Ariz R. Mehta M.D., P.C

377 Jersey Avenue
2ND Fl, Suite 270
Jersey City, NJ 07302

REGISTRATION FORM

(Please Print Neatly)

Today's Date: PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐		
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age: Sex: ☐ M ☐ F
Street address:	City:	State, ZIP Code		
Social Security no.:	Home phone no.: ( ) -	Cell Phone no.: ( ) -	Email Address	
Occupation:	Employer:	Employer phone no.: ( )		
Chose clinic because/referred to clinic by (Please check one box):	☐ Dr.	☐ Insurance plan	☐ Hospital	
☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Other

Chief Complaint (main pain)

Do you have any impairment (i.e. visual, hearing speech, learning, etc.) Yes _ No_
What language do you speak or write?
Do you have a living will or advanced directives?

INSURANCE AUTHORIZATION

12% Interest Per Annul Will be charged on ALL UPAID BILLS

I have read the above and I hereby authorize Dr. Ariz R. Mehta. M.D., P.C. To be my agent for billing and collection purposes. I am authorizing them to bill the insurance in my name C/O 191 Palisade Avenue Jersey City, NJ 07306 and to endorse my name to all checks in payment of medical services rendered to me and to furnish information concerning my illness and treatments to any insurance company and medical provider. I hereby assign to you all payments for medical services rendered to myself or to my dependents. I understand that I am responsible for any amount not covered by insurance and that this assignment of benefits may not be applicable for injuries sustained in a motor vehicle accident. I am responsible for any charges incurred by the doctor for providing any medical records to the insurance companies. For auditing purposes. All charges have been explained to me clearly, in the event that the insurance CO fails to pay my bill. I am giving permission to take legal action against the insurance CO. I may be responsible for giving fees. **I f the first insurance does not pay; I am authorizing you to bill the second insurance of third insurance.** I understand that I am responsible for payments of fees not paid by the insurance company.

Patient/Guardian signature: x *Date*

Acknowledgment

I hereby acknowledge that I have sought Ariz R. Mehta .M.D., P.C. Services on my own and have not been referred to him by Dr. Monica Mehta M.D., P.A.

I am also aware that Ariz R. Mehta .M.D., P.C. will be billing for his services rendered to me from the address 191 Palisade Avenue Jersey City, NJ 07306. Also that I have assigned all my benefits to Ariz R. Mehta .M.D., P.C. I am responsible for services that are not paid by the insurance company and provided. I am also authorizing Ariz R. Mehta .M.D., P.C. to bill my secondary insurance or my tertiary insurance and assign the benefits of the same to Ariz R. Mehta .M.D., P.C.

Patient/Guardian signature: x *Date*

Patient Acknowledgements of Dr. Ariz R. Mehta M.D. Office Policies

Insurance Information

Co-payments and Deductibles

Payment is required for all services at the time they are rendered. All applicable co-payments and deductibles will be collected at the time of service. An administrative billing fee of $10 will be applied if co-payments are not paid at the time of service. In the event that your account must be turned over for collections interest and/or a collection fee, at the provider's current rate may be charged on all balances owing to the provider that are past due. Your signature below signifies your understanding and wiliness to comply with this policy.

Referral Information

If a referral is required by my health insurance plan, I understand that it is my responsibility to obtain the referral from my Primary Care Provider and assure it is available to be presented at the time of my visit. I further understand it is my responsibility to keep track of the number of visits I have used on my referral and the expiration date of my referrals and obtain new ones as needed. Or should you choose to go out of network you will be expected to pay a $75 office visit fee for existing patients and $295 for new patients. I understand that once this payment is made I cannot bill the insurance company.

Insurance Cards

New patients or those patients with a change in their insurance information must provide a valid insurance card or temporary print out at the time of the visit. Should you be unable to produce this documentation, patients may pay in full at the time of service and submit the claim to your insurance carrier at your convenience for reimbursement. I understand by signing below that I am responsible for notifying the office of any changes to my insurance or contact information.

