

Malik Momin, M.D.  
*Diplomat American Board of Anesthesiology  
Certified (ABA) Pain Management*

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*Diplomat American Board of PM&R  
Certified (ABPMR) Pain Management*

### ***Pre Procedure Instructions***

You have been scheduled to have a procedure performed at Harrisburg Interventional Pain Management Center.

Maximilian Braun III, M.D.  
*Diplomat American Board of PM&R  
Certified (ABPMR) Pain Management*

#### **General Information:**

- Please bring a list of all medications (prescribed and over the counter) as well as the dosages of the medications that you take.
- Please bring your insurance cards. Co-pays are to be paid at the time of check in.
- Please bring your driver's license or photo identification.
- If a medical emergency occurs while you are at our facility, you may require admission to a hospital.
- We do not allow smoking in our facility.
- We request that cell phones be turned off while in the facility.
- We do not allow animals except service animals in our facility.
- Weapons are not permitted in the facility.
- We request that you do not bring valuables to the facility. If you do, we will ask that you place the valuables in a locker.
- If you are unable to keep the scheduled appointment, please call to reschedule the appointment. If you do not call to reschedule 24 hours prior to the appointment and do not keep the appointment, you will be charged \$50.00. This charge will be your responsibility, and your insurance will not cover this cost.
- \*If you are taking an anticoagulant or "blood thinner" (listed below), you will need to check with the physician who prescribed the medication to determine if you can stop the medication for the appropriate amount of time.

Coumadin/ Warfarin -3days	Persantine- 7 days	Aggrastat-7 days
Plavix -7 days	Pletal- 7 days	Aggrenox- 7 days
Ticlid- 7 days	Trental- 7 days	Heparin- 12 hours
Lovenox- 12 hours	Rivaroxaban- 24 hours	

#### **Pre-procedure Instructions**

- Please continue to drink and eat as you normally would.
- Take all your usual medications except anticoagulants.
- Please allow 2 hours for your first visit to our facility.
- You should not need a driver to accompany you.

#### **IF YOUR PROCEDURE REQUIRES THAT YOU HAVE SEDATION:**

- Do **not** eat or drink anything 6 hours before your scheduled procedure.
- You must remain at the facility for at least 1 hour after the procedure.
- You **must** have a driver take you home. You should not drive for 12 hours after receiving sedation.

Please call 717.901.5008 if you have any questions.

Susquehanna Valley Pain Management P.C.

**Patient Information Today's Date: / /**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_  
(LAST) (FIRST) (MI)

Address \_\_\_\_\_  
(CITY) (STATE) (ZIP CODE)

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Age \_\_\_\_\_ Marital Status: S M W D Sex: Male/Female Race: \_\_\_\_\_

Employer \_\_\_\_\_ Phone# \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone# \_\_\_\_\_ Referring Physician \_\_\_\_\_

**Insurance Information**

PRIMARY INSURANCE \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_

Subscriber SS# \_\_\_\_\_ Subscriber Address \_\_\_\_\_  
(IF DIFFERENT FROM PATIENT ADDRESS)

SECONDARY INSURANCE \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_

Subscriber SS# \_\_\_\_\_ Subscriber Address \_\_\_\_\_  
(IF DIFFERENT FROM PATIENT ADDRESS)

**Workers Compensation/ Automobile Accident Information** Date of Injury \_\_\_\_\_

(CIRCLE IF APPLICABLE)

Insurance Carrier Name \_\_\_\_\_ Contact Person \_\_\_\_\_

Policy # \_\_\_\_\_ Claim # \_\_\_\_\_ Group# \_\_\_\_\_

Insurance Co Address \_\_\_\_\_ Phone# \_\_\_\_\_

Attorney Name \_\_\_\_\_ Address \_\_\_\_\_ Attorney Phone# \_\_\_\_\_

Employer Name (IF WC) \_\_\_\_\_ Employer Phone# \_\_\_\_\_ Contact Name \_\_\_\_\_

Employer Address \_\_\_\_\_

## Susquehanna Valley Pain Management Patient Health History

**The following information is very important to your treatment. Please take time to fully and completely fill out this important information. We are counting on you!**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Age: \_\_\_\_\_

