Welcome from the staff at Pain Care Associates!

In order for Dr. Gupta to perform a comprehensive assessment, we must have all information pertinent to your condition. Please bring the actual films and/or cds, and if possible, written results of all diagnostic studies (MRI, CT, etc) as well as any lab test results with you. Please bring a written statement, signed by your doctor, requesting a "Pain Management consultation" and advising of their reason for this request. We develop an individualized plan of care for each of our patient which may consist of diagnostic testing, interventional care, consultations, and possibly medication. Please be aware we do not always prescribe pain medication for every patient we see, especially on the first visit.

Please complete the online or paper registration forms before you arrive, and bring them with you at the time of your appointment. Also bring your health insurance cards, two forms of identification (ex. drivers license & social security card) and all referral / precertification forms that may be required by your health insurance carrier.

All copays will be collected at the time of the office visit, we are unable to bill patients for copays. Please be prepared to pay by cash, cashier's check, money order made payable to "Pain Care Associates" or credit card (Visa, Master Card or Discover) / debit card.

If this is an Auto or Workmans' Compensation claim, we will need your Auto or Workman's Compensation case number, as well as the name, address, and telephone number of your claims representative.
For Auto or Workman's Compensation cases, we will require your health insurance information and referral or precertification forms, if applicable, in the event that your claim is rejected / payment denied.

Directions to our office are available to you on the Patient Portal and we look forward to seeing you. If you have any questions, please call 609-267-1707. If for any reason you are unable to keep your appointment, please notify our office at least 48 hours prior to your appointment to avoid no-show charge of $35.00. Your help in this matter is greatly appreciated.

PAIN CARE ASSOCIATES
FINANCIAL RESPONSIBILITY POLICY

If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy.

- Co-payments for office services are required at the time you register. For your convenience we accept cash, cashier checks / money orders made payable to Pain Care Associates, credit cards (Visa, Master Card, Discover) and debit cards.
- As a courtesy, we will process and file your insurance claims for services at no cost to you.

You must realize that:

1. Your insurance is a contract between you and your employer and/or the insurance company. While we may be a provider of services, we are not a party to that contract. We encourage you to contact your insurance carrier personally in order to remain informed of your benefits.

2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover or which they may consider medically unnecessary, and, in some instances, you will be responsible for these amounts. We will make every effort to ascertain your coverage for our services before treatment and will make you aware of our findings. However, this does not guarantee payment from your insurance carrier.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. We will allow you 90 days to pay any balance remaining after insurance payment. After that time, your account will be turned over to our collections agency. Our staff can also make arrangements for you to make monthly payments over an approved term.

If you have any questions about the above information, or any uncertainty regarding your insurance coverage, please do not hesitate to ask us. We are here to help you.

Patient Agreement

Assignment of Benefits

I authorize and direct my insurer or payor to pay directly to Pain Care Associates / Dr. Rakesh Gupta, any / all benefits, that would otherwise be payments to me (or the patient, if signed by a responsible party) up to the amount of my bill, accruing to me in connection with my treatment at Pain Care Associates or by Dr. Rakesh Gupta.

Insurance Participation

I understand that PCA / Dr. Gupta is a participating provider with some insurances and a non-participating provider with others. My out of pocket expenses may be higher in some instances. I will check with PCA / Dr. Gupta and with my insurance company about these costs before starting my treatment plan.

In some instances, my insurance company may send the payment for medical services to me instead of PCA / Dr. Gupta. I will endorse the payment check to PCA and mail or the bring the check to PCA immediately. Otherwise, I will be held financially responsible for the unpaid amount of my medical bills from PCA / Dr. Gupta. In the event my account is referred to a collection agency, I will be responsible for the account balance plus collection costs and reasonable attorney fees.

Notice of Privacy Practice

I have received Notice of Privacy Practice from Dr. Rakesh Gupta, Pain Care Associates located at 120 Madison Ave, Suite D, Mount Holly, NJ 08060.

Ownership in Healthcare Facilities

I have been informed by PCA / Dr. Gupta about his minority ownership in the following healthcare centers

- Vantage Surgery Center, Medford, NJ. Majority Shareholder is Virtua Health.
- Millenium Surgery Center, Cherry Hill, NJ. More than thirty Physician Shareholders
- Memorial Ambulatory Surgery Center, Mount Holly, NJ. Majority Shareholder is Virtua Health.

As a patient, I have the right to chose any facility that I may like including where Dr. Gupta does not have an ownership interest. I will inform PCA / Dr. Gupta if I want a change in the site of service.

MEDICATION AGREEMENT

This agreement between_____(hithereto: "the patient") and Pain Care Associates, PA (Rakesh Gupta MD) is for the purpose of establishing an agreement between the physician and the patient on clear conditions for the prescribing and usage of pain controlling medications prescribed by the physician for the patient. The physician and patient agree that this agreement is an essential factor in maintaining the trust and confidence necessary in the physician-patient relationship.

