PRECISION
PAIN MANAGEMENT

REGISTRATION FORM

Name_____ Date: _____

Last First Middle Initial

Home Address: _____

Street Apt.

City _____ State ____ Zip Code_____

Social Security Number:_____-_____-_____ **Gender**: Male Female

Date of Birth: _____/_____/_____

Marital status: Single Marriage/Civil Union Widowed Divorced Separated

Primary Care doctor: _____ **Phone Number**: _____

The United States government requires the following to be completed. Please circle which applies:

Race: White / American Indian / Asian / African American / Other: _____

Ethnicity: Hispanic or Latino - Not Hispanic or Latino **Language**:_____

Home Phone:_____ **Cell Phone**:_____

Occupation:_____ **Employer**:_____

Address:_____

City _____ State ____ Zip Code_____

Patient's email address: _____

Emergency contact: Spouse Child Friend Other: _____

Name:_____ Phone_____

Address:_____

City _____ State ____ Zip Code_____

The undersigned hereby authorizes PRECISION PAIN MANAGEMENT, LLC to release or obtain information as may be necessary to determine benefits entitlements, process payment of claim and/or diagnostic and therapeutic information for healthcare services provided to the above named patient. I authorize payment of medical benefits to PRECISION PAIN MANAGEMENT, LLC for medical services. Should my insurance(s) deny or if PRECISION PAIN MANAGEMENT, LLC does not participate with my insurance, I am aware I am responsible for the payment. Also, or obligations of my insurance (such as referrals written to PRECISION PAIN MANAGEMENT, LLC, referral dates and visits, properly determining primary versus secondary insurance, etc.) are my responsibility. Should PRECISION PAIN MANAGEMENT, LLC submit to my nonparticipating insurance as a courtesy I realized I may be responsible for payment. If this is a workers comp claim and the workers comp insurance fails to make payment after one year I will be responsible for payment. I also authorize the office of PRECISION PAIN MANAGEMENT, LLC to contact my pharmacy, to release or obtain information as well as speak to my family members and/or emergency contacts, leave messages pertaining to my medical condition and/or appointment on an answering machine if applicable. I authorize PRECISION PAIN MANAGEMENT, LLC to download insurance eligibility and medication history. I authorize a copy of this authorization to be used in the place of an original. I also understand I have the right to revoke this authorization except to the extent the action has a ready been taken in reliance of the authorization. This authorization will be in effect until seven years after the last date of treatment or until it is revoked by either party. Once the information is disclosed to a third-party, they may intern disclose it to someone else and they may not be a covered entity under the Health Insurance Portability and Accountability Act. I may be held responsible for collection costs, attorney fees, and court costs for delinquent accounts. I understand that the aforementioned office is not responsible for loss of, damage to or theft of my personal possessions while I am on the premises.

Regarding Medicare patients:

I request that payment of authorized Medicare and/or MediGap benefits be made either to me on my behalf or to PRECISION PAIN MANAGEMENT, LLC for any services furnished me by the physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents and/or the Medigap insurer any information needed to determine these benefits or the benefits payable for related services.

Signature_____ Date_____ (if signed by patient representative, state relationship)

Relationship_____

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PAIN MANAGEMENT

PATIENT HISTORY

Name_____ date of birth_____ date_____

Is this problem a result of an: Please check mark where applicable

_____Auto/motorcycle accident? Date of injury_____

_____ Injury? Date of injury_____Where?_____

_____ Injury at work? Date of injury_____Date you last worked_____

_____ Other Date of injury_____How long?_____

Briefly describe how this problem occurred and when it first appeared.

