



Dear New Patient:

Thank you for choosing the Javery Pain Institute for your pain management needs. We would like to take this opportunity to provide you with some information about what you can expect during your first visit.

Your first visit will focus on learning about your specific pain condition. You can expect to learn important information such as;

- What is causing my pain?
- Are there any other tests or diagnostic studies that need to be done to help treat my pain?
- What can be done to reduce my pain? What are the risks and benefits of these pain relieving treatments?
- Education on the various techniques that may be used as a comprehensive treatment protocol.
- Development of a customized pain treatment plan.

How can you help make your visit go smoothly?

- **Bring your completed new patient paperwork with you to your appointment.**
- **Arrive 15 minutes before your appointment to fill out necessary paperwork.** If you don't arrive early enough, we may ask you to reschedule.
- You must bring all of your insurance cards and a picture ID or your appointment will be rescheduled.
- Bring a list of all of the medication(s) that you take or bring the bottles if that is easier.
- If any imaging (X-Ray, MRI, CT) has been done due to your pain, please come with the details; what was done and where/when it was done?

Co-payments will be collected before services are rendered. Cash and credit cards are accepted for your convenience.

We take pride in our mission to provide effective pain management solutions, under the highest standards of patient safety and competent medical care in a clean, safe and comfortable environment. We hope that we can make a difference in the quality of your life! Please visit our website, www.javerypain.com, to learn more about our office.

Sincerely,

Keith B. Javery, DO

Javery Pain Institute, PC

Patient Information – Please Print

Name _____ Date of Birth _____ Age _____
Last First MI
Address _____ City _____ State _____ Zip _____
Home Phone () _____ Work/Other Phone () _____ Cell Phone () _____
Email _____ Social Security Number _____ Driver's License # _____
Race/Ethnicity _____ Primary Language _____
Employer _____ Marital Status _____ Male/Female _____
Referring Physician _____ Primary Care Physician _____
First Last First Last
Name of nearest relative with whom you do NOT live with and whom we may contact in case of emergency.
Name _____ Phone () _____
Address _____ Relationship _____

Insurance Card Holder's Information

Relationship to Patient _____

Name _____ Date of Birth _____ Age _____
Last First MI
Address _____ City _____ State _____ Zip _____
Home Phone () _____ Work/Other Phone () _____ Cell Phone () _____
Social Security Number _____ Driver's License # _____
Employer _____ Marital Status _____ Male/Female _____

Primary Insurance Carrier _____ Insurance Card Holder _____

Policy No _____ Group No _____ Phone No (____) _____

Secondary Insurance Carrier _____ Insurance Card Holder _____

Policy No _____ Group No _____ Phone No (____) _____

I understand according to the State of Michigan, Department of Health, Act 488 of 1988 that if a health care professional in this practice sustains a coetaneous, mucous membrane or open wound exposure to blood or other body fluids from myself that a HIV and Hepatitis-B (HBV) blood test will be performed.

Signature _____ Date _____

I authorize payment of medical benefits by the insured directly to Javery Pain Institute, PC. I also request payment of government benefits directly to the party who accepts assignment. I understand that I am financially responsible for payment of all services or materials provided to myself and for any yearly deductible or co-payment amounts. I agree to pay all services within 30days unless a payment plan is negotiated in advance. I authorize Javery Pain Institute, PC to release any information required to process my claim. This request shall remain in effect until revoked by myself in writing.

Signature _____ Date _____

How did you hear about our office?

☐ Doctor ☐ Friend/Relative ☐ Web Search
☐ Yellow Pages ☐ Other _____

Javery Pain Institute, PC

Authorization For Specific Confidential Communications

I authorize my physician and/or administrative and clinical staff to disclose the following protected health information to:

Name: _____	Relationship to Patient _____
Name: _____	Relationship to Patient _____
Name: _____	Relationship to Patient _____
Name: _____	Relationship to Patient _____

Select the Protected Health Information to be used or disclosed to the above listed individual(s) from the list below:

- ☐ Medical Care / Treatment: **Yes** ____ **No** ____ Level of Information _____
- ☐ Billing Information **Yes** ____ **No** ____
- ☐ Pick up PHI: (such as prescriptions, billing statements, labs etc.) **Yes** ____ **No** ____
- ☐ Other (specify in detail – such as date of service, type of service, level of detail to be released, origin of information etc.) _____

This authorization shall be in force and effect and does not expire until it is revoked in writing. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at: Javery Pain Institute, PC, 710 Kenmoor Ave SE, Suite 200, Grand Rapids, MI 49546. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Parent / Guardian Signature

Date _____

I request that all communications to me (by telephone, mail, etc.) by Javery Pain Institute, PC. and/or its staff be handled in the following manner:

