TIMOTHY GROTH MD PC
PAIN MANAGEMENT
SENSITIVITY COMPASSION TREATMENT

TIMOTHY D GROTH, MD. PC.
994 WEST JERICHO TURNPIKE SUITE 104
SMITHTOWN, NEW YORK 11787
PHONE: (631)543-1440
FAX: (631)543-1930

Dear Patient,

Welcome to our office! We look forward to meeting with you, reviewing your medical history, and working together to address the causes of your pain.
Enclosed you will find a patient questionnaire. It is very important that you take the time to complete this prior to your initial visit. This information will help us understand your condition and current overall health, so we can best treat your pain, and all aspects of your spine related disorders.

The doctors in our practice work collaboratively with NP's and PA's to enhance your care and help you get faster relief. We are a multi-disciplinary office and offer the latest state of the art medical and pain management care, along with chiropractic care, massage therapy, and physical therapy. Research has shown that collaborative care results in better clinical outcomes and faster results.
A NP/PA will be assigned to your case and monthly office visits will be scheduled with the assigned provider. If any injection procedures under fluoroscopy are requested for your treatment, it will be performed by a doctor.

Due to HIPAA regulations, it is your responsibility to obtain as many medical records as possible that are available to you. This includes office visit notes and diagnostic testing (i.e., MRIs, X-rays, CT scans, EMG reports). Complete and accurate information will enable us to meet your medical and other needs appropriately. Failure to do so, may result in a delay of treatment, as our review of records are essential in determining the best way to relieve your pain.

Please be sure to complete and sign the "Authorization to Obtain Health Information" form. If you need copies of your records from this office, we require two weeks notice to process. A signed written request must be presented to our office with specific details of the records you are requesting.

Please bring the following to your appointment:

1. Driver's license/ Photo ID
2. Health Insurance cards
3. Imaging reports (MRIs, CTs, X-rays, etc.)
4. If applicable, Referrals or related medical records
5. Co-payment due upon arrival

Thank you very much for your cooperation. We look forward to meeting you.

Sincerely,

Timothy Groth, MD. Medical Director and Director of Pain Management
David BenEliyahu, DC. Director of Chiropractic Services

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PATIENT DEMOGRAPHICS

Date:_____

Last Name:_____ First Name:_____ M:_____

Date of Birth:_____ Age:_____ SS #:_____

Address:_____

City:_____ State:_____ Zip:_____

Cell #:_____ Home #:_____ Email:_____

Emergency Contact:_____ Phone #:_____

Referring Physician:_____ Phone #:_____

Primary Care Physician:_____ Phone #:_____

INSURANCE INFORMATION

(For NF/WC Cases, skip this section & fill out next page)

Primary Insurance:_____ Phone #:_____

Address:_____ City:_____ State:_____ Zip:_____

Policy Holder's Name:_____ Date of Birth:_____

ID #:_____ Group #:_____

Place of Employment:_____ Phone #:_____

Secondary Insurance:_____ Phone #:_____

Address:_____City:_____ State:_____ Zip:_____

Policy Holder's Name:_____ Date of Birth:_____

ID #:_____ Group #:_____

Place of Employment:_____ Phone #:_____

I authorize my insurance benefits to be paid directly to Timothy Groth MD PC. I understand that I am financially responsible for any fees and balances.

Signature:_____ Date:_____

WORKER'S COMP/ NO FAULT QUESTIONNAIRE (IF APPLICABLE)

Patient Name:_____ **Date:**_____

Do you have No Fault Insurance? ☐ YES ☐ NO Date of Accident:_____
Do you have Workers Comp Insurance? ☐ YES ☐ NO Date of Accident:_____

Insurance Carrier:_____ Address:_____

Claim #:_____ WCB #:_____

Employer:_____ Phone #:_____

Address:_____

Is this injury from a motor vehicle accident?