Cancellation Policy / Late

Should you be unable to keep your appointment, please contact our office to cancel your appointment. Failure to contact the office will result in a $25.00 fee/ $50 fee for procedures / testing. This fee is not reimbursable by your insurance company. If you are going to be late, please call. If no call has been received and you are 15 minutes late for your appointment you will be rescheduled unless approved by the office manager.

HIPAA Policy

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of Dr. Ariz R. Mehta MD from discussing appointments, medication, test results or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or caretakers to obtain information for them. If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below.
Only these individuals will be provided with information. Should you wish to update the names provided below, please ask the receptionist for a HIPAA Form.

I have read the above and hereby authorize Dr. Ariz R. Mehta, M.D., P.C. to be my agent for billing and collection purposes. I am authorizing them to bill the insurance in my name C/O 377 Jersey Ave Jersey City, NJ 07302 / 191 Palisade Ave Jersey City, NJ 07306 and to endorse my name to all checks in payment of medical services rendered to me and to furnish information concerning my illness and treatment to any insurance company and medical provider. I hereby assign to you all payments for medical services rendered to myself or to my dependents. I understand that I am responsible for any amount not covered by insurance and that this assignment of benefits may not be applicable for the injuries sustained to a motor vehicle accident. I am responsible for any charges incurred by the doctor for providing and medical records to the insurance companies, For auditing purposes, all charges have been explained to me clearly, in the event that the insurance CO fails to pay my bill. I am giving permission to take legal actions against the insurance company CO. I may be responsible for giving fees. **If the primary insurance does not pay; I am authorizing you to bill the secondary or the tertiary insurance**. I understand that I am responsible for payments of fess not paid by the insurance company.

I hereby acknowledge that I have sought Ariz R. Mehta M.D. P.C. Services on my own and have not been referred to him by Dr. Monica Mehta M.D. P.A.
I am also aware that Ariz R. Mehta M.D., P.C. will be billing for his services rendered to me from the address 191 Palisade Ave, Jersey City, NJ 07306. Also I have assigned all my benefits to Ariz R. Mehta M.D., P.C. to bill my secondary or my tertiary insurance and assign the benefits of the same to Ariz R. Mehta M.D., P.C.

Patient Signature _____ **Date** _____

Ariz R. Mehta, M.D., P.C
377 Jersey Avenue
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Jersey City, NJ 07302

Urine Testing Policy

The office of Dr. Ariz R. Mehta M.D., P.C, requires random drug testing when care is being transferred from one Physician to the other. Please be aware if refused it is cause immediate discharge. We hope that you comply with our rules and regulations thank you.

Office Manager:_____

Patient Print Name:_____

Patient Signature:_____

Date:_____

ARIZ R. MEHTA, M.D., P.C
377 Jersey Avenue
2nd Fl, Suite 270
Jersey City, NJ 07302
Tel. 201-333-4199
Fax. 201-333-5724

WORKERS COMP/PIP AGREEMENT

I _____ understand that I am here solely to seek treatment from Dr Ariz Mehta for a non work / Auto related accident.

I am also aware that before any medical records are released from this office I will have prior authorization through Workers comp or my auto carrier.

I understand that under ***no circumstances*** will Dr. Ariz Mehta release any medical documentation to myself or my attorney without prior authorization.

Until authorization is established I understand that Dr. Mehta will be treating me based on my non work/auto related issues.

I also understand that my private insurance will be billed or payment will be from my out of pocket expenses.

Print Name:_____
Sign Name:_____
Date:_____

Cc: Dr. Ariz R. Mehta MD PC
Patient chart

Ariz R. Mehta, M.D., P.C
377 Jersey Avenue
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Fax. 201-333-5724

Opioid / Controlled Substance Agreement

The purpose of this agreement is to prevent misunderstandings about certain medications that I, _____, may be taking for pain management. This is to help all of us comply with the DEA and CDS laws and regulations regarding controlled pharmaceuticals. I understand that my other (pervious and current) treating Physicians will be notified of the prescribed medications under the care and treatment of Dr. Ariz R. Mehta. It is still my responsibility to inform all of my other physicians of any prescription from your office to avoid potential drug interactions.