### Chief Complaint

(Reason for today's visit) What kind of symptoms are you having? Include numbness, tingling, weakness of arms or legs, etc. \_\_\_\_\_

How long have you had these symptoms? \_\_\_\_\_  
Please check any of the following treatments you have tried to relieve your symptoms and indicate if it was successful:

Tried Successful	Tried Successful
____ Physical Therapy	____ TENS Unit
____ Pain Medication	____ Oral Steroids
____ Heat	____ Reduction of Activity
____ Ice	____ Epidural Steroid Injections
____ Anti-inflammatory medications	____ Bed rest
____ Chiropractic Care	____ Exercise program
____ Massage Therapy	____ Other: _____
____ Work Hardening Program	_____

What makes the pain better? \_\_\_\_\_

What makes the pain worse? \_\_\_\_\_

Has anyone in your family ever had the same or similar problem? (Please list who & what type of problem) \_\_\_\_\_

Please name any physicians that you have seen about your pain:  
\_\_\_\_\_  
\_\_\_\_\_

Occupation: \_\_\_\_\_ Are you currently working? Yes No

If no, when did you last work? (Please give date) \_\_\_\_\_

Do you have any medical work-related restrictions Yes No. If yes, please give the name of the physician who put you on restrictions \_\_\_\_\_

How long have you been on restrictions? \_\_\_\_\_

### Social History

Marital Status: Single Married Divorced Widowed

Do you have children Yes No How many \_\_\_\_\_

Do you live alone? Yes No Who lives with you? \_\_\_\_\_

Do you smoke? No Yes Packs per day \_\_\_\_\_

Do you drink alcohol?	No, never or rarely	No, but I used to
Yes Daily	1 or more times per week	1 or more times per month

### Past Medical History

Please list any significant medical diseases you are currently being treated for or have had in the past. (For example, heart disease, high blood pressure, diabetes, etc.) Please include anything for which you take medication. \_\_\_\_\_

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### Surgeries-please list year of surgery

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Have you ever had any problems with anesthesia?    Yes    No

### Medications

*List any medications, vitamins and/or herbal supplements that you take.*

_____	Dose _____ mg	_____	Times per day
_____	Dose _____ mg	_____	Times per day
_____	Dose _____ mg	_____	Times per day
_____	Dose _____ mg	_____	Times per day
_____	Dose _____ mg	_____	Times per day
_____	Dose _____ mg	_____	Times per day
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_____	Dose _____ mg	_____	Times per day
_____	Dose _____ mg	_____	Times per day
_____	Dose _____ mg	_____	Times per day

Please list any allergies to medications: \_\_\_\_\_

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### Diagnostic Studies

MRI \_\_\_\_\_ When \_\_\_\_\_ Where \_\_\_\_\_

X-ray \_\_\_\_\_ When \_\_\_\_\_ Where \_\_\_\_\_

CT Scan \_\_\_\_\_ When \_\_\_\_\_ Where \_\_\_\_\_

EMG \_\_\_\_\_ When \_\_\_\_\_ Where \_\_\_\_\_

Other tests \_\_\_\_\_

## Review of Systems

### Constitutional Symptoms

Poor general health lately.....No Yes  
Recent weight change.....No Yes  
Fever.....No Yes  
Fatigue.....No Yes

### Eyes

Eye disease or injury.....No Yes  
Wear glasses/contacts.....No Yes  
Glaucoma.....No Yes  
Cataracts.....No Yes

### Ear/Nose

Hearing loss.....No Yes  
Wear hearing aids.....No Yes  
Nose bleeds.....No Yes

### Neurological

Frequent/recurring headaches.....No Yes  
Lightheadedness or dizziness.....No Yes  
Convulsions or seizures.....No Yes  
Stroke.....No Yes  
Head injury.....No Yes

### Cardiovascular

Heart trouble.....No Yes  
Chest pain or angina.....No Yes  
Palpitations.....No Yes  
High Blood Pressure.....No Yes  
Swelling of ankles, hands, or feet.....No Yes

