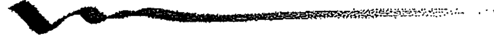
The Kahan Center
FOR PAIN MANAGEMENT



170 Jennifer Road, Suite 240
Annapolis MD 21401
www.thekahancenter.com

Welcome to our practice. Enclosed is your new patient paperwork. Please fill this out and bring it along with any films, records, referral (if required by insurance), insurance card as well as picture ID, copay/patient portion. It is very important to bring all that is required to your appointment, it also imperative that you arrive at least 15-20minutes early for your appointment; if you fail to do so the office will have to reschedule you.

What to expect at your initial appointment:

Welcome. Your first appointment will be an evaluation/consultation. The doctor will review with you the information you have supplied. Based on the information and your examination, the doctor will determine / recommend what the right course of treatment (plan of care) for your condition will be (this is based on their knowledge of pain). Once the doctor has developed a treatment plan, we will schedule you for follow-ups, appropriate diagnostic tests and therapy in order to help reduce your pain and improve your quality of life. Please understand that this doesn't mean the doctor will continue the treatment you have received prior to this exam. The doctor reserves the right to determine their own treatment plan for your condition and this plan might not agree with what you have been receiving so far. The doctor is making their judgment based on their expertise in the field of pain medicine. If our practice decides that medication will be part of your plan of care please note the following- all request for non-narcotic medication (medications that can be called in or electronically prescribe will be addressed with-in 48 hours of the request) for all other medication that can't be called in require an appointment. Please also note if our office has not seen you as a patient in 6 months or great regardless of the medication you will require an appointment.

Thank you,
The Kahan Center for Pain Management
Revised 06/2011,10/2012

The Kahan Center for Pain Management

Fellow Interventional Pain Physicians
Fellow American Academy of PM&R
www.thekahancenter.com
170 Jennifer Road, Suite 240 * Annapolis, Maryland 21401
410-571-9000

PERSONAL INFORMATION

FULL NAME: (Mr. Ms. Mrs. Miss Dr.) ____________________

NICKNAME: ____________ REFERRED BY: ____________________

ADDRESS: ____________________

CITY: ____________ STATE: ____________ ZIP CODE: ____________

HOME PHONE: ____________ WORK PHONE: ____________ CELL: ____________
SOCIAL SECURITY: ____________ BIRTH DATE: ____________ AGE: _____ Gender: _____

MARITAL STATUS: Single ____ Married _____ Divorced _____ Widowed _____ Other _____

EMPLOYER NAME: ____________ OCCUPATION: ____________
EMPLOYER'S ADDRESS: ____________________

IF A STUDENT: Full-time ___ Part-Time ___ DATE OF GRADUATION: ____________
NAME OF SCHOOL ATTENDING: ____________________

PRIMARY CARE PHYSICIAN NAME (if different than "Referred by"): ____________
PERSON TO NOTIFY IN CASE OF EMERGENCY, RELATIONSHIP AND TELEPHONE
____

INSURANCE INFORMATION

PRIMARY INSURANCE: NAME: ____________________
RELATIONSHIP TO INSURED: Self _____ Spouse _____ Child _____ Specify Any Other ____________
INSURED'S SSN: ____________ BIRTH DATE: ____________ GENDER: Male ___ Female ___
INSURED'S EMPLOYER: ____________ INSUREDS NAME: ____________
SUBSRIBERS ID#: ____________ GROUP: ____________

SECONDARY INSURANCE: NAME ____________________
RELATIONSHIP TO INSURED: Self _____ Spouse _____ Child _____ Specify Any Other ____________
INSURED'S SSN: ____________ BIRTH DATE: ____________ GENDER: Male ___ Female ___
INSURED'S EMPLOYER: ____________ INSURED'S NAME: ____________
SUBSCRIBERS ID#: ____________ GROUP: ____________

- I ATTEST THAT ALL THE INFORMATION GIVEN HEREWITH IS TRUE AND CORRECT.
- I AGREE TO NOTIFY **THE KAHAN CENTER FOR PAIN MANAGEMENT** OF ANY CHANGE IN NAME, ADDRESS, PHONE NUMBER, EMPLOYMENT STATUS OR INSURANCE COVERAGE.
- I AUTHORIZE RELEASE OF MY MEDICAL RECORDS AND/OR INFORMATION REGARDING MY TREATMENT TO MY PRIMARY CARE OR REFERRING PHYSICIAN(S), AND/OR SPECIALIST PROVIDER TO WHICH **The Kahan Center for Pain Management** MAY REFER ME. I FURTHER ACKNOWLEDGE THAT A COPY OF THIS RELEASE CAN BE USED IN PLACE OF THE ORIGINAL.
- CONSENT TO TREAT A MINOR- SIGNATURE OF LEGAL GUARDIAN(PERMISSION)

PATIENT OR LEGAL GUARDIAN SIGNATURE: ____________ DATE: ____________

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FINANCIAL POLICY
(REVISED 04/08, 05/09, 06/11,07/12,01/14,03/15, 6/17,03/21)

In order to avoid any miscommunications regarding payment for service rendered in this office, there are several payment options available as detailed below. Please select your preferred method of payment and sign in the appropriated area.