Dr. Ariz R. Mehta is prescribing oral opioid and other controlled medication(s) that are to be taken as prescribed. I understand that I may become physically dependent on this / these medication(s). If I suddenly stop taking this medication(s), I may experience withdrawal Symptoms, such as chills, shaking, stomach cramping, irritability, and/or pain. I understand that some people may become psychologically dependent on these medications and that this is one of the risks of using them.

I understand that while using this medication, my ability to react as quickly as usual and driving and/or operate machinery or equipment may be impaired. It is my responsibility to use the medication appropriately, and if I do not feel full alert, I will not drive impaired or operate potentially dangerous equipment. I understand that the medication may cause me to feel sleepy and may slow my response time.

I understand that this agreement is essential to the trust and confidence necessary in a doctor- patient relationship and that Dr. Ariz R. Mehta understands to treat me, in every respect. Based on this agreement, I will communicate honestly and fully with Dr. Ariz R. Mehta about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medication is helping to reduce or relieve the pain for which it is being prescribed.

I understand that if I break this agreement, Dr. Ariz R. Mehta, and his co-workers, will stop prescribing these pain- control medications. In such, case, Dr Ariz R. Mehta will either taper the medications as necessary to provide a single / final (30) day prescription along with instructions on contacting another health care provider or system. Also, a drug-treatment program may be recommended.

I agree that I will use my medications at a rate no greater than prescribed rate (unless it has been approved personally by Dr. Ariz R. Mehta) and that the use of my medication at a greater rate can potentially result in my being without medication for a period of time with possible results of adverse effects, such a uncontrolled pain and/or withdrawal symptoms.

I, _____, Herein authorize Dr. Ariz R. Mehta and my pharmacy to cooperate fully with any city, sate of federal law enforcement agency, including the New Jersey and/or New York State Boards of Pharmacy in the investigation of any possible misuse, sale or other diversion of my prescribed pain or controlled medications. I authorize Dr. Ariz R. Mehta to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right to privacy or physician-patient confidentiality with respect to these authorizations.

I will not use any illegal or other controlled substances, including marijuana, cocaine, etc. I will not share, sell or trade my medications with anyone. I will not attempt to obtain any controlled medication, including opioid pain medications, stimulants, or anti-anxiety medications from any other healthcare provider. I will not consume alcoholic beverages while I am on pain medications. I will safeguard my pain medications from loss or theft. Lost or stolen medications, even if reported to the police, will not be replaced.

I agree that pain medication prescription refills will be made during evenings or on weekends or "called" into a office hour times. No refills will be made during evenings or on weekends or "called" into a pharmacy. Additionally, I will use only one pharmacy for my pain medication prescription.

I agree to follow these guidelines that have been explained fully to me. All of my questions and concerns regarding treatment have been adequately and reasonably answered.

I understand that violation of this agreement can result in either cessation of my opioid and/or other controlled substance prescriptions and/or referral to a substance abuse program for detoxification, and discharge from my office. A copy of this "OPIOID / CONTROLLED SUBSTANCE AGREEMENT" document has been given to me.

This agreement is entered into on this date:_____

Patient's Signature:_____

I agree to use _____ Pharmacy.

Located at _____

Phone_____ for filing of my pain medication prescriptions.