### Respiratory

Chronic or frequent cough.....No Yes  
Spitting up blood.....No Yes  
Shortness of breath at rest.....No Yes  
Shortness of breath with exercise.....No Yes  
Asthma or wheezing.....No Yes

### Gastrointestinal

Loss of appetite.....No Yes  
GERD (acid reflux).....No Yes  
Nausea or vomiting.....No Yes  
Constipation.....No Yes  
Frequent diarrhea.....No Yes  
Ulcer (stomach or duodenal).....No Yes

### Genitourinary

Frequent urination.....No Yes  
Incontinence.....No Yes  
Kidney stones.....No Yes

### Musculoskeletal

Joint pain.....No Yes  
Joint stiffness or swelling.....No Yes  
Weakness of muscles or joints.....No Yes  
Muscle pain or cramps.....No Yes  
Back pain.....No Yes  
Neck pain.....No Yes  
Difficulty walking.....No Yes  
Cold extremities.....No Yes

### Endocrine

Glandular/hormonal problem.....No Yes  
Thyroid disease.....No Yes  
Diabetes.....No Yes

### Hematologic/Lymphatic

Cuts slow to heal.....No Yes  
Bleeding/bruising tendency.....No Yes

### Allergic/Immunologic

History of skin reaction or other adverse reaction to:  
Morphine, Demerol or other narcotic.....No Yes  
Penicillin or other antibiotic.....No Yes  
Novocain or other anesthetic.....No Yes

### Infections

Do you currently have tuberculosis? .....No Yes  
Have you ever had an infection requiring long-term antibiotics or other medications? ....No Yes

### Cancer

Type: \_\_\_\_\_  
Chemotherapy.....No Yes  
Radiation.....No Yes  
Currently being treated.....No Yes

Please state: Height \_\_\_\_\_

Weight \_\_\_\_\_

**The above is true and correct to the best of my belief.**

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**Patient Signature or Signature of Person completing the form.**

Date: \_\_\_\_\_

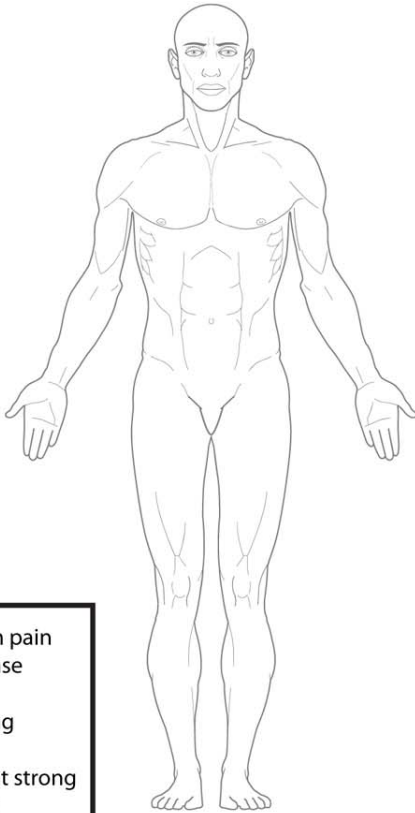
Please indicate your level of pain using a scale of 0-10 (0 is no pain, 10 is the worst pain imaginable.)