Date of Accident:_____
Were you the: ☐ Driver ☐ Passenger ☐ Front seat ☐ Back seat
Road Condition: ☐ Dry ☐ Wet
Were you wearing a seat belt? ☐ YES ☐ NO
Was it a frontal/ rear or side impact collision? ☐ Frontal/ Rear ☐ Side
Did you hit your head? ☐ YES ☐ NO Did you lose consciousness? ☐ YES ☐ NO
Did you go to the hospital? ☐ YES ☐ NO Did you go by ambulance? ☐ YES ☐ NO
Treatment given at hospital:_____ Imaging:_____ Medications:_____
Did you have any prior accidents in the past before this one? ☐ YES, when_____ ☐ NO
Did you have any neck or back issues prior to this accident? ☐ YES ☐ NO
If yes, did they resolve and completely go away?_____
Have you seen any other doctors prior to seeing us for this accident? ☐ YES ☐ NO
If yes, who/when_____

Is this injury from a work-related accident?

Date of Injury:_____
Are you employed:_____
Occupation:_____
Did you file an injury report with your employer: ☐ YES ☐ NO
Are you currently working? ☐ YES ☐ NO
Did you go to the hospital? ☐ YES ☐ NO
Did you have any prior work-related injuries? ☐ Yes, type of injury:_____ ☐ NO
Have you seen any other doctors prior to seeing us for this accident? ☐ YES ☐ NO
If yes, who/when_____

If your case is NF or WC, do you have an attorney? ☐ YES ☐ NO

Attorney Name:_____ Law Firm:_____

Address:_____

Phone #:_____ Fax #:_____

Email:_____

Name:_____ Date:_____

INITIAL CONSULT

Where Is Your Pain Now?

Please use the appropriate symbols to describe your symptoms and mark the location as accurately as possible on the body drawing.

ACHING ΛΛΛΛΛΛΛ ☐

STABBING ////////// ☐

TINGLING = = = = = = = ☐

BURNING ***XXXXXXXX*** ☐

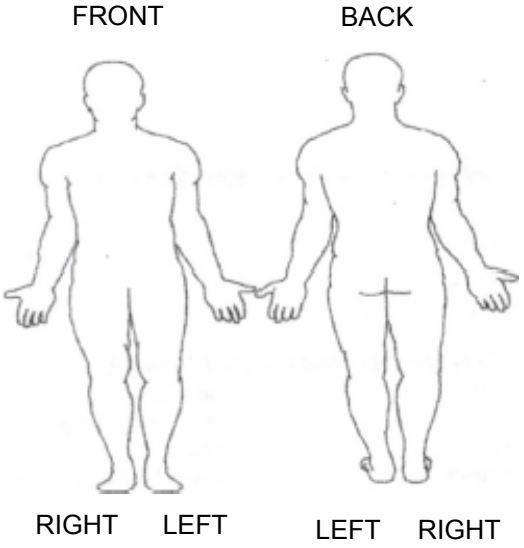
NUMBNESS OOOOOOO ☐

ALLERGIES:

DIABETIC: (TYPE 1 OR 2) A1C:_____

BLOOD THINNERS:

INSURANCE:



How bad is your pain?

(No Pain) ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 (Worst)

List current medications for your pain:

_____

_____

DO NOT WRITE BELOW THIS LINE (FOR OFFICE USE ONLY)

REFERRED:_____

PAIN:_____

_____

WHEN:_____

BETTER:_____

WORSE:_____

P:_____

I:_____

T:_____

S:_____

B/P: HEIGHT: WEIGHT: POC:

PATIENT PAIN PROFILE

Name:_____ DOB:_____ Date:_____

Date problem started:_____ Did your pain begin suddenly or gradually?_____

Describe your pain:

_____

_____

_____

_____

Pain level (1-10) without medications:_____ With medications:_____

Do you experience any weakness? ☐ LEFT- ARM / LEG ☐ RIGHT- ARM / LEG

Do you experience numbness/tingling? ☐ LEFT- ARM / LEG ☐ RIGHT- ARM / LEG

Which hand is dominant? ☐ LEFT ☐ RIGHT

Does pain interrupt your sleep? ☐ YES ☐ NO

Has pain changed your normal activities? (✓)

Sleeping	☐	Dressing	☐	Enjoyment of life	☐
Walking	☐	Hobbies	☐	Relationships	☐
Eating	☐	Sports	☐	Work/Housework	☐
Exercising	☐	Mood	☐	Other_____	

What percentage has your pain/injury adversely affected your Activities of Daily Living?_____%

What percentage has your pain/injury decreased your Quality of Life?_____%

Please indicate below what makes your pain better (**B**) or worse (**W**):