1. CASH/CHECK/VISA-MASTERCARD
If you choose this option, all fees are due and payable in full at the time services are rendered. At check in $150.00 will be paid towards your visit and when checking out if any further payment is due it will be expected. No exceptions will be made unless discussed with the Office Manager prior to your appointment.

2. MEDICAL INSURANCE
For your convenience, your health insurance can be billed by this office and you will be responsible for any deductible, co-payments, and co-insurance and denied claims. Claims should be paid within 30-45 days of filing by your health insurance carrier. Any claims still outstanding after this time frame will become the financial liability of the policy holder.*(* Subject to limitations on insurance companies that the physicians are contracted with.) All copay's are due at check in.

3. MEDICARE
Since the physicians are Medicare contracted providers, your insurance claim will be filed on your behalf and an assignment of benefits (a statement that the insurance carrier will pay the doctor directly) must be on file. Please Note: Secondary and supplemental insurance policies will be billed for you, as long as the information is provided on your initial visit. Our office would suggest to you to contact Medicare with your secondary/supplemental information, as they will often forward your claims automatically. Please be advised that if you don't have a secondary/supplemental insurance you will be responsible for the co-insurance Medicare assigns.

4. PERSONAL INJURY / AUTO ACCIDENT
The office does not accept personal injury protection insurance as a method of payment. Nor does this office wait for settlement of claims. If you have health insurance, we will submit your claims on your behalf. If you do not have health insurance our office will supply the insured all necessary forms /documents to get reimbursed from your personal protection insurance (PIP).

5. WORKER'S COMPENSATION
If you are injured on the job, this is considered a worker's compensation case. You are responsible to provide this office with verification from your employer that you were injured on the job as well as all applicable insurance information. Once verification is received, your bill will be sent to the authorized insurance company. (Taking the responsibility of payment off of the patient) REMEMBER, if your employer or you neglect to meet the requirements of the Worker's Compensation Commission and they deny your claim, you are responsible for all charges. If this information is not provided at your initial visit the office will not bill any back dates of service, those claim then become your responsibility.

6. SPECIAL ARRANGEMENT
If you feel that your case is unique or that none of the options above fit your financial situation, please discuss arrangements with the Office Manager prior to being seen by the Doctor.

- ## ADDITIONAL INFORMATION

Our office also reserves the right to charge for all missed appointments and appointments cancelled with less than 24 hours notice. Telephone consults / conferences/ Pages between providers and patient are subject to a fee that may not be reimbursable by insurance. There will be a $30.00 fee for all paper work completed by physicians or office staff. Patient balances copay/co-insurances are due at time of service, if payment is missed our office reserved the right to charge a late fee of $10.00 for any unpaid balance on a monthly basis. All past due accounts will be subject to a collection agency.
***Effective immediately – If your insurance policy has out of network benefits our practice will bill your insurance company for all services rendered.**

As far as your responsibility:

- If the services are applied toward your deductible.
- The difference between what is reimbursed and what is allowed.
- Non covered services

For all insurance policies that don't have out of network benefits you will be responsible for all services at time of service. See Fee Schedule

DISCLOSURE

The physicians and/or employees of this practice own interest in providing physical therapy, pain treatment and rehabilitation services at (**The Kahan Center for Pain Management), Center for Pain Medicine and Physiatric Rehab, Kent Island Surgery Center, LLC, Riva Road Surgical Center,LLC** (***Riva Road***), **Deer Pointe Surgery Center(*Salisbury,MD*), Maryland Medicinal, LLC, Back to fit, Inc.** Given notice the above name physicians and/or employees disclose the existence of ownership of the businesses previously mentioned. Under Maryland Law, this disclosure is to inform you of such and that you may choose to obtain the above-described healthcare services from another health care facility. Maryland law further requires that you acknowledge in writing the receipt of the above statement.

I AGREE TO USE PLAN #_____ FOR MY CARE.

