# United Interventional Pain Management

**Tel: 718-886-7246 Fax: 718-886-7247**

| Patient's Name 病人姓名 Last 姓氏 First 名 Middle | | Sex 性别 Male 男 Female 女 |
|---|---|---|
| Patient's Address 病人住址<br><br>Email 电子邮箱: | | Chinese Name 中文姓名 |
| Social Security Number 社會安全號 | Date of Birth 出生日期 | Race 种族 |
| Marital Status 婚姻狀況 | Home Phone 住宅電話 | Cell Phone 手機電話 |
| Emergency Contact 緊急聯絡人 | Relationship 關係 | Tel. No. 聯絡人電話 |
| Guardian Name (Patients Under 18) 監護人姓名(十八歲以下病人) | Guardian Tel. 監護人聯系電話 | |
| Primary Language 主要語言 | Primary Pharmacy 药房 | |
| Primary Health Insurance 主要醫療保險 | Policy Number 保险号 | |
| Secondary Health Insurance 第二醫療保險 | How did you know about us 您是如何知道我们的 | |

I hereby authorize Drs. Wensong Li and their medical staffs to perform any necessary routine examinations, diagnostic tests and procedures, injections and treatments on me.
本人授權李尉崧及其醫療人員做任何有關病情的各項檢查化驗，注射和治療.
I hereby authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicaid, Medicare, commercial insurances and other health plans to Dr. Wensong Li. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.
本人允許李醫生及其醫務所向我的保險公司獲取一切有關資料，以了解我的受保情況並且要求保險公司替我支付醫療費用．我允許我的保險公司，包括 Medicare, Medicaid, 私營保險和其他保險公司，向醫生及其醫務所支付我的醫療費用．本授權文件在書面取消前一直有效，本文件的影印件將同樣有效.
**I understand that I am financially responsible for any balance if my insurance is invalid or I have deductible and copays. I will provide my credit card number and give permission to draw payments from it If the doctors' office first attempt to file a claim is denied. I will pay the bill in cash prior to providing care if I have no credit card. I understand that I will get fully refund if my insurance make payment to all claims.**
本人明白如果我的醫療保險無效，或有自付部分，我願意負擔一切診金和醫療費用．如果我的保险公司拒绝向我的医生支付我的医疗费用，我在此提供我本人的信用卡账号并允许我的信用卡账户直接向醫生及其醫務所支付我的医疗费用（大额费用可分次支付，每次$500）。如果我无信用卡，在诊治以前，我必须以现金支付全部医疗费用。我明白一旦我的保险公司支付了全部医疗账单，我将获得全数退费（不含信用卡公司手续费）。

I certify that the above information is accurate and correct. 我保證以上資料准確無誤.

Patient or Guardian Signature 病人或監護人簽名 ____________________ Date 日期 ____________________

# 联合微创痛症专科

## 李尉崧 医生

Board Certified Anesthesiologist, Interventional Pain Management

## 病人同意書

為遵守紐約州立之 1996 年健康保險流通和責任法案的新規定，本醫務所公佈了法案給與您的某些權力，以及我們對醫療資料所做之保密和維護的守則。本醫務所之醫療資料保密通知書里，其中有一段說明了您身為病人在法律下所應有的權力。在您簽署此病人同意書前，您有權閱讀本醫務所的醫療資料保密通知書。此醫療資料保密通知書的內容，也許日後因需要會有所更改，屆時您可以與本醫務所聯絡要求索取一份紙版複印。

在醫療程序，領取醫療費和執行健康照顧方面，您有權限制本醫務所，如何運用或透露您的醫療資料。您有權以親自簽署的書信來取消此同意書。但是，這並不影響本醫務所，在收到您正式書面取消信之前，根據醫療程序之需要和您原先的同意的情況下，對您的健康資料所做的運用和透露。