Heat _____	Humidity_____	Standing _____	Laying down _____
Ice _____	Cold _____	Sitting _____	Massage _____
Noise _____	Coughing ____	Sneezing ____	Bowel movements ___
Stairs _____	Fatigue _____	Alcohol _____	Anxiety/Emotions____

Please indicate any treatments you have undergone for your pain problem. Place a (**+**) to those that were effective and (**-**) next to those that did not help:

Acupuncture	Chiropractic	Massage
Bed Rest	TENS	Traction
Physical Therapy	Relaxation Therapy	Psychotherapy
Trigger Point Injections	Epidural Steroid Injections	Other Cortisone Injections
Nerve Blocks	Other (specify)_____	

MEDICAL HISTORY

Name:_____ DOB:_____ Date:_____

Height:_____ Weight:_____ Blood thinners:_____

Indicate any current/ previous medical problems or conditions (✓):

Anemia ☐	Chemotherapy/Radiation ☐	Kidney Problems ☐
Anxiety ☐	Depression ☐	Liver Problems ☐
Arthritis ☐	Diabetes ☐	Low Blood Pressure ☐
Asthma ☐	Epilepsy/ Seizures ☐	Migraines ☐
Back Problems ☐	Glaucoma ☐	Mitral Valve Prolapse ☐
Blood Clots ☐	Hepatitis ☐	Polio/Meningitis ☐
Cancer ☐	Hiatal Hernia/Reflux ☐	Stroke/TIA ☐
CAD/Angina/MI ☐	High Blood Pressure ☐	Thyroid Problems ☐
CRPS ☐	Jaw Problems/TMJ ☐	Ulcer ☐
		Other:_____

List all previous surgeries/hospitalization and when:

_____

_____

_____

List any medications you take (dosage and frequency):

_____

_____

_____

_____

List all allergies and related reactions:

_____

_____

_____

Indicated if you have experienced any of the following (✓):

Blackout/Dizziness ☐	Headaches/Migraines ☐	Motion Sickness ☐
Chest Pain ☐	Indigestion ☐	Shortness of Breath ☐
Constipation ☐	Loss of Bladder Control ☐	Skin Rashes ☐
Diarrhea ☐	Loss of Bowel Control ☐	Swollen or Sore Legs ☐

Family History (✓ all that apply):

Back/ Neck Surgery ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ Stroke ☐

Other: _____

Social History

Occupation:_____ Work Status: ☐ YES ☐ NO Disability %:_____

Marital Status:_____ # of children (if applicable):_____

Do you smoke? ☐ YES ☐ NO If yes, what_____ how much_____

Do you drink alcohol? ☐ YES ☐ NO If yes, frequency_____ how much_____

Do you use or have used recreational drugs (i.e., marijuana, cocaine, heroin)? ☐ YES ☐ NO

Last time used:_____

ORT

Patient Name:_____ **Date:**_____

Please fill out check boxes:

	YES	NO	OFFICE USE ONLY	
1. Family history of substance abuse			**F**	**M**
a. Alcohol	◯	◯	**1**	**3**
b. Illegal drugs	◯	◯	**2**	**3**
c. Rx drugs	◯	◯	**3**	**4**
2. Personal history of substance abuse				
a. Alcohol	◯	◯	**3**	**3**
b. Illegal drugs	◯	◯	**4**	**4**
c. Rx drugs	◯	◯	**5**	**5**
3. Age between 16-45 years old	◯	◯	**1**	**1**
4. History of preadolescent sexual abuse	◯	◯	**3**	**0**
5. Psychological disease				
a. Attention-Deficit Disorder, Obsessive-Compulsive Disorder, Schizophrenia	◯	◯	**2**	**2**
b. Depression	◯	◯	**1**	**1**
			Scoring Total:	