By signing below, I agree to the following:

*I authorize the use of this form on all of the insurance submissions.
*I authorize release of information to all my insurance companies.
*I understand I am responsible for my bill.
*I authorize my doctor to act as my agent in helping me obtain payments from my insurance company
*I authorize payment directly to my doctor
*I permit a copy of this authorization to be used in place of the original.

PATIENT OR LEGAL GUARDIAN SIGNATURE

____

DATE

Patient Name:____

____

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CANCELLATION POLICY

If you cancel an appointment with our office

less than 24 hours notice you will be charged a fee:

Cancellation fees:

Office visit:	**$50.00**
Procedure:	**$100.00**

Effective January 1, 2021

NEW PATIENT INFORMATION FORM

PATIENT NAME: ______________________ **DATE:** ______________

HISTORY

CHIEF COMPLAINT: ______________________________

HISTORY of PRESENT ILLNESS: *For an "Extended" history, document at least 4 of these elements

***Location** ______________
(Where is the pain/problem (ex: back,neck,knee ?)

***Quality** ______________
How does it feel(ex. Sharp,dull,aching,stabbing)

***Severity** ______________
(How severe is the pain/problem ex:mild/moderate ?)

***Duration** ______________
(How long have you had this pain/problem or date of onset?)

***Timing** ______________
(Does this pain/problem occur at a specific time?)

***Context:** ______________
(Where were you at the onset of this pain/problem?)
(Has this injury resulted in a lawsuit) ________

***Associated symptoms:** ______________
(Ex: numbness/walking difficulty)

***Modifying factors:** ______________
(What makes the pain/problem worse or better?)

MEDICAL HISTORY
*For a "Pertinent" history - at least 1 specific item for ANY ONE of the 3 histories
* For a "Complete" history - at least 1 specific item for EACH ONE of the 3 histories

***Patient medical history**

Diabetes	No	Yes
Hypertension.	No	Yes
Cancer	No	Yes type:________
Stroke	No	Yes
Heart Trouble	No	Yes
Arthritis/Gout(circle)	No	Yes
Bleeding Tendency	No	Yes
Stomach Problems (ex:GERD/ulcer)	No	Yes

Previous Hospitalizations/Surgeries/Injuries
____
____
____
(Previous Work / Auto injuries)

Medications
1) __________ 2) __________
3) __________ 4) __________
5) __________ 6) __________

*** Patient Social History**

Who Do you Live with: ________ **Are you able to take care of yourself:** _____
Marital Status: Single _____ Married_____ Separated_____ Divorced_____ Widowed_____
Use of Alcohol: Never _____ Rarely _____ Moderate _____ Daily_____ No. Drinks_____
Use of Tobacco: Never _____ Previously, but quit (packs/years) _____ Current Packs/Day_____
Use of Drugs: Never _____ Type/Frequency: _____ Past/ Current ___ History of Abuse:_____
Excessive exposure at home or work to: Fumes ___ Dust ___ Solvents ___ Air-borne particles___ Noise
Employment: ______________________________

***Family Medical History**

	Diseases/ Problems
Father	______________________
Mother	______________________
Siblings	______________________

NEW PATIENT INFORMATION FORM

Review of System:

***Constitutional Symptoms**

Good general health	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

***Eyes**

Eye disease or injury	No	Yes
Wear glasses/contact lens	No	Yes
Blurred vision/double vision	No	Yes
Glaucoma	No	Yes

***Ears/Nose/Mouth/Throat**

Hearing loss or ringing	No	Yes
Earaches or damage	No	Yes
Chronic sinus problems	No	Yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Swollen glands	No	Yes

***Cardiovascular**

Heart trouble/attack	No	Yes
Chest pain/angina	No	Yes
Shortness of breath with walking	No	Yes
Swelling of feet/ankles/hands	No	Yes

***Respiratory**

Coughing blood	No	Yes
Shortness of breath	No	Yes
Asthma/wheezing	No	Yes
Chronic or frequent coughs	No	Yes
Sleep Apnea	No	Yes
Spitting up of blood	No	Yes

***Gastrointestinal**

Loss of appetite	No	Yes
Change in bowel habits	No	Yes
Frequent diarrhea	No	Yes
Nausea or vomiting	No	Yes
Constipation	No	Yes
Rectal bleeding/blood in stool	No	Yes
Abdominal pain/heartburn	No	Yes
Peptic ulcer	No	Yes

***Genitourinary**

Incontinence	No	Yes
Blood in urine	No	Yes
Burning or painful urination	No	Yes
Female- pain with periods	No	Yes
Female- irregular periods	No	Yes
Female- vaginal discharge	No	Yes