病人清楚的瞭解以下幾個重點：

- 病人的保密醫療資料將因醫療程序需要，領取醫療費或執行健康照顧而被運用或透露；
- 本醫務所有一份醫療資料保密通知書，提供機會給病人參閱；
- 本醫務所有權更改此醫療資料保密通知書；
- 病人有權限制本醫務所如何運用或透露病人的醫療資料，但本醫務所並不需要贊同病人所提出的限制；
- 病人有權在任何期間，以親自簽署的書信后來取消此同意書，接到取消信後，本醫務所將停止運用或透露病人的醫療資料；
- 本醫務所可以要求病人簽此同意書後才開始為病人進行醫療的程序。

同意書簽署人 ______________________

病人或病人代表姓名的正楷

______________________ ____________

簽署 日期

與病人關係 ______________________
（若是病人代表）

見證人 ______________________

醫務所代表人的姓名正楷

______________________ ____________

簽署 日期

42-35 Main Street, #3A Flushing, NY 11355
757 60th Street, 7th Floor, Brooklyn, NY 11220
T: 718-886-7246 F: 718-886-7247

United Interventional Pain Management
Wensong Li, MD

# PATIENT CONSENT FORM

Our notice of privacy practices provides information about how we may use disclosed protected health information about you. The notice contains a patient rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the health insurance portability and accountability act of 1996 (HIPAA)

The patient understands that:

- protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice has a notice of privacy practices and that the patient had the opportunity to review this notice.
- the practice reserves the right to change the notice of privacy practices.
- the patient has the right to restrict the uses of their information but the practice does not have to agree to those restrictions.
- the patient may revoke this consent in writing at any time and all future disclosures will then cease.
- the practice may condition receipt of treatment upon the execution of this consent.

This consent was signed by: ______________________________
Printed name – patient or representative

______________________________ ___/___/___
Signature Date

Relationship to patient
(if other than patient): ______________________________

Witness: ______________________________
Printed name – practice representative

______________________________ ___/___/___
Signature Date

42-35 Main Street, #3A, Flushing, NY 11355
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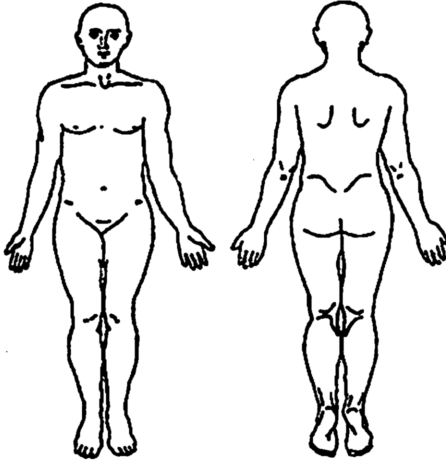
## 疼痛相關問卷

日期:

姓名: ________________年齡:________
你的家庭醫生: ____________________
家庭醫生電話: ____________________
你的轉診醫生: ____________________
轉診醫生電話: ____________________

怎麽知道我們的: 医生( ). 朋友( ). 报纸( ).
电视( ). 广播( ). 其他( )____________
第一次疼痛發生的時間: ____________
有無受傷或其他原因: ____________

請在圖中標出疼痛的部位 ( xxxxx )



妳的疼痛的性質(可選多項)

- ☐ 銳痛
- ☐ 鈍痛
- ☐ 刺痛
- ☐ 麻木感
- ☐ 疼痛放射至肢體
- ☐ 疼痛部位發熱
- ☐ 疼痛部位發冷
- ☐ 晝夜持續疼痛
- ☐ 疼痛部位變色
- ☐ 疼痛部位非常敏感

疼痛強度: 輕度( ) 中度( ) 重度( ) 嚴重( ) 劇烈( )
疼痛對你的影響: 影響你活動 ( ). 影響你的睡眠 ( ). 影響你的生活和自理 ( )
你是否爲緩解疼痛在其他專科醫生處求診?
針灸科 ( ) 脊椎科( ) 神經科( ) 物理理疗科( ) 麻醉痛症科 ( ) 骨科( ) 其他:
請列出你正在服用的鎮痛相關藥物:

______________________________________________

你是否患有或曾經患有以下疾病或症狀:

| | | |
|---|---|---|
| ☐ 高血壓 | ☐ 胃病反酸 | ☐ 頭暈(昏厥) |
| ☐ 心絞痛 | ☐ 胃潰瘍 | ☐ 出血疾病 |
| ☐ 心肌梗塞 | ☐ 消化道出血 | ☐ 關節炎 |
| ☐ 心脏雜音 | ☐ 腎衰 | ☐ 肝炎或黄疸 |
| ☐ 腳水腫 | ☐ 小便困難 | ☐ 癌症或腫瘤 |
| ☐ 哮喘 | ☐ 偏頭疼 | ☐ 糖尿病 |
| ☐ 吸煙 | ☐ 癲痫(抽風) | ☐ 其他疾病 |

做過什麼手術:
有無過敏史:
生活狀況: 與家人居住 ( ); 在工作( ); 飲酒( ); 吸烟( )____ (年) ___ (包/天)
請確認以上內容後簽名
簽名: ________________________ 日期: ____________________

# PAIN QUESTIONAIRE

Your name ______________________________ How old are you? ________________

Your primary doctor ________________________ Telephone ________________________

Your referral doctor ______________________ Telephone _________________________

How do you know us? Your doctor ( ); Friend ( ); Newspaper ( ); Radio / TV ( ); Other ( )

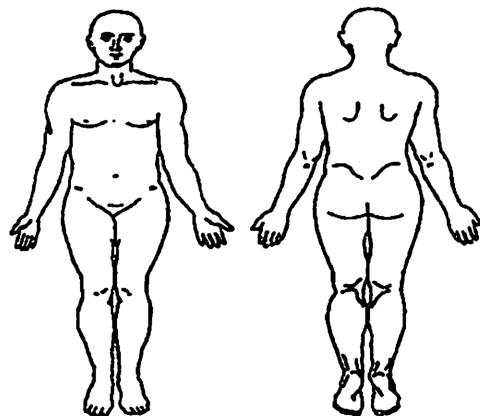
When did your pain first begin? ______________________________________

Were there any particular events that started your pain? ___________________________

**WHAT IS THE QUALITY OF YOUR PAIN?**

❑Sharp ❑Dull ❑Electrical
❑Burning ❑Numbness
❑Pins and needles ❑Shooting ❑Hot
❑Cold

**PLEASE MARK ON YOU PAIN**



**How Strong is Your Pain?**
1. Mild 2. Discomforting 3. Distressing
4. Horrible 5. Excruciating

**THE IMPACT OF YOUR PAIN**

❑Sleep ❑Daily activities ❑Standing and Walking

**PAST PAIN TREATMENT:** Check if you visited:→

❑Acupuncturist ❑Anesthesiologist
❑Chiropractor ❑Internist
❑Neurologist ❑Orthopedist
❑Physical Therapist ❑Psychiatrist
❑Other

**PAIN MEDICATIONS:** ____________________

**PAST MEDICAL HISTORY:**

**Any Allergy: Yes( ); No( )**

❑High Blood Pressure ❑Migraine Headaches
❑Angina/Chest Pain ❑Seizures
❑Asthma ❑Hepatitis/Jaundice
❑Smoking ❑Alcoholism
❑Stomach Ulcers ❑Kidney Failure

❑Cancer- any type
❑Diabetes
❑Other illness

**CURRENT MEDICATIONS** (Include blood thinners) _________________________

**PAST SURGICAL HISTORY:** _________________________________________

**SOCIAL HISTORY (CHECK IF YES)**

Married( ); Employed( ); Disability( ); Live with family( ); Alcohol( ); Smoking( ); Lawsuit( ) ________________

Please sign your name verifying that the above medical history is correct.

Signature ___________________________________ Date _______________