_____

_____

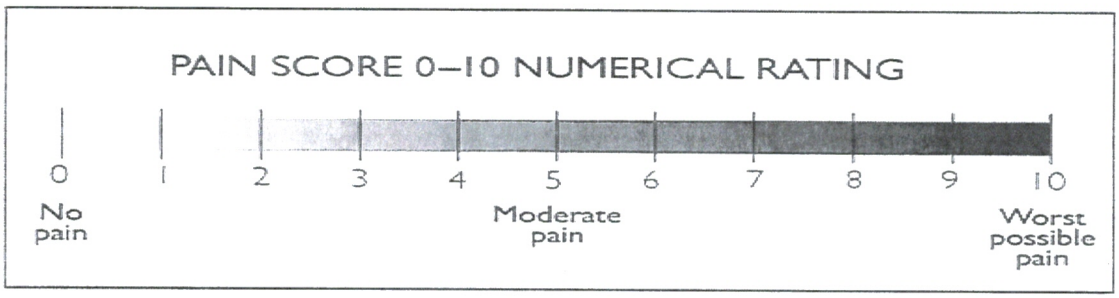
_____

_____

Describe your pain. Circle all that apply:

SHARP	SHOOTING	DULL	TINGLING	BURNING	CRAMPING
PRESSURE	STINGING	PINCING	SQUEEZING	NAGGING	ELECTRIC

Please use the following pain chart to describe the intensity of your pain. If multiple body parts, please label and mark accurately for each body part. Circle the number that applies:



What makes the pain better? Circle all that apply:

ICE HEAT BENGAY BANDAGES OR BRACES CRUTCHES OR CANE TYLENOL ADVIL ALEVE ASPIRIN TIGER BALM OTHER _____

What makes the pain worse? Circle all that apply:

PHYSICAL ACTIVITY BENDING WALKING DAILY ROUTINE DRIVING SITTING FOR LONG PERIODS STRESS WORK STANDING FOR LONG PERIODS OTHER_____

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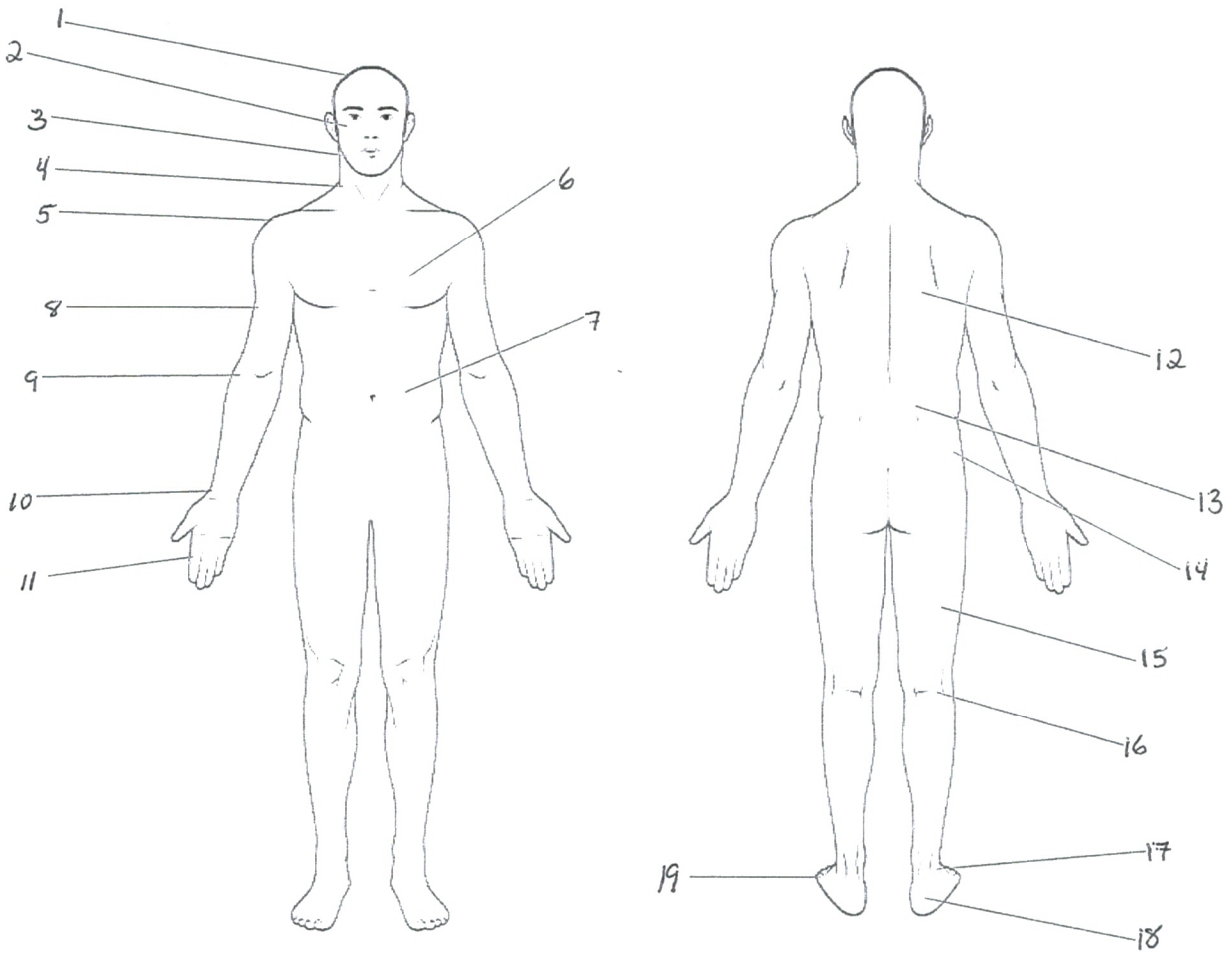
Pain Body Chart