* For **written** communications: Address to: _____

* For **oral** communications: Call: _____ May we leave a message? YES ☐ NO ☐
(telephone number)

If the above address is not a street address or is not your home address, please provide us with a (home) street address for purposes of ensuring payment:

(street number and address)

City

State

Zip

Patient Signature

_____/_____/_____
Date

**Needed for alternative Written or Oral communication listed in above box only.*

For Practice Use Only: Practice: Accepts ☐ Denies ☐

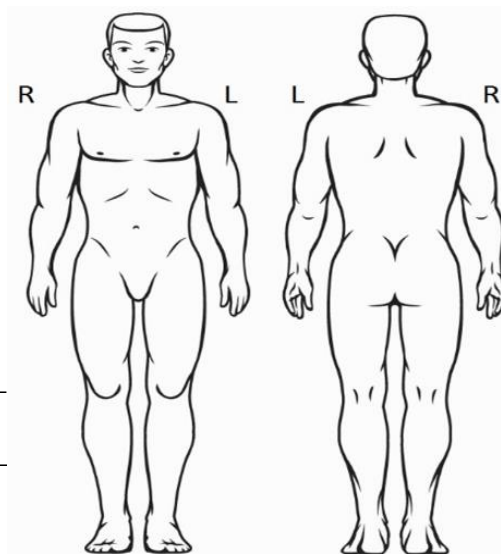
Privacy Officer's Signature _____ Date: _____

Patient Name: _____ Date of Birth _____

Primary Care Dr. _____ Referred by _____

For Intake staff on day of appointment		BP	HR
RR	T	Wt	Ht
		O2	Pain Rating

Mark all areas of pain on the diagram

Where is your pain today?How long have you had this problem?Describe how your pain first began?How often do you have pain? (Select all that apply)
☐ constantly
 ☐ comes and goes
 ☐ daily
 ☐ once in a while
 ☐ other _____
My pain is? (Select all that apply) ☐ sharp ☐ dull ☐ aching ☐ throbbing
☐ burning
 ☐ shooting
 ☐ electrical
 ☐ other: _____
Do you have any of the following?Numbness or tingling ☐ yes ☐ no Swelling in affected area ☐ yes ☐ noMuscle weakness ☐ yes ☐ no Muscle spasms or cramps ☐ yes ☐ noWhat makes your pain worse? (Select all that apply) ☐ sitting ☐ standing ☐ walking ☐ lying down ☐ bending
☐ climbing stairs
 ☐ lifting
 ☐ squatting
 ☐ other _____
What are you doing to reduce your pain? (Select all that apply) ☐ medication ☐ massage ☐ physical therapy ☐ ice
☐ heat
 ☐ walking
 ☐ chiropractic care
 ☐ avoiding activity
 ☐ rest more
 ☐ weight loss
 ☐ stretching

☐ other _____
Is your pain worse at night? ☐ yes ☐ no New loss of bowel or bladder function? ☐ no ☐ yes

If yes, please explain: _____

Are you on any anti-coagulants or any blood thinning medicines? ☐ yes ☐ no If yes, please list? _____

Please list Allergies: _____

PREVIOUS TREATMENTS	YES/NO	WHEN/WHERE?	HOW HELPFUL WAS THIS?
Nerve Blocks			
Surgery			
TENS Unit			
Physical Therapy			
Chiropractic			
Biofeedback/Hypnosis			
Previous Pain Doctor			
Other Treatment			

What pain medication have you tried/used, include the length of trial & when? _____

Please list your current medications (over the counter and prescription), vitamins, & supplements.
Include dose and how often you take them:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If you run out of space, write on back of this paper, or include a separate sheet of paper

Please explain how pain affects the function(s) in your life
If you are having trouble with any of the areas listed below due to your pain,
please give us details on the items that only apply to you.

	List the affected area(s) in the boxes below	Include % of affect
!!!! Example Only!!!!	<i>I am unable to enjoy my hobby of gardening due to my hip and low back pain. I miss it, and would love to enjoy gardening again. Now I have to pay someone to do it for me.</i>	<i>My gardening activity declined by 100%, 12 months ago</i>
Daily Living activities: Dressing, Bathing, meal prep, taking care of your home, etc..		
Interacting with others: such as playing with or caring for children/caring for a family member		
Movement functions: such as standing, sitting, walking, bending		
Sleeping		
Enjoyment of Life/Quality of Life		
Hobbies		
Exercise		
Other:		

List any tests or surgeries you have had:

Test	Date/Place	Results	Surgery	Date/Surgeon
X-Rays				
CT Scan				
MRI				
EMG				
Bone Density				
Other				

Review of Systems/Medical History: please check any that you currently have or had in the past

Constitutional

- ☐ Recent fever/sweats
☐ Unexplained weight loss/gain
☐ Unexplained fatigue/weakness