Pain level at its lowest (0-10): \_\_\_\_\_

Pain level at its most intense (0-10): \_\_\_\_\_

Current pain level (0-10): \_\_\_\_\_

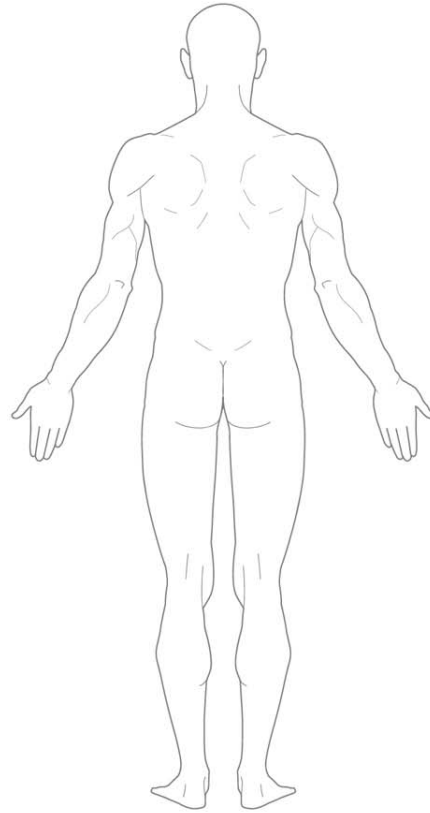
**USING THE DIAGRAM BELOW, PLEASE INDICATE WHERE YOUR PAIN IS LOCATED.**



Front



Left side



Back



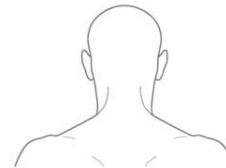
Right side



Front



Left side



Back



Right side

- 10 - Maximum pain
- 9 - Very intense
- 8 - Intense
- 7 - Very strong
- 6 - Strong
- 5 - Somewhat strong
- 4 - Moderate
- 3 - Weak
- 2 - Very, very weak
- 1 - Slight pain
- 0 - No pain

**BP:** \_\_\_\_\_ **HR:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Reviewed by:** \_\_\_\_\_

Susquehanna Valley Pain Management  
**HIPPA Acknowledgement and Consent**

Patient's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

I have received the "Notice of Privacy Practices" for Susquehanna Valley Pain Management.

\_\_\_\_\_  
Signature of Patient (or Patient's Personal Representative)

Date \_\_\_\_\_  
Relationship \_\_\_\_\_

**Assignment of Insurance Benefits and  
Billing Policy**

I hereby assign all rights and privileges and authorize payment directly to Susquehanna Valley Pain Management for any claim filed on my behalf or on the behalf of the person for whom I am duly authorized to sign for insurance benefits.

Patient Signature or Legal Representative \_\_\_\_\_ Date \_\_\_\_\_

I understand that my insurance is a contract between my insurance company and I and that I am financially responsible for all charges whether or not the charges are paid by my insurance. Patient Initials here \_\_\_\_\_

I understand that co-pays and deductibles are to be paid at the time of service. I am aware that co-pays and deductibles are determined by my contract with my health insurance plan. Patient Initials here \_\_\_\_\_

I hereby authorize Susquehanna Valley Pain Management to act on my behalf in requesting a reconsideration of medical determination, to file an appeal or grievance to my insurance company for underpayment or payment related issues. Patient Initials here \_\_\_\_\_

I understand that if I fail to make timely payment to Susquehanna Valley Pain Management, I agree to pay any collection cost or attorney fees resulting from collection of my account. Patient Initials here \_\_\_\_\_

**Medicare and Medicaid ONLY**

Assignment of Benefits- I request that payment of authorized Medicare and/ or Medicaid benefits to be made to Susquehanna Valley Pain Management. I authorize the release of medical information as may be required to secure payment for the medical services that were rendered. I understand that I am responsible for any coinsurance, unmet deductibles and services not covered by Medicare and/ or Medicaid.

Signature of Patient or Legal Representative \_\_\_\_\_

Date \_\_\_\_\_

**HARRISBURG INTERVENTIONAL PAIN MANAGEMENT CENTER**  
*Billing Information*

**ITEM I:** You were seen by your physician, Dr. Momin, Dr. Haueisen, or Dr. Braun, of **Susquehanna Valley Pain Management** for evaluation of your medical condition. Your physician has recommended a surgical procedure at **Harrisburg Interventional Pain Management Center**. Please be advised that Dr. Momin, Dr. Haueisen and Dr. Braun own interest in **Harrisburg Interventional Pain Management Center**.

**Harrisburg Interventional Pain Management Center** is a Medicare-approved facility and is licensed by the Commonwealth of Pennsylvania to provide ambulatory/outpatient surgery in its location at 825 Sir Thomas Court, Harrisburg, PA. **Harrisburg Interventional Pain Management Center** is accredited by the American Association for Ambulatory Health Care, Inc. (AAAHC), the renowned Chicago-based accrediting organization that operates in this capacity.