Physicians Signature: _____

Witness's Signature: _____

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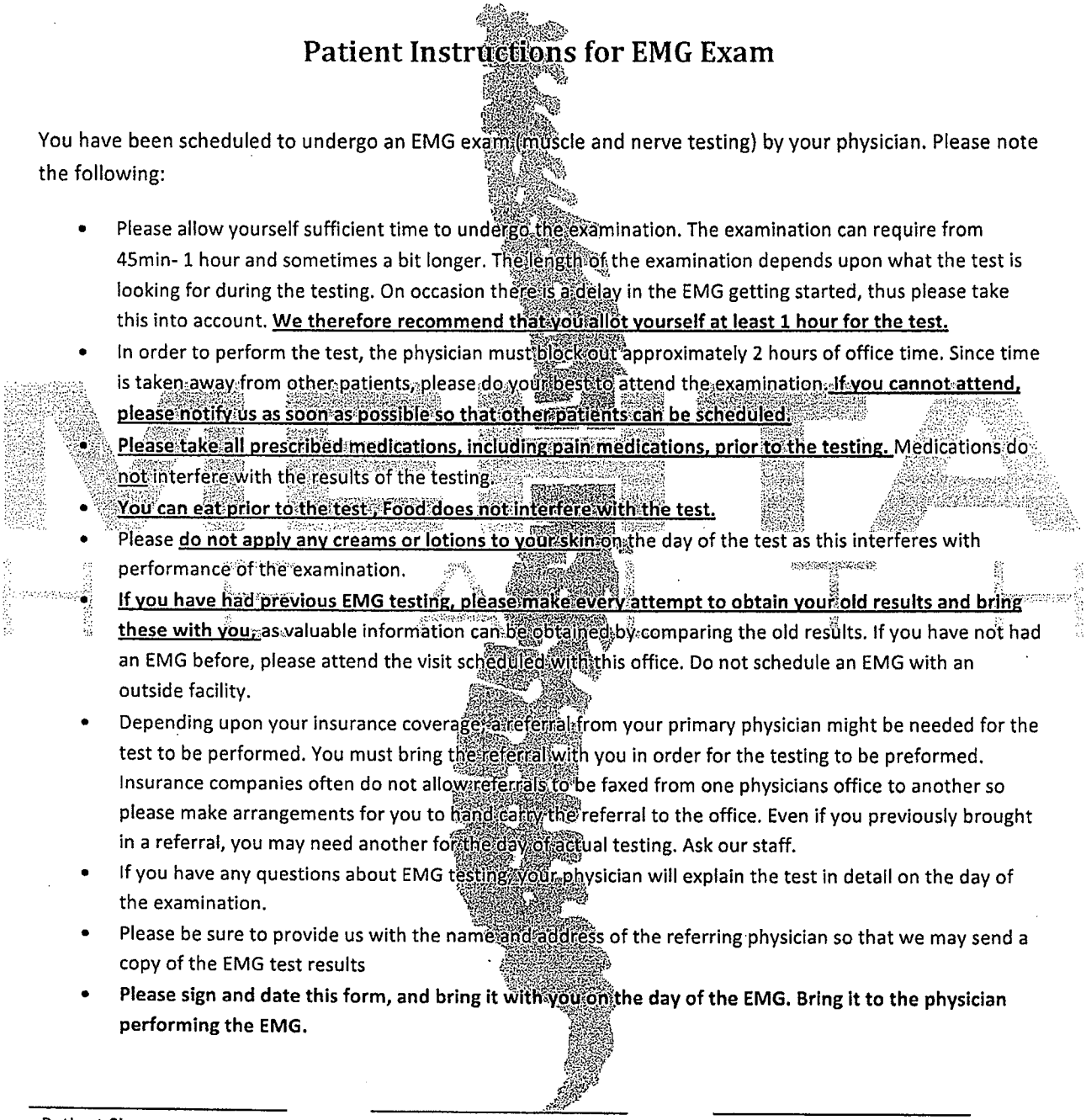
Patient Instructions for EMG Exam



You have been scheduled to undergo an EMG exam (muscle and nerve testing) by your physician. Please note the following:

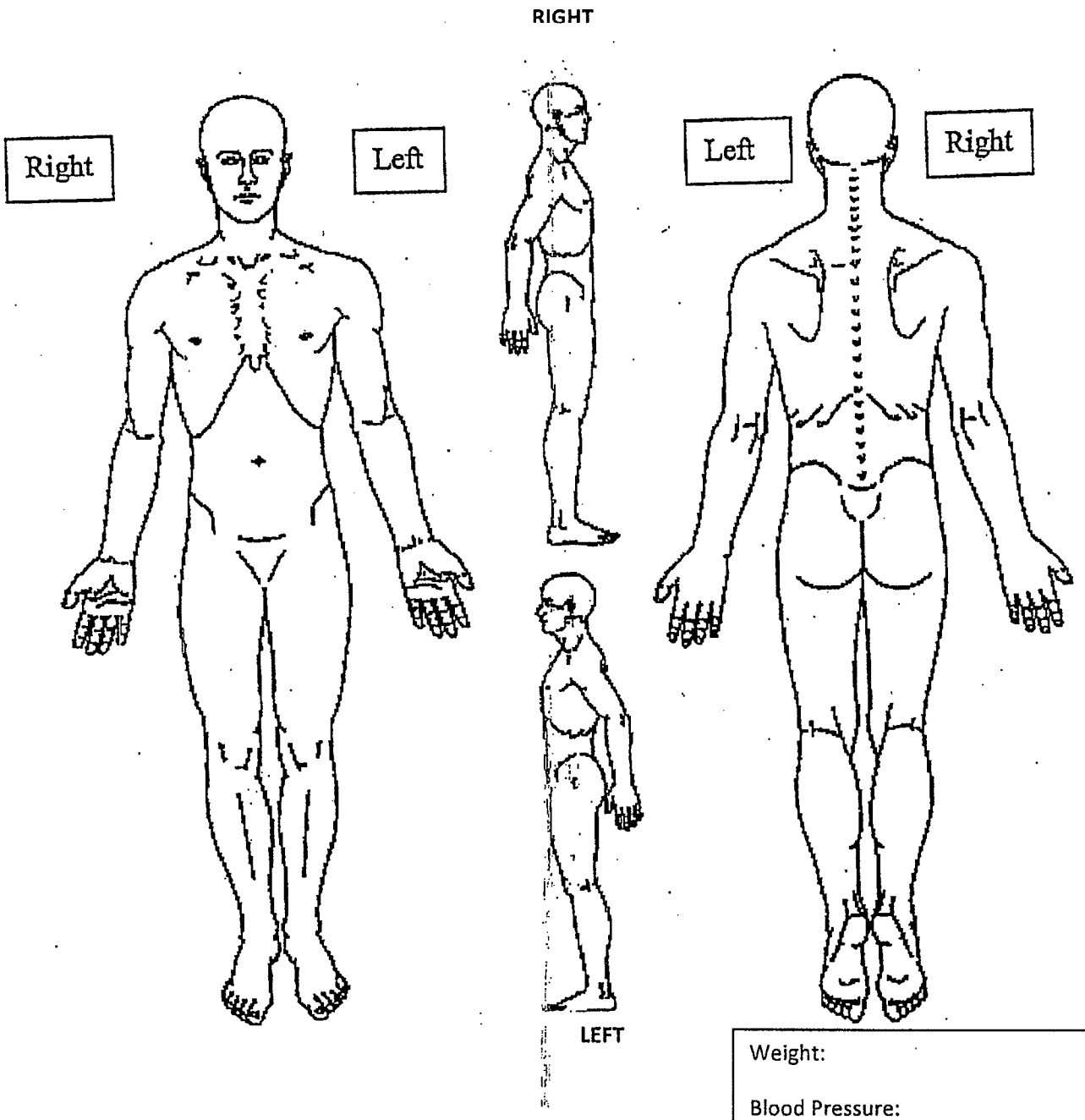
- Please allow yourself sufficient time to undergo the examination. The examination can require from 45min- 1 hour and sometimes a bit longer. The length of the examination depends upon what the test is looking for during the testing. On occasion there is a delay in the EMG getting started, thus please take this into account. **We therefore recommend that you allot yourself at least 1 hour for the test.**
- In order to perform the test, the physician must block out approximately 2 hours of office time. Since time is taken away from other patients, please do your best to attend the examination. **If you cannot attend, please notify us as soon as possible so that other patients can be scheduled.**
- **Please take all prescribed medications, including pain medications, prior to the testing.** Medications do not interfere with the results of the testing.
- **You can eat prior to the test. Food does not interfere with the test.**
- Please **do not apply any creams or lotions to your skin** on the day of the test as this interferes with performance of the examination.
- **If you have had previous EMG testing, please make every attempt to obtain your old results and bring these with you**, as valuable information can be obtained by comparing the old results. If you have not had an EMG before, please attend the visit scheduled with this office. Do not schedule an EMG with an outside facility.
- Depending upon your insurance coverage, a referral from your primary physician might be needed for the test to be performed. You must bring the referral with you in order for the testing to be preformed. Insurance companies often do not allow referrals to be faxed from one physicians office to another so please make arrangements for you to hand carry the referral to the office. Even if you previously brought in a referral, you may need another for the day of actual testing. Ask our staff.
- If you have any questions about EMG testing, your physician will explain the test in detail on the day of the examination.
- Please be sure to provide us with the name and address of the referring physician so that we may send a copy of the EMG test results
- **Please sign and date this form, and bring it with you on the day of the EMG. Bring it to the physician performing the EMG.**