The goal of this treatment is to improve your functional ability, as well as your social and work activities by a reduction in the intensity of your pain. This treatment has risks and potential side effects as listed below:

1) Sedation
2) Constipation
3) Nausea and vomiting
4) Confusion or change in thinking abilities
5) Difficulty with balance which may make it unsafe to operate heavy equipment and motor vehicles.
6) Sleepiness and drowsiness
7) Decreased respiration or breathing
8) Physical dependence, which means if you abruptly stop taking this medication(s), you may begin withdrawal. Signs of withdrawal include diarrhea, abdominal cramping, "goose flesh" and anxiety.
9) Psychological dependence or addiction.
10) Tolerance, which means that you may need more drugs to get the same effect.
11) Risk regarding pregnancy: children born to mothers on opioids will likely physically dependent to the drug at birth.

The patient agrees and accepts the following conditions for the management of pain by utilization of narcotic (opioid) agents:

1) Other reasonable non-opioid treatment measures have not been effective or have produced intolerable side effects.
2) I do not currently have problems with substance abuse or dependence.
3) I realize that all the medications have potential side effects, and I will have the Recommended laboratory studies required to keep the regimen as safe as possible.
4) I am not currently involved in the sale, diversion, illegal possession or transport of controlled substances, including narcotics, sleeping pills, and / or pain killers.
5) I realize that it is my responsibility to keep myself and others from harm, Including the safety of my driving. If I am taking narcotic medications, I agree that I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have not used my medication for at least four (4) days.
6) I will not use any illegal controlled substances, including marijuana, cocaine, etc.
7) I will not share, sell, or trade my medication for money, goods, or services.
8) I will not attempt to get pain medications from other healthcare providers. I must inform any other healthcare provider that I am taking pain medication. I understand it is against the law to obtain pain medication from anyone else.
9) If I have surgery or dental work, or any new pain, I may take post-operative pain medications from these providers but I must report this to Pain Care Associates immediately.
10) I will take the medications exactly as prescribed. I will not take more than prescribed. If I do, I understand additional medications may not be given and I could be without medications for that period of time.
11) I will safeguard my medication(s). Failure to do so could result in the consequences of being without my medications for that period of time. Replacement may not be given due to loss, theft, fire or any other reason.
12) I will keep all scheduled appointments with this office and any other specialists involved in my pain management care.
13) If I am female of child bearing years, I will use appropriate measures to prevent pregnancy during the

course of treatment and I will notify this office immediately should I become pregnant.
14) I will use only one pharmacy to fill my medications. I agree to utilize_____
_____, located on _____, _____
(name of pharmacy) (street) (city)
_____ _____.
(state) (phone number)
If I change my pharmacy for any reason, I agree to notify this office at the time I receive a prescription and advise my new pharmacy of my prior pharmacy's address and telephone number.
15) I agree to waive my applicable privilege or right to privacy or confidentiality With respect to the prescribing of my pain medication, and I authorize the physician and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, in the investigation of any possible misuse, sale or other diversion of my pain medication. I authorize the physician to provide a copy of this agreement to my pharmacy.
16) I agree to allow the physician to communicate with my healthcare provider i.e. referring physician, pharmacist, regarding my misuse of narcotic.
17) Participation of a psychologist, psychiatrist and/or addiction specialist may be required to monitor your behavior for changes associated with addiction. If these behaviors become apparent, your opioid treatment may be changed or continued.
18) I agree to submit a blood or urine test, if requested by the physician, to determine any compliance with any regimen of pain control medications.
19) I will follow the advice of the physician in regards to the the cessation of controlled substances if it is felt that this will be necessary.
20) If the physician decides to discontinue your opioid treatment, the dosage will be Gradually lowered over several days to avoid withdrawal symptoms. If it is felt you have a dependency problem, you will be referred elsewhere for management of dependency and detoxification.
21) I understand that this treatment may be discontinued if any of the following occur:

- if the physician feels that the narcotics have not been effectively managing your pain
- if I give away, sell or misuse the drug(s)
- if I develop a tolerance or loss of effect from the narcotic(s)
- if the side effects become intolerable
- if I obtain narcotics from any other source other than this physician

22) I authorize the physician to access my medication history from prescription / pharmacy databases. I also authorize Pain Care Associates, PA to receive information from your pharmacy(ies) and the state pharmacy board regarding your current and past prescriptions as needed for continuity and quality of care.

I have read this document and have received a copy of this agreement for my records I understand it, and all questions have been satisfactorily answered. I consent to all the terms and conditions stated. I acknowledge the failure to abide by the terms of this agreement will result in termination of the physician-patient relationship, and I may be discharged from the practice.

_____ _____
Patient's Signature Date

_____
Patient's Printed Name

_____ _____
Physician's Signature Witness Signature

_____ _____

Physician's Printed Name Witness Printed Name

PLEASE READ THE ABOVE CAREFULLY BEFORE SIGNING. By signing below, I acknowledge that I have read and understand this policy.

Signature: _____ Date:_____

(Patient and/or Responsible Party)