Nothing above applies ☐

2025 MIPS FORM

Name: _____ DOB: _____ Date: _____

1. Patients aged 12 and older:

Are you a tobacco user (cigarettes, chew, vape, etc)? ◯ Yes ◯ No

**For office use only: Was the patient counseled? _____ (Y/N)*

2. Have you been diagnosed with Depression? ◯ Yes ◯ No

If answered NO:

a. Do you feel down, depressed, or hopeless? ◯ Yes ◯ No

b. Do you feel tired or have little energy? ◯ Yes ◯ No

3. Women aged 21-64:

Have you had a cervical cancer screen in the past 3 years? ◯ Yes ◯ No

If YES:

a. Date of last screening: _____

4. Patients aged 65 and older:

Have you had any falls in the past 12 months? ◯ Yes ◯ No

If YES:

a. Approximately how many falls?: _____

b. Were any of them severe falls?: _____

5. Patients aged 65 and older:

Do you have an Advanced Care Plan, or surrogate decision maker? ◯ Yes ◯ No

If YES:

a. Surrogate Decision Maker: _____

b. Advanced Directive: _____

6. Adult Immunization Status (Check applicable):

A. Influenza Vaccine (19 years and older):

◯ Patient received a flu vaccine on or between July 1 of the year prior and June 30 of the current year

*Approx. Date Vaccine Received: _____

◯ Documentation of a medical reason for patient **not** receiving the flu vaccine

Check applicable medical reason:

a. ☐ Allergic reaction/ Anaphylaxis

b. ☐ Doctor recommended not getting

c. ☐ Contraindications

d. ☐ Other: _____

B. Tdap Vaccine (19 years and older):

◯ Patient received at least 1 Td or 1 Tdap vaccine within the last 9 years

*Approx. Date Vaccine Received:_____

◯ Documentation of a medical reason for patient **not** receiving the Tdap

Check applicable medical reason:

a. ☐ Allergic reaction/ Anaphylaxis

b. ☐ Doctor recommended not getting

c. ☐ Contraindications

d. ☐ Other: _____

Name: _____ Date: _____

C. Shingles Vaccine (50 years and older):

◯ Patient received at least 2 doses of the shingles recombinant vaccine (at least 28 days apart) anytime on or after the patients 50th birthday

*Approx. Date Vaccine Received: _____

◯ Documentation of medical reason for patient **not** receiving the shingles vaccine

Check applicable medical reason:

a. ☐ Allergic reaction/ Anaphylaxis
b. ☐ Doctor recommended not getting
c. ☐ Contraindications
d. ☐ Other: _____

☐ Documentation that administration of the second recombinant vaccine could not occur during the year (if first dose received after 10/31)

D. Pneumococcal Vaccine (66 years and older):

◯ Patient received any pneumococcal vaccine on or after their 60th birthday

*Approx. Date Vaccine Received: _____

◯ Documentation of medical reason for patient **not** receiving the pneumococcal vaccine

Check applicable medical reason:

a. ☐ Allergic reaction/ Anaphylaxis
b. ☐ Doctor recommended not getting
c. ☐ Contraindications
d. ☐ Other: _____

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AUTHORIZATION TO OBTAIN HEALTH INFORMATION

FOR OFFICE USE ONLY

Doctor, Hospital Facility:_____

Address:_____

Patient Name:_____

Address:_____

Phone Number:_____ Date of Birth:_____

I authorize you to disclose health information of the above named individual to:

TIMOTHY D GROTH, MD. PC.
PAIN MANAGEMENT
994 WEST JERICHO TURNPIKE SUITE 104
SMITHTOWN, NY 11787
PHONE: (631)543-1440
FAX: (631)670-7567 (Medical Records)
FAX: (631)543-1930 (Main)

TIMOTHY D GROTH, MD. PC.
CHIROPRACTIC CARE
1500 MIDDLE COUNTRY RD.
CENTEREACH, NY 11720
PHONE: (631)736-4414
FAX: (631)736-7490

Please select from below any information you would like to be sent to TIMOTHY D GROTH, MD. PC. to aid in your diagnosis and treatment. Please provide dates of service where it applies.

Operative Report	Consultation Reports from _____ to _____
Anesthesia Record	Medications Sheet
Discharge Instructions	Physicians Progress Notes from_____to_____
Discharge Summary	Physicians Orders from _____to_____
EKG	Imaging Reports from _____to_____
History and Physical	Entire medical record
Laboratory Results	Other (specify)_____

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and treatment for alcohol and drug abuse. For AIDS or HIV status, the Department of Health Authorization form must be completed, instead of this authorization.

I understand I have the right to revoke this authorization at any time; I must do so in writing and present my written revocation to medical records. Unless revoked, this authorization will expire on the following date, event, or condition.

_____

(You may indicate “none” if you wish to indicate a specific date)

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain copies of the information to be used or disclosed, as provided in the applicable Federal and State law. If I have questions about the disclosure of my health information, I can contact the medical records department.