1) Head/headaches
2) Facial
3) Jaw
4) Neck
5) Shoulder
6) Chest
7) Stomach
8) Arm
9) Elbow
10) Wrist
11) Finger
12) Mid Back
13) Low Back
14) Hip
15) Leg
16) Knee
17) Ankle
18) Foot
19) Toe

PRECISION PAIN MANAGEMENT

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PATIENT HISTORY page 2

Have you ever had ANY of the FOLLOWING? Circle all that apply:

EPIDURAL INJECTIONS PHYSICAL THERAPY CHIROPRACTIC TREATMENT ACUPUNCTURE

Dates and location(s) if applicable: _____

**If so, please sign a Medical Record Release Form and our office will request reports of your treatments.

Have you been to: (Circle all that apply:) Your Family Doctor Emergency Room?
If yes, did you have?
X-RAYS MRI OTHER_____

If X-rays or MRI was performed: Where?_____Date_____

Have you had this problem before? NO YES If yes, when_____

Describe any previous pain problems or surgery and give dates_____
_____
_____

I authorize a copy of this form and my signature to be used in lieu of an original.

_____ _____

Patient Signature (if signed by representatives state relationship) Date Signed

PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARDS TO BE COPIED.
ALSO, PLEASE GIVE THE RECEPTIONIST ANY X-RAYS, FILMS, OR CD's AND/OR REPORTS YOU MAY HAVE.

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MEDICAL HISTORY

Name_____ Date of Birth_____ Date_____

Have you had any previous operations or pain procedures? NO YES If so, please complete below:

	Type of Operation	Approximate Date
1.	_____	_____
2.	_____	_____
3.	_____	_____

Please list any other medical problems- past or present that you may have which are not listed below.

_____

_____

_____

IMPORTANT MEDICATIONS: List ALL medications and dosages you are now taking.

_____

_____

_____

ALLERGIES: NO YES If so, please list _____

_____

Do you use tobacco? NO YES If so, how much?_____

Do you use alcohol? NO YES If so, how much?_____

PATIENT: Height_____ Weight_____ Last known Blood Pressure_____

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FEMALE PATIENT: Are you pregnant? NO YES

FAMILY HISTORY:	L=Living D=Deceased	Age Now or At Time of Death	Medical Condition including Cause of Death (if Deceased)
Mother	_____	_____	_____
Father	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Please circle any of the following conditions that you have had in the past or presently have:

No major medical problems

Coronary Artery Disease (CAD)

High Blood Pressure – Hypertension (HTN)

Chronic Obstructive Pulmonary Disease(COPD)

Congestive Heart Failure Neck Pain

Diabetes

Hypothyroid disorder

Hyperthyroid disorder

Cancer (Body part)_____

Other_____

I authorize a copy of this form and my signature to be used in lieu of an original.