Female- #pregnancies____________________

Female-#miscarriages____________________

Female- date of last PAP smear______________

Male-testicular pain	No	Yes
Sexual difficulty	No	Yes
Frequent urination	No	Yes
Kidney stones	No	Yes
Difficulty starting/stopping	No	Yes

***Allergic/Immunologic**

History of skin reaction or other adverse reaction to:

Penicillin/other antibiotics	No	Yes
Morphine, Demerol, narcotics	No	Yes
Novocain or anesthesia	No	Yes
Aspirin or other pain remedies	No	Yes
Other drugs or foods	No	Yes

***Musculoskeletal**

Neck pain	No	Yes
Back pain	No	Yes
Joint pain	No	Yes
Joint stiffness/swelling	No	Yes
Abnormal joints	No	Yes
Fractures	No	Yes
Arthritis	No	Yes
Cold extremities	No	Yes
Limitation of joint movement	No	Yes
Muscle wasting	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Night cramps	No	Yes
Atrophy	No	Yes
Posture abnormalities	No	Yes
Difficulty in walking	No	Yes

***Integumentary (skin, breast)**

Breast cancer	No	Yes
Breast discharge	No	Yes
Breast lump	No	Yes
Breast pain	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Rash or itching	No	Yes
Varicose veins	No	Yes

***Neurological**

Frequent or recurring headaches	No	Yes
Lightheaded or dizzy	No	Yes
Numbness or tingling sensations	No	Yes
Head injury	No	Yes
Tremors	No	Yes
Convulsions or seizures	No	Yes
Blackouts	No	Yes
Gait disturbance	No	Yes
Stroke	No	Yes
Epilepsy/seizures	No	Yes
Headaches	No	Yes
Incoordination	No	Yes
Memory loss	No	Yes
Involuntary movement	No	Yes
Spasticity	No	Yes
Paralysis	No	Yes

***Psychiatric**

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Insomnia	No	Yes
Depression	No	Yes

***Endocrine**

Glandular or hormone problem	No	Yes
Thyroid disease	No	Yes
Diabetes	No	Yes
Excessive thirst or urination	No	Yes
Excessive urination	No	Yes
Heat or cold intolerance	No	Yes
Skin becoming dryer	No	Yes
Change in hat or glove size	No	Yes

***Hematologic/Lymphatic**

Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Easy bruising	No	Yes
Enlarged glands	No	Yes
Past transfusion	No	Yes
Phlebitis	No	Yes
Slow to heal after cuts	No	Yes

NEW PATIENT INFORMATIONFORM

Do you have any of the following? (Circle all that apply)

Headaches	Stomach Pain	Chest Pain	
Vision Problem	Nausea	Shortness of Breath	
Hearing Problem	Vomiting	Urinary Problem	
Dizziness	Constipation	Rashes	
Difficulty Swallowing	Diarrhea	Swollen Joints	Chronic Fatigue

DOMESTIC STIUATION

With whom do you live? ______________________________

Any substance abuse issues in the household? NO YES

If positive for substance abuse, explain:______________________________

Are you able to take care of yourself? NO YES

If not, please enter name of caregiver:______________________________

WORK HISTORY

Job	Years Worked?	Why did you leave?
____________	________	____________

LEGAL MATTER

Involved in any legal proceedings or lawsuits? NO YES If yes, please explain: ____________

SUBSTANCE USE

Which of the following drugs or substance, if any, have you used in the past? Next to each drug or substance that you've circled, indicated if you used it Occasionally ("O"), Frequently ("F"), or Continuously ("C"). (Circle all that apply)

Drugs/Substance	Used in the Past?		Frequency			Drug/Substance	Used in the Past?		Frequency		
Alcohol	No	Yes	O	F	C	Barbiturates	No	Yes	O	F	C
Heroin	No	Yes	O	F	C	Amphetamines	No	Yes	O	F	C
Cocaine	No	Yes	O	F	C						
Marijuana	No	Yes	O	F	C	Other	No	Yes	O	F	C

Are you presently using any of the drug or substance below?? Next to each drug or substance that you've circled, indicated if you used it Occasionally ("O"), Frequently ("F"), or Continuously ("C"). (Circle all that apply)