Patient Signature:_____ **Date:**_____

Patient Name:_____

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NOTICE OF PRIVACY PRACTICES

I, _____, understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information will be used to:

*Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and indirectly.

*Obtain payment from third party payers.

* Conduct standard healthcare operations, such as quality assessments and Physician certifications.

I understand that I may request in writing that Timothy D. Groth, MD. PC. restrict how my private information is to be used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that Timothy D. Groth, MD. PC. is not required to agree to my requested restrictions, but are bound to abide by such restrictions to them.

List below any friend or family member(s) you give the authority to release Protected Health Information concerning your care, if you are unable to come to the office.

I have read and/or received a copy of the HIPAA Notice of Privacy Practices.

_____ _____
Name Relationship to patient

_____ _____
Name Relationship to patient

_____ _____
Name Relationship to patient

_____ _____
Patient Signature **Date**

NOTICE OF DISCLOSURE OF OWNERSHIP INTEREST

Please be advised that corporations, including local physicians own the North Shore Surgi-Center and Suffolk Surgery Center, one of whom is Timothy D. Groth, MD. These physicians have become owners as a result of their commitment to quality healthcare and services to their patients.

The NorthShore Surgi-Center and Suffolk Surgery Center may have a financial relationship with your physicians as indicated above. You have the right to choose where to receive services, including an entity in which your physician may have a financial relationship. Other medical facility options include:

St. Catherine of Siena Medical Center
50 Route 25A
Smithtown, NY 11787
(631)862-3000

Peconic Bay Medical Center
1 Heroes Way
Riverhead, NY 11901
(631)548-6000

Please INITIAL _____

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PAIN MANAGEMENT RISKS AND COMPLICATIONS AGREEMENT

INTERVENTIONAL PAIN MANAGEMENT injections are safe and have a long track record with complications occurring rarely. However, the complication rate is not 0%. The most common complication is a post dural puncture headache (Spinal Headache), which occurs in approximately one percent of cases.

CORTISONE INJECTIONS may have the following side effects: increased appetite, facial flushing, fluid retention, increased heart rate, feeling energized. Frequent, repetitive cortisone injections can increase bone loss, and contribute to osteoporosis. Therefore, we recommend that you take calcium and vitamin D.

EXTREMELY RARE COMPLICATIONS including bleeding, infection, or adverse reaction to medication, which can result in death, paralysis, loss of bowel or bladder control, increased pain or weakness, or the need for emergency surgery.

I have been informed of the risk of developing tolerance, or an addiction to opioids, and also the risk of addiction to any newborn children of female patients taking opioids while pregnant.

I give permission of the prescribing physician to contact my pharmacy directly, at the physician's discretion, to review and evaluate data. My signature below grants permission to release such requested information.

I, _____, understand all of the above and will comply.
(**Print Name)**

_____ _____

Patient Signature **Date**

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INFORMED CONSENT FOR OPIOID TREATMENT