_____ _____

Patient Signature (if signed by patient representative, state relationship) Date

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Is today's visit in regard to an auto or workmen's comp claim? **YES** **NO**

If **YES** please fill out the following:

Patient Name: _____

Auto/Comp Insurance Carrier: _____

Claims Address:_____

Claim Number:_____

Date of Accident/Loss: ____/_____/_____

Adjusters Name: _____

Adjusters Phone Number: _____

Adjusters Fax Number:_____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.

I authorize the release of any information pertinent to my case to any insurance company, adjustor or attorney involved in this case.

I authorize the doctor to initiate a complaint to the insurance commissioner for any reason on my behalf.

Signature:_____

Date: _____

Precision Pain Management, LLC
Dr. John A. Coccaro
300 West Water Street, Suite A, Toms River, NJ 08753
P 732-800-2760
F 732-505-5432
www.drcppm.com
email: DRC@DRCPPM.COM

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security # _____

I request and authorize (Authorized Individual) to release Healthcare information of the patient named above to:

Precision Pain Management
300 West Water St, Suite A,
Toms River, NJ 08753

This request and authorization applies to:

_____ Healthcare information relating to the following treatment, condition, or dates

List here _____

_____ All Healthcare Information _____ Other

List Here _____

Additional Information _____

_____ Yes_____ No

I authorize the release of any records regarding Pain Management treatment to the person(s) listed above.

Patient Signature _____ Date _____

PRECISION
PAIN MANAGEMENT

Patient Name:_____

Date of Birth:_____

I request that all communications to me (via telephone, mail, or otherwise) by Precision Pain Management and/or staff be handled in the following manner:

- **For written communication:**

_____

- **For oral communication:**

_____

- **For e-mail communication:**

_____

I give my permission for Precision Pain Management to leave a message on my voicemail.

Yes **No**

- We may discuss your medical history with (Name & Relationship to You)

_____

- We may discuss your bill with (Name & Relationship to You)

_____

Patient Signature: _____

Date: _____

Precision Pain Management, LLC
John Anthony Coccaro, MD
Diplomate American Board of Anesthesiology Diplomate
American Board of Pain Management TELEPHONE #
(732) 800-2760 FAX # (732) 505-5432

PAIN MANAGEMENT AGREEMENT

The purpose of this Agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement.

I understand that if I break this Agreement, my doctor will stop prescribing these pain-control medicines and most likely discharge me from Precision Pain Management. In this case, my doctor will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug- dependence program will be recommended. The decision to participate in such a program will be mine alone.

I will communicate fully with my Doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

I will not use illegal controlled substances, including marijuana, cocaine, etc. I will not share, sell or trade my medication with anyone.

I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or antianxiety medicines from any other doctor.

I will safeguard my pain medicine from loss of theft. Lost or stolen medicines will **NOT** be replaced.

I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. NO refills will be available during evenings or on weekends.

I agree to use _____ Pharmacy, located at

_____, telephone number _____

for filling all of my pain prescriptions.

I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible

misuse, sale or other diversion of my pain medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I fully understand that at my doctor's discretion he may require me to undergo routine or random drug testing and agree that I will submit to a blood, saliva or urine test if requested by my doctor to determine my compliance with my program of pain control medicine. If the cost of the above test is not paid by my insurance company, I further agree to pay for drug testing prior to being seen by my doctor and this cost will be fifty dollars ($50.00) payable with cash prior to my office visit.

I agree that I will use my medicine at a rate no greater than the prescribed rate and that the use of my medicine at a greater rate will result in my being without medication for a period of time.

I will bring all unused pain medicine to every office visit.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me.

This Agreement is entered on this _____ day of _____, _____
(day) (month) (year)

Signed by Patient:

_____ _____
Name (please print) Signature

_____
Witnessed by Office Staff

Physician:

John A. Coccaro, MD _____

PRECISION
PAIN MANAGEMENT

Dear Patient,

Please be advised Precision Pain Management is ***Out of Network*** with your insurance company. We'll be submitting a claim directly to your insurance carrier for you. However, because our facility is ***Out of Network***, your insurance company may make the payment directly to you.