Patient Signature	Patient Name (Print)	date form was given to you

Pain Diagram

Please mark the figure with the location of your symptoms:
Pain: X; Numbness/Tingling: #

Name:_____ **Date:**_____



Weight:
Blood Pressure:
CCX:

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MEDICINE AND SURGERY
(NJ, NY, PA, DC)

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Neuromuscular Medicine
Cardiopulmonary Rehabilitation
Spinal Cord Injury
Traumatic Brain Injury
Stroke Rehabilitation
Amputee Management
Disability and Worker's Compensation

Date: _____

Accident Injury Inquiry

1. How did your injury occur? _____
   _____
2. When did your injury occur? Date: _____
3. Where did your injury occur? (State the place and time of injury)
   _____
4. Is this injury in any way work related or due to a motor vehicle accident? ☐ yes ☐ no
5. Has this claim been filled with a no-fault carrier or auto insurance? _____
   _____
6. Is there any other insurance that is primary? ☐ yes ☐ no
7. Will there be a law suit or any third party liability? ☐ yes ☐ no

Please complete information in full:

Members Name: _____ **Members SSN:** _____

Sign and Date this form:

I declare under penalty of perjury that the above information is true to the best of my knowledge.

Signature: _____

Date: _____

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Stroke Rehabilitation
Amputee Management
Disability and Worker's Compensation

Date: _____

Patient History

General Health Review

Medical History (such as heart disease, stroke, cancer, arthritis, diabetes, hypertension, as well as psychiatric illnesses, etc.)

_____ _____ _____
_____ _____ _____
_____ _____ _____

Surgical History (**unrelated** to pain; such as appendectomy)

_____ _____ _____
_____ _____ _____

Surgical History (**related** to pain; such as appendectomy)

_____ _____ _____
_____ _____ _____

Allergies (include medication and food allergies)

_____ _____ _____
_____ _____ _____

Intolerances (include side effects from previous medications, such as gastritis, nausea, constipation, etc.)

_____ _____ _____
_____ _____ _____

Current Medications (include vitamins and over-the-counter medications, if applicable).

_____ _____ _____
_____ _____ _____

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Patients Name: _____ Date: _____

Past symptoms History Checklist: Within the past year have you had any of the following (check all that apply):

☐ No symptoms in the past year	☐ Difficulty Walking	☐ Joint pain or swelling	☐ Tremors
☐ Bowel problems	☐ Dizziness/blackouts	☐ Loss of Appetite	☐ Urinary problems
☐ Chest Pain	☐ Excessive sweating	☐ Loss of Balance	☐ Vision Problems
☐ Cough (persistent)	☐ Fatigue	☐ Nausea/ Vomiting	☐ Weakness in arms/legs
☐ Decreased coordination	☐ Headaches	☐ Numbness in arms/legs	☐ Weight gain (unexplained)
☐ Difficulty Sleeping	☐ Hearing Problems	☐ Pain at Night	☐ Weight Loss (unexplained)
☐ Difficulty Swallowing	☐ Heart Palpitations	☐ Shortness of Breath	☐_____

Diagnostic Tests/Measures: Within the past year, have you had any of the following (check all that apply):

