North Shore LIJ North Shore Long Island Jewish Health System

NORTH SHORE UNIVERSITY HOSPITAL
DEPARTMENT OF SURGERY

NAME:_____
DOB:_____

PAIN SCREENING:

HAVE YOU EXPERIENCED PAIN WITHIN THE PAST WEEK? ☐ NO ☐ YES
(If no, stop here. If yes, please continue)

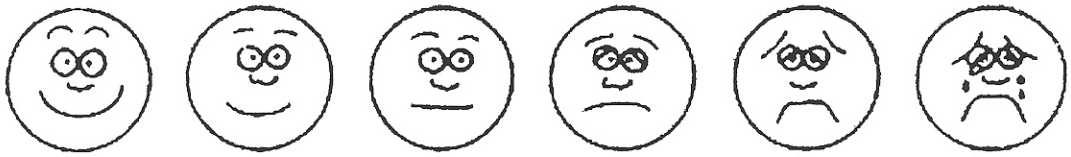
WHERE IS THE PAIN LOCATED?_____

ARE YOU BEING TREATED FOR YOUR PAIN? ☐ NO ☐ YES

CIRCLE A NUMBER FROM 0-10 THAT BEST DESCRIBES HOW MUCH PAIN YOU ARE HAVING NOW

NO PAIN	0	1	2	3	4	5	6	7	8	9	10	MOST SEVERE PAIN

PLEASE CIRCLE THE FACE THAT BEST DESCRIBES HOW YOU FEEL



0 2 4 6 8 10

PAIN ASSESSMENT – TO BE COMPLETED BY HCP

WHAT DOES YOUR PAIN FEEL LIKE?

☐SHARP	☐THROBBING	☐GNAWING	☐MISERABLE
☐DULL	☐TENDER	☐SHOOTING	☐UNBEARABLE
☐BURNING	☐NUMB	☐EXHAUSTING	☐CONTINUOUS
☐ACHING	☐STABBING	☐PENETRATING	☐OCCASSIONAL

WHAT MAKES THE PAIN BETTER?_____

WHAT MAKES THE PAIN WORSE?_____

_____ _____
PHYSICIAN/RN SIGNATURE DATE

5/24/2006

Financial Policy

The following is our financial policy. We are pleased to discuss our professional fees with you at any time. Please ask if you have any questions about our fees, financial policy, or your financial responsibility.

INSURANCE CARDS: We will request to photocopy your insurance cards(s) for your file. If you have more than one insurance plan, please be sure to present all your cards.

CO-PAYMENT PLANS: The Health Insurance Portability & Accountability Act requires that we collect your carrier co-payments at the time of service. Please be prepared to pay them at this time. If we participate in your plan, we will accept the designated fee.

NON CO-PAYMENTS: If your insurance plan does not require a co-payment, and we participate in your plan, we will also accept the designated fee. You are responsible for any deductible and balance your plan indicates on their explanation of benefits.

NON-PARTICIPATING PLANS: The doctors at our Center wish to work with you in every way possible. If you have a plan in which we do not participate in, arrangements can be made to accept your insurance companies' fees to non-participating doctors. You are responsible for any yearly deductibles that have not been met. Please speak with our accounts representative in regard to these plans.

REFERRALS: If your plan requires a referral from a primary care physician, it is **YOUR** responsibility to obtain it and have it with you at the time of your office visit. We will also accept referrals that are faxed to us from your physician's office if they are received prior to your visit. Your insurance company will not make payment of your bills without the proper referrals.

This office will obtain the proper precertification for your surgery if surgery is necessary, however, many insurance plans stipulate that they be informed of pending surgery by the patients also. Not doing so could jeopardize your payment. Therefore, it is **YOUR** responsibility to call your insurance company and make them aware of your upcoming surgery.

MEDICARE: We will submit claims to Medicare for the Medicare allowed amount. You are responsible for your deductible and the 20% co-insurance. If you have a secondary insurance, we will bill them for you also.

Anesthesia and **Hospital** costs are billed **separately** and have nothing to do with our fees to you. Please speak with your insurance company if you have any questions in regard to these fees.

You are responsible for the timely payment of your account.

Thank you for taking the time to review our policy. Please feel free to ask any questions or share your special concerns with us.

Patient Signature_____ **Date**_____

Responsible party signature if not the patient_____ **Date**_____

North Shore LIJ

North Shore-Long Island Jewish Health System

I agree to allow disclosure of my PHI (including date/time of appointments) to:

___ My Spouse _____
(Printed name and phone number)

___ Member(s) of my Family _____

_____

_____
(Printed name and phone number)

___ Other _____
(Printed name and phone number)

___ Myself only

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have been provided and have reviewed the *Notice of Privacy Practices*.

_____
Print Name of Patient or Legal Representative Date

_____
Signature of Patient or Legal Representative Date

_____
Relationship to patient

Authorization to release information via e-mail

By proving your e-mail address, you agree to receive e-mail information about your healthcare, including protected health information.

_____ _____
Signature Date

This does not serve as an Authorization to Release Medical Records

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ an emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

Witness: _____ Date: _____