Both entities, **Susquehanna Valley Pain Management** and **Harrisburg Interventional Pain Management Center** are located in the same building at 825 Sir Thomas Court, Harrisburg, PA. Each of the aforementioned entities is a separate and distinct business.

**ITEM II:**

If you have decided to have your surgical procedure at **Harrisburg Interventional Pain Management Center**, there will be two separate charges:

1. A charge from **Susquehanna Valley Pain Management** for your surgeon's fee. This charge is what your physician charges for performing a surgical procedure.
2. A charge from **Harrisburg Interventional Pain Management Center** for a facility fee. This charge covers the use of the operating and recovery rooms, sedation/analgesia (if used), equipment, supplies and medications necessary to perform your surgical procedure. It also covers the services of the clinical staff.

Both you and your insurance carrier will receive a separate bill for each of these services. Your surgeon and the facility are two separate entities and are required to bill separately for these services. **Regardless of where you have your surgical procedure performed, you will receive two separate bills. (This billing method is standard and required by all insurance carriers.)**

My signature acknowledges that the information in Item II was given to me and that I understand the billing method for service(s) which I have chosen to have performed at Harrisburg Interventional Pain Management Center.

My signature also acknowledges that the information in both Item I and Item II was explained to me, and that I understand and agree to the statement made in both Items.

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Signature of Patient/Guardian

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Signature of Witness

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Date

## Patient Rights<sup>1</sup>

- A patient has the right to expect to respectful care by competent personnel.
- A patient has the right, upon request, to be given the name of his/her attending practioners, the names of all other practioners directly participating in his/her care and the names and functions of other heath care persons having direct contact with the patient.
- A patient has the right to consideration of privacy concerning his/her own medical care program. Case discussion, consultation, examination and treatment is considered confidential and shall be conducted discreetly.
- A patient has the right to have records pertaining to his/her medical care treated as confidential except as otherwise provided by law or third party contractual arrangements.
- A patient has a right to know what facility rules and regulations apply to his/her conduct as a patient.
- The patient has the right to expect emergency procedures to be implemented without unnecessary delay.
- The patient has the right to good quality care and high professional standards that are continually maintained and reviewed.
- The patient has the right to full information in layman's terms, concerning diagnosis, treatment and prognosis including information about alternative treatments and possible complications. When it is not medically advisable to give such information to the patient, the information will be made available to an appropriate person on his behalf.
- Except for emergencies, the practioners shall obtain the necessary Informed Consent prior to the start of a procedure.
- A patient or, if the patient is unable to give informed consent, a responsible person, has the right to be advised when the practioner is considering the patient as part of a medical care research program or doctor program, and the patient or responsible person, shall give informed consent prior to actual participation in the program. A patient, or responsible person, may refuse to continue in a program to which he has previously given informed consent.
- A patient has the right to refuse drugs or procedures to the extent permitted by statue, and a practioners shall inform the patient of the medical consequences of the patient's refusal of drugs or procedures.
- A patient has the right to medical and nursing services without discrimination based upon age, race, color, religion, sex, national origin, handicap, disability or source of payment.
- The patient who does not speak English shall have access, where possible to an interpreter.
- The ASF shall provide the patient, or patient designee, upon request, access to the information contained in his medical records, unless access is specifically restricted by the attending practitioner for medical reasons.
- The patient has the right to expect good management techniques to be implemented within the ASF. These techniques shall make effective use of the time of the patient and avoid the personal discomfort of the patient.
- When an emergency occurs and a patient is transferred to another facility, the responsible person will be notified. The institution to which the patient is to be transferred shall be notified prior to the patient's transfer.
- The patient has a right to examine and receive an explanation of his bill.
- A patient has the right to expect that the ASF will provide information for continuing health care requirements following discharge and the means for meeting them.
- A patient has the right to be informed of his/her rights at the time of admission.

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<sup>1</sup> In accordance with the Pennsylvania Provisions for Licensure 553.12

## Patient Directives – Advance Directives

The 1990 Patient Self-Determination Act is a federal law that says patients must be informed of their rights under state law to make decisions about their medical care, including the right to accept or refuse medical or surgical treatment and the right to have an advance directive. The advance directive is a way for patients to communicate what type of medical care and treatment they do or do not want if they become unable to make the decision on their own.