Eye/Ear/Nose/Throat

- ☐ Vision changes
☐ Difficulty Hearing
☐ Hay fever/allergies
☐ Difficulty swallowing

Endocrine

- ☐ Cold/Heat intolerance
☐ Increased thirst/appetite
☐ Thyroid problems
☐ Diabetes
☐ Severe Diabetes

Genitourinary

- ☐ Painful/bloody urination
☐ Night-time urination
☐ Discharge: penis or vagina
☐ Unusual vaginal bleeding
☐ Kidney problems
☐ Concern with sexual function

Other

- ☐ Implantable Device

Gastrointestinal

- ☐ Stomach/intestinal problems
☐ Nausea/Vomiting/diarrhea
☐ Changes in bowel movement
☐ Blood in stool

Respiratory

- ☐ Emphysema/COPD
☐ Asthma
☐ Coughing/wheezing
☐ Coughing up blood
☐ Communicable disease-TB

Psych/behavioral

- ☐ Anxiety/stress
☐ Depression
☐ Substance abuse/addiction
☐ Sleep problems
☐ Sleep problems

Neurological

- ☐ Headaches
☐ Numbness
☐ Tremors
☐ Poor balance
☐ Epilepsy
☐ Stroke
☐ Loss of balance

Blood/Lymphatic

- ☐ Unexplained lumps
☐ Easy bruising/bleeding
☐ Cancer
☐ Communicable disease (HIV,AIDS, Hep B or C)

Musculoskeletal

- ☐ Arthritis
☐ Muscle/Joint Pain
☐ Recent back pain
☐ Muscle weakness
☐ Osteopenia
☐ Osteoporosis

Cardiovascular

- ☐ Chest pain/discomfort
☐ Shortness of breath
☐ Heart attack
☐ High blood pressure
☐ Palpitations/irregular heart
☐ Pacemaker/defibrillator

Skin

- ☐ Sores
☐ Psoriasis
☐ Eczema
☐ Rash
☐ Communicable Disease-MRSA

Please give further details on selections above?

Have you felt you ought to cut down on your drinking or drug use?

Have people annoyed you by criticizing your drinking or drug use?

Have you felt bad or guilty about your drinking or drug use?

Have you ever had a drink or used drugs first thing in the morning to steady your nerves, get rid of a hangover, or as an eye opener?

Questions for Medicare Patients Only

Colonoscopy ☐ yes ☐ no If yes, when?

Mammography ☐ yes ☐ no If Yes, When?

If you are a tobacco user, are you interested in Tobacco Cessation information? ☐ yes ☐ no

If 65 or older, have you fallen, or have a history of falls in last 12 months? ☐ yes ☐ no How many falls?

Any injury occurred due to fall(s)? ☐ yes ☐ no If yes, please explain injury?

If you have Osteoporosis or Osteopenia? Circle which one, what medicine are you taking for it?

Any bone imaging studies or DXA studies? ☐ yes ☐ no If yes, When/Where?

Have you been an inpatient in the hospital for any reason in the last 30 days?

If aged 65 or older, have you received a Pneumonia Vaccination? ☐ yes ☐ no If Yes, When?

Tobacco use: ☐ never ☐ quit in _____ ☐ currently # _____ /day for _____ years

Recent Flu shot? ☐ yes ☐ no If yes, when?

Oral Antibiotic in past 3 months? ☐ yes ☐ no IV antibiotic in past 12 months? ☐ yes ☐ no

If yes, to either antibiotic questions, please explain?

Anything else you would like to share?

Patient Signature _____ Date _____

Patient Follow Up Visit Form

Patient Name: _____ ID# _____ DOB _____

For intake staff only BP HR RR T Wt Ht O2

Only answer in this box, if you are receiving a **PROCEDURE TODAY**,
Chance you're pregnant? ☐ No ☐ Yes Blood thinner in the last 7 days? ☐ No ☐ Yes

Have you had any new x-rays, CT or MRI's? ☐ no ☐ yes – where done? _____

Any changes in? ☐ Stress ☐ Family situation ☐ Sleep pattern ☐ Activity ☐ Weight

Please describe any changes? _____

Any changes in medications or are you taking any new vitamins or herbal supplements? ☐ no ☐ yes

Please explain any changes in meds? _____

Allergies: _____

Please mark your **IMPROVEMENTS** in each of the following areas as they apply to you by marking the column that reflects your best response to your last procedure & then include **how long** for each area. See example for details.

	Poor 0-25%	Fair 26-49%	Satisfactory 50-60%	Good 61-79%	Very Good 80-85%	Great 86-94%	Excellent 94-100%
!!!!EXAMPLE ONLY!!!!			✓ 3 mos				
Pain							
Daily living activities: Dressing, bathing, preparing a meal							