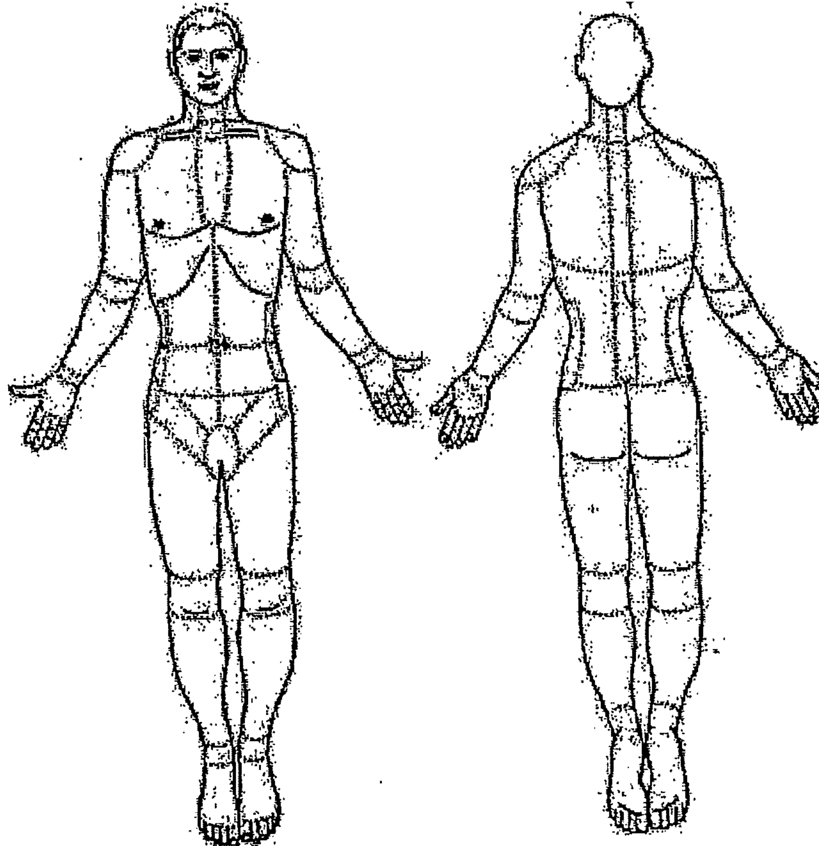
Drugs/Substance	Used in the Past?		Frequency			Drug/Substance	Used in the Past?		Frequency		
Alcohol	No	Yes	O	F	C	Barbiturates	No	Yes	O	F	C
Heroin	No	Yes	O	F	C	Amphetamines	No	Yes	O	F	C
Cocaine	No	Yes	O	F	C						
Marijuana	No	Yes	O	F	C	Other	No	Yes	O	F	C

Do you presently smoke/use tobacco in any form? NO YES

If no, did you ever smoke/use tobacco in any form? NO YES

How many packs do/did you smoke a day?____________ For how many year?____________

NEW PATIENT INFORMATIONFORM



Circle the numbers below that best describe how pain has interfered with your daily functioning this past week.

0= Does not interfere   10= Completely interferes

General Activity	0 1 2 3 4 5 6 7 8 9 10
Mood	0 1 2 3 4 5 6 7 8 9 10
Walking Ability	0 1 2 3 4 5 6 7 8 9 10
Normal Work Routine	0 1 2 3 4 5 6 7 8 9 10
Relations with Other People	0 1 2 3 4 5 6 7 8 9 10
Sleep	0 1 2 3 4 5 6 7 8 9 10
Enjoyment of Life	0 1 2 3 4 5 6 7 8 9 10
Ability to Concentrate	0 1 2 3 4 5 6 7 8 9 10
Appetite	0 1 2 3 4 5 6 7 8 9 10

Do you have any history of drug or alcohol abuse? **YES** **NO**

Patient Name **Date**

1. Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.

   a. Little interest or pleasure in doing things

   Not at all Several days More than half the days Nearly every day

   b. Feeling down, depressed, or hopeless

   Not at all Several days M ore than half the days Nearly every day

   c. Trouble falling asleep, staying asleep, or sleeping too much

   Not at all Several days More than half the days Nearly every day

   d. Feeling tired or having little energy

   Not at all Several days More than half the days Nearly every day

   e. Poor appetite or overeating

   Not at all Several days More than half the days Nearly every day

   f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down

   Not at all Several days More than half the days Nearly every day

   g. Trouble concentrating on things such as reading the newspaper or watching television

   Not at all Several days More than half the days Nearly every day

   h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual

   Not at all Several days More than half the days Nearly every day

   i. Thinking that you would be better off dead or that you want to hurt yourself in some way

   Not at all Several days More than half the days Nearly every day

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

   Not Difficult at All Somewhat Difficult Very Difficult Extremely Difficult