DO NOT CASH THE INSURANCE CHECK.

Instead, please address the back of the check and write "Payable to Precision Pain Management" below your signature. You must then send the insurance check to Precision Pain Management, 300 W. Water Street, Suite A, Toms River, NJ 08753 as soon as you receive it. The check must be sent within 10 days of receipt otherwise your account will be put into collection for an outstanding balance. Unfortunately, we will not be able to provide further services until the balance is satisfied.

FORWARD A COPY OF THE EXPLANATION OF BENEFITS WITH THE INSURANCE CHECK.

Along with the payment will be an Explanation of Benefits (EOB) statement. The EOB explains how your carrier arrived at the amount of money they issued. Failure to provide this copy to us may impact the balance we consider to be your remaining obligation.

Thank you for your understanding and cooperation.

Sincerely,

Precision Pain Management, LLC

_____ _____

Patient or Authorized Representative Signature Date

PRECISION PAIN MANAGEMENT,LLC
HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. ♦PLEASE SIGN THE BACK OF THIS FORM♦

INTRODUCTION

Precision Pain Management,LLC and staff understand that your medical information is private and confidential. Further, we are required by law to maintain the privacy of "protected health information." "Protected health information" is also referred to as PHI. PHI includes any individually identifiable information that we obtain from you or others that relates your past, present or future physical or mental health, the health care you have received, or payment for your health care.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of PHI. This notice also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all PHI we maintain. You can always request a written copy of our most current privacy notice from the Practice's Privacy Officer,

PERMITTED USES AND DISCLOSURES

We can use or disclose your protected health information for purposes of treatment, payment and health care operations. For each of these categories of uses and disclosures, we have provided a description and an example below. However, not every particular use or disclosure in every category will be listed.

♦ *Treatment* means the provision, coordination or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another. For example, a doctor treating you for a post surgical care may need to know if you have diabetes because diabetes may slow the healing process.

♦ *Payment* means the activities we undertake to obtain reimbursement for the health care provided to you, including billing, collections, claims management, determinations of eligibility and coverage and utilization review activities. For example, prior to providing health care services, we may need to provide information to your Third Party Payor about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the Third Party Payor for the services rendered to you, we can provide the Third Party Payor with information regarding your care if necessary to obtain payment. Federal or State law may require us to obtain a written release from you prior to disclosing certain specially PHI for payment purposes, and we will ask you to sign a release when necessary under applicable law.

♦ *Health care operations* means the support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient comments and complaints, physician reviews, compliance programs, audits, computer maintenance and support, backup maintenance and support, development, management and administrative activities. For example, we may use your PHI to evaluate the performance of our staff when caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. In addition, we may remove information that identifies you from your patient information so that others can use the de-identified information to study health care and health care delivery without learning who you are.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

In addition to using and disclosing your information for treatment, payment and health care operations, we may use your PHI in the following ways:

- We may disclose to your family or friends or any other individual identified by you PHI directly relevant to such person's involvement with your care or payment for your care. We may use or disclose your PHI to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care of your location, general condition or death. If you are present or otherwise available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not present or otherwise available, we will determine whether a disclosure to your family or friends is in your best interest, taking into account the circumstances and based upon our professional judgment.
- We may disclose your PHI to a pharmacy on your behalf. As well as download /upload prescription information.
- We may contact you to provide appointment reminders for treatment or medical care or leave a message for you.
- When permitted by law, we may coordinate our uses and disclosures of PHI with public or private entities authorized by law or by charter to assist in disaster relief efforts.
- We will allow your family and friends to act on your behalf to pick-up prescriptions, medical supplies, X-rays, and similar forms of PHI, when we determine, in our professional judgment that it is in your best interest to make such disclosures.
- Subject to applicable law, we may make incidental uses and disclosures of PHI. Incidental uses and disclosures are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.
- Photographs, videotapes, digital, or other images may be recorded to document your care. The Practice will retain the ownership rights to these photographs, videotapes, digital, or other images, but you will be allowed access to view them or obtain copies. The images will be stored in a secure manner that will protect your privacy and that they will be kept for the time period required by law or outlined in the Practice's policy.
- We may use or disclose your PHI for research purposes, subject to the requirements of applicable law. For example, a research project may involve comparisons of the health and recovery of all patients who received a particular medication. All research projects are subject to a special approval process which balances research needs with a patient's need for privacy. When required, we will obtain a written authorization from you prior to using your health information for research.
- We will use or disclose PHI about you when required to do so by applicable law.