☐ No diagnostic testing	☐ Bronchoscopy	☐ Mammogram	☐ Stress Test
☐ Anglogram	☐ CT scan	☐ MRI	☐ Urine Test
☐ Arthroscopy	☐ Ultrasound	☐ Pap smear	☐ X-ray
☐ Biopsy	☐ EEG	☐ Pulmonary Function Test	☐_____
☐ Blood Test	☐ EKG	☐ Spinal Tap	☐_____
☐ Bone Scan	☐ EMG/ Nerve Conduction	☐ Stool Test	☐_____

2. Is the pain constant? (Circle one) **Yes** or **No**, If not, How often does it occur? _____

3. How would you describe your pain? ☐ **Aching** ☐ **Throbbing** ☐ **Stabbing** ☐ **Shooting** ☐ **Burning** ☐ **Deep** ☐ **Sharp**

4. How long have you been feeling the pain? ☐ **5 or more years** ☐ **4 months** ☐ **6 months** ☐ **2 weeks** ☐ **less than one week**

5. Manner of Expressing Pain: _____
_____

7. What helps calm the pain down? _____
_____

8. What makes the pain worse?_____
_____

9. Effects of Pain: (note decreased function, decreased quality of life.)

- Accompanying symptoms (e.g., nausea) :_____
- Sleep:_____
- Appetite:_____
- Physical Activity:_____
- Relationship with others (e.g irritability):_____
- Emotions: _____
- Concentration _____
- Other _____

10. Other Comments: _____
_____

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Patients Name:_____ Age:_____ Date:_____

Family History: Please indicate the current status of your immediate family members: (please note this is strictly confidential)
Please indicate family members (parents, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism: _____

Cancer, specify type: _____

Heart disease:_____

Depression/suicide: _____

Genetic disorders: _____

Diabetes: _____

High cholesterol:_____

High blood pressure: _____

Stroke: _____

Bleeding or clotting disorder:_____

Asthma: _____

Other: _____

Social History:

Tobacco Use

Cigarettes: ☐ Never ☐ Quite Date: _____

☐ Current Smoker: Packs/day _____ # of yrs _____

Other Tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Are you interested in quitting? ☐No ☐ Yes

Alcohol Use

Do you drink alcohol? ☐No ☐Yes #drinks/week_____

Is your alcohol use a concern for you or others? ☐No ☐Yes

Drug Use

Do you use any recreational drugs? ☐ No ☐Yes

Have you ever used needles to inject drugs? ☐ No ☐Yes

Sexual Activity

Sexually active: ☐ No ☐Yes ☐ Not Currently

Current Sex partner (s) is/are: ☐ Male ☐ Female

Birth Control Method:_____ ☐ None needed

Have you ever had any sexually transmitted disease (STDs)?
☐ No ☐ Yes

Are you interested in being screened for sexually transmitted diseases?
☐ No ☐ Yes

Other Concerns

Caffeine Intake: ☐ None ☐Coffee/tea/soda ___ Cups/day

Weight: Are you satisfied with your weight? ☐ No ☐ Yes

Diet: How do you rate your diet? ☐ Good ☐ Fair ☐Poor
Do you eat or drink for servings of dairy or soy daily or take calcium supplements? ☐ No ☐ Yes

Exercise: Do you Exercise regularly? ☐ No ☐ Yes
What kind of exercise?_____
How long (Minutes) _____ How Often_____
If you do not exercise. Why?_____

Safety: Do you use a bike helmet? ☐ No ☐ Yes
Do you use seatbelts consistently? ☐ No ☐ Yes
Is violence at home a concern for you? ☐ No ☐ Yes
Have you ever been abused? ☐ No ☐ Yes
Do you have a gun in your home? ☐ No ☐ Yes

Have you completed a living will or Or durable power of attorney for health care? ☐ No ☐ Yes

Socioeconomics: Occupation:_____ Employer:_____
Years of education/ highest degree:_____ Marital Status: Single Partner/Married Divorced Widowed Other:_____

Spouse/partner's name: _____
Who lives at home with you? _____

Women's Health History: # pregnancies _____ #Deliveries_____ #abortions _____ #miscarriages _____
Age at start of period: _____ Age at end of periods: _____