, please leave your name, date of birth, pharmacy information and phone number.

Please do not leave repeat messages as this will delay response time.

- Refill requests will be addressed 9:00 AM- 4:00 PM, Monday through Friday. **Requests made after 4:00 PM will not be addressed until the next business day**

- Please check with your pharmacy for completed refill requests. We will only call you if there is a question regarding your refill. If you are experiencing an emergency, please call 911 or go to an Emergency Room.

- Early refills will not be given.

- It is not our practice to make changes to your prescriptions by telephone. You may be scheduled for an office visit to address medication concerns or changes.

- New prescriptions, changes to prescriptions or medication refills will not be addressed after office hours, on weekends, or on holidays.

- We do not accept walk-ins for refill requests.

- Lost or stolen prescriptions/medications will not be replaced.

- No refills will be given for canceled or no show appointments.

Please refer to your Medication Agreement for more information regarding Prescription Refills.