According to Pennsylvania law, an individual of sound mind who is 18 years of age or older (or who has graduated from high school or is married) may execute a declaration governing the initiation, continuation, withholding, or withdrawal of “life-sustaining treatment.” The declaration must be signed by the declarant (or by another person at the request of the declarant if the declarant is unable to sign) and must be witnessed by two individuals over the age of 18. The declaration may include a designation of another person (a “surrogate”) to make decisions for the declarant if the declarant later becomes incompetent.

A declaration becomes effective when the attending physician has determined that the declarant is incompetent and in a terminal condition or is in a state of permanent unconsciousness. A declaration can be revoked at any time and in any manner, regardless of the mental or physical condition of the declarant.

Compliance with the 1990 Patient Self-Determination Act is intended for inpatient hospital admissions, not for outpatient surgery centers. Harrisburg Interventional Pain Management Center does not honor Advance Directives. Healthcare providers at HIPMC are bound to do all in their power to assure the safe recovery of every patient, including resuscitation if that becomes necessary. All patients are asked if they have an advance directive at the initial visit and the answers indicated on the stamp on the outside of his/her chart. If the patient gives the staff a copy of his/her Advanced Directive, it will be placed on the left side of the chart.

## CONSENT TO TREATMENT AND FINANCIAL RESPONSIBILITY

I desire to be treated at Harrisburg Interventional Pain Management Center. I understand that I may discontinue treatment at any time.

1. I consent to the rendering of medical care.
2. I hereby authorize all professional staff to release any information acquired in the course of the examination and treatment to referring physician, insurance company, workers compensation carrier, the center's attorneys and consultants in accordance with the privacy laws.
3. As part of the medical procedures or tests, I understand that I may be tested for H.I.V. infection and/or hepatitis, or any other blood- borne infectious disease if the doctor orders the test for diagnostic purposes.
4. Guarantee of Payment: I agree to be responsible to the center for charges resulting from services and supplies rendered at the prevailing rates unless I qualify for discount. I agree all bills are due in full upon demand. Should I fail to honor this agreement I agree to pay any collection cost or attorney fees resulting from the collection of my account.
5. Pre- Certification Requirements: If my insurance company or third –party requires pre-certification, then I understand that it is my responsibility to contact them to obtain such certification. Exception: Medicare.
6. Assignment of Benefits (other than Medicare and Medicaid): I hereby assign all rights and privileges and authorize payment directly to the center for any claim filed on my behalf or on the behalf of the person for whom I am duly authorized to sign for insurance benefits. I also understand that I am financially responsible to the center for co-pays, deductibles, co insurances and charges not covered by this assignment or by my insurance plan.
7. Assignment of Benefits (Medicare and Medicaid): I request that payment of authorized Medicare and/or Medicaid benefits to be made to the center or on my behalf for any services or supplies furnished by the center, including physician services. I authorize any holder of medical or other information about me to release it to the center for Medicare and Medicaid services and its agents, as appropriate, any information needed to determine these benefits for related services. I understand that I am responsible for any coinsurance, unmet deductibles and services not covered by Medicare and/or Medicaid.
8. Grievance Appeal Consent: I hereby authorize Harrisburg Interventional Pain Management Center to act on my behalf in requesting a reconsideration of medical determination made by my managed care plan or utilization review entity regarding my medical care.
9. It is the policy of the physicians and staff of the Facility to honor Advance Directives presented to them by their patients. However, should an untoward event happen to a patient while he or she is in our Facility, it is our policy to stabilize the patient and transport him or her to the hospital of his or her choice with a copy of the Advance Directive (if available).
10. Complaints, concerns, grievances regarding treatment, service, damaged or lost articles or billing should be directed to the Director of Nursing/Administrator for investigation and appropriate response.

\_\_\_\_\_ PRIVACY NOTICE- I acknowledge that I have received a copy of Harrisburg Interventional Pain Management Center's Privacy Notice.

I have received information concerning Patient Rights, Advanced Directives and physician ownership in the facility prior to the date indicated on this form.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date Signed