[Note: In accordance with applicable law, we may disclose your PHI to your employer if we are retained to conduct an evaluation relating to medical surveillance of your workplace or to evaluate whether you have a work-related illness or injury. You will be notified of these disclosures by your employer or the Practice as required by applicable law.]

SPECIAL SITUATIONS

Subject to the requirements of applicable law, we will make the following uses and disclosures of your PHI:

- Organ and Tissue Donation. If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- Military and Veterans. If you are a member of the Armed Forces, we may release health information about you as required by military command authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.
- Worker's Compensation. We may release health information about you for programs that provide benefits for work-related injuries or illnesses.
- Public Health Activities. We may disclose health information about you for public health activities, including disclosures:
  - * to prevent or control disease, injury or disability;
  - * to report births and deaths;
  - * to report child abuse or neglect;
  - * to persons subject to the jurisdiction of the Food and Drug Administration (FDA) for activities related to the quality, safety, or effectiveness of FDA-regulated products or services and to report reactions to medications or problems with products;

* to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
* to notify the appropriate government authority if we believe that an adult patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if the patient agrees or when required or authorized by law.

- Health Oversight Activities. We may disclose health information to Federal or State agencies that oversee our activities. These activities are necessary for the government to monitor the health care system, government benefit programs, and compliance with civil rights laws or regulatory program standards.
- Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if the Practice is given assurances that efforts have been made by the person making the request to tell you about the request or to obtain an order protecting the information requested.
- Law Enforcement. We may release health information if asked to do so by a law enforcement official:

* In response to a court order, subpoena, warrant, summons or similar process;
* To identify or locate a suspect, fugitive, material witness, or missing person;
* About the victim of a crime under certain limited circumstances;
* About a death we believe may be the result of criminal conduct;
* About criminal conduct on our premises; and
* In emergency circumstances, to report a crime, the location of the crime or the victims, or the identity, description or location of the person who committed the crime.

- Coroners, Medical Examiners and Funeral Directors. We may release health information to a coroner or medical examiner. Such disclosures may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.
- National Security and Intelligence Activities. We may release health information about you to authorized Federal officials for intelligence, counterintelligence, or other national security activities authorized by law.
- Protective Services for the President and Others. We may disclose health information about you to authorized Federal officials so they may provide protection to the President or other authorized persons or foreign heads of state or may conduct special investigations.
- Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- Serious Threats. As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public or is necessary for law enforcement authorities to identify or apprehend an individual.

Note: HIV-related information, genetic information, alcohol and/or substance abuse records, mental health records and other specially protected health information may enjoy certain special confidentiality protections under applicable State and Federal law. Any disclosures of these types of records will be subject to these special protections.

OTHER USES OF YOUR HEALTH INFORMATION

Other uses and disclosures of protected health information not covered by this notice or the laws that apply to us will be made only with your permission in a written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we already have taken action in reliance on your authorization.