- ➔ **IF I AM** prescribed opioid pain medication, I understand that pain medication may help improve my pain, but it may also cause some serious health problems such as:
  - Confusion, poor judgment, feeling sleepy or drowsy, poor coordination and balance, respiratory depression, addiction, increased feeling of pain, dry mouth, nausea, vomiting, constipation
  - For men: Pain medications may lead to decreased interest in sex and poor sexual performance.
  - For women: Pain medications may harm an unborn child, and can cause the child to be born addicted to the pain mediation.
- ➔ I understand that my medication may make me drowsy, and that my reflexes and reactions may be slowed.
  - I agree that things such as operating heavy machinery or equipment, a motor vehicle, or working in unprotected conditions may result in harming others or myself. I understand I must be responsible for my actions while taking any controlled substances.
- ➔ I will not consume alcohol or any illicit drugs while taking pain medications under the care of the practice. The problems may become worse if I consume alcohol or other drugs while taking pain medication.
- ➔ I will not request any controlled substance or prescriptions from another physician or practice while I am receiving such medications from Timothy D. Groth, MD. PC., unless discussed previously. You must notify this office if additional pain medications are prescribed by another healthcare provider (e.g., hospital or emergency room).
- ➔ Refill prescriptions for controlled maintenance medications will be rewritten every 30 days. It is your responsibility to schedule a monthly office visit.
- ➔ I agree to take my pain medications as prescribed by my provider, and store my prescriptions responsibly to avoid loss or theft.
  - I understand that if my medication is finished early, I must wait until the next refill due date.
  - I understand in the event of loss or theft of my medication, it will not be replaced, and I will have to wait for my next scheduled medication refill date.
- ➔ I will only have my medications prescribed by a provider from Timothy D. Groth, MD. PC. office, and not from family or friends.
- ➔ I understand that as part of my treatment, my provider will request unannounced urine toxicology screenings, and pill counts at office visits and by phone. I must provide my urine sample before leaving the office; if non compliant, I may not receive my medication.
- ➔ I will notify the office if my pharmacy needs to be changed.
- ➔ I will follow my provider's orders regarding physical therapy, home exercise, physical activities, as well as any testing recommendations that may help me manage my pain.
- ➔ I understand that my provider is under no obligation to provide prescriptions for opioid pain medications or for any controlled substances.
- ➔ I will not share, sell, or trade my pain medication(s).
- ➔ I will notify my provider if I plan to become pregnant.
- ➔ By signing the Opioid Agreement, I understand that I agree to abide by all the above mentioned statements. I understand that failure to comply with this agreement can result in my provider no longer prescribing my pain medications and possibly being discharged from the entire practice.

Patient Signature	**Patient Name**
Timothy Groth, M.D.	
Provider Signature	**Date**

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FINANCIAL POLICY AND AGREEMENT

Timothy D. Groth, MD. PC. is committed to serving our patients with professionalism and care. From our patients we expect the same commitment, which includes being on time for your appointment and calling to notify us of any delays or cancellations, financial responsibility, such as copay and deductible payments at the time of your office visit, and informing us of any changes to health insurance.

It is the patient's responsibility to provide us with accurate and complete information concerning your primary and secondary insurance medical benefits, including referral documents from other providers, if needed.
I understand that providing incomplete or inaccurate information about my insurance benefits may result in the denial of my claim or a delay in payment. Timothy D. Groth, MD. PC. has a contract with my insurance company and will receive payments from my insurance company for covered services provided by my insurance benefits.

I understand that if my insurance benefit requires me to provide a referral, but has not been obtained before my appointment, that I will be responsible to pay in advance an estimate of charges for my office visit or reschedule my appointment.

For services outside of our clinic, such as radiology, laboratory, surgery centers, physical therapy, hospitals, and rehabilitation centers, it is the patient's responsibility to know which facility you are required to use. If you are not sure, please talk to your insurance member services, or one of our staff before scheduling.

For Medicare patients: I authorize payment to be made on my behalf to Timothy D. Groth, MD. PC. for any services rendered to me by my provider. I understand my signature allows payment requests to be made to pay my claims. My signature also authorizes the release of medical information necessary to Medicare and any secondary insurance payer (if applicable) to pay my claim and authorize the release of benefits payable.
For visits related to a work injury or auto accident: I agree to provide Timothy D. Groth, MD. PC. all case related information, including case number, policy number, insurance carrier, address, and other contact information at the time of my appointment to ensure appropriate billing for services rendered. If the applicable information is not provided, I agree to pay all charges for my visit.

I understand that all services rendered to me by Timothy D. Groth, MD. PC. are considered medically necessary. Failure to have a procedure performed or noncompliance with my healthcare provider's instructions may be against medical advice and may void my insurance benefits.
I understand that my benefits may not cover all services or might deny payment for services that have been approved of in advance. Should this occur, I agree to pay the balance remaining on my account after my insurance has been processed.

I understand that failure to pay any outstanding balances may make my account delinquent, which may result in forwarding to an outside collection agency without notice. If this occurs, I will be responsible for all costs of collection, including, but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency costs.

I agree to be financially responsible for payment of services rendered by Timothy D. Groth, MD. PC. Acceptable forms of payment include cash, check or credit cards. There will be a $50.00 fee for all returned checks.
I agree to pay the remaining balance on my account after my insurance claim has been processed immediately upon receipt of statement.

I have read and understand Timothy D. Groth, MD. PC. financial policies and I accept financial responsibility for payment of services and any fees associated with my care.

Patient Signature:_____ **Date:**_____

Patient Name:_____