YOUR RIGHTS

1. You have the right to request restrictions on our uses and disclosures of protected health information for treatment, payment and health care operations. However, we are not required to agree to your request. To request a restriction, you must make your request in writing to the Practice's Privacy Officer.
2. You have the right to reasonably request to receive confidential communications of protected health information by alternative means or at alternative locations. To make such a request, you must submit your request in writing to the Practice's Privacy Officer.
3. You have the right to inspect and copy the protected health information contained in your medical and billing records and in any other Practice records used by us to make decisions about you, except:

(i) for psychotherapy notes, which are notes that have been recorded by a mental health professional documenting or analyzing the contents of conversations during a private counseling session or a group, joint or family counseling session and that have been separated from the rest of your medical record;

(ii) for information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;

(iii) for protected health information involving laboratory tests when your access is restricted by law;

(iv) if you are a prison inmate, obtaining a copy of your information may be restricted if it would jeopardize your health, safety, security, custody, or rehabilitation or that of other inmates, or the safety of any officer, employee, or other person at the correctional institution or person responsible for transporting you;

(v) if we obtained or created protected health information as part of a research study, your access to the health information may be restricted for as long as the research is in progress, provided that you agreed to the temporary denial of access when consenting to participate in the research;

(vi) for protected health information contained in records kept by a Federal agency or contractor when your access is restricted by law; and

(vii) for protected health information obtained from someone other than us under a promise of confidentiality when the access requested would be reasonably likely to reveal the source of the information.

In order to inspect and copy your health information, you must submit your request in writing to the Practice's Privacy Officer. If you request a copy of your health information, we may charge you a fee for the costs of copying and mailing your records, as well as other costs associated with your request.

We may also deny a request for access to protected health information if:

- a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger your life or physical safety or that of another person;
- the protected health information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or
- the request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to you or another person.

If we deny a request for access for any of the three reasons described above, then you have the right to have our denial reviewed in accordance with the requirements of applicable law. I authorize a copy of this form & my signature to be used in lieu of an original. This notice is effective 07/02/12.

Signature_____

If signed by patient representative, state relationship

Date ___/___/___ Relationship_____

PRECISION
PAIN MANAGEMENT

300 West Water Street, Suite A, Toms River, NJ 08753
PHONE 732 800-2760 FAX 732 505-5432

Letter to patients at Precision Pain Management...

Prescription narcotics continues to present a major healthcare concern and though opioid narcotics is a necessary and sole option for some patients I have decided to change the opioid prescribing policy at Precision Pain Management. There are many alternatives to narcotics available to you including abstinence, non-narcotics, anti- depressant and anti- seizure medications to name a few.

As you should be aware Governor Christie and the State of NJ have outlined and passed major reform regarding narcotic prescribing. This legislation despite affecting mostly patients with acute pain and initial prescriptions will have a major impact on patients receiving prescription opioids on a chronic basis.

I will remain committed to providing you state of the art interventional pain management as an alternative to opioids. At the same time, I will work with you to reduce or totally eliminate your narcotic usage. Precision Pain Management provides medical and implantable therapies to accomplish these goals. Should you require medical means of management my practice will assist you in attaining these medications.

While these changes will be unpopular and felt to be personal, please understand they are not. There are very few true indications for long term and chronic narcotic therapy. I am sure by working together in a healthy doctor patient relationship we can move your life in a healthy and opioid free direction.

Sincerely,

John A. Coccaro, MD

Please Read carefully and Sign!

Signature: _____

Print Name: _____ Date: _____

PRECISION
PAIN MANAGEMENT

Welcome to Precision Pain Management, we are happy to have you as a new patient and cannot wait to meet you. If your insurance carrier requires referrals, i.e, HMO, POS, you are responsible and must bring or have your referral in NaviNet at the time of your appointment. If you do not have your referral in or at the time of your appointment or you will be rescheduled.

Scheduled Appointments

If at patient is 15 minutes past their scheduled time, their appointment will need to be rescheduled. If in future appointments a patient does not have a valid referral at the time of visit the patient will be rescheduled as well.

Cancellation/ No- Policy for Surgery

Due to large block of time needed for surgery, last- minute cancellations can cause problems and added expenses for the office.

Account Balances

We will require that patients with self- pay balances pay their account balances to zero prior to receiving further services by our practices.

Patients who have questions about their bill or who would like to discuss a payment plan option may call and ask to speak to our medical biller with whom they can review their account and concerns.

Patients with a balance over $100.00 must make a payment arrangement prior to future appointments being made.

_____	_____	_____
Print Name	**Signature Patient/ Guardian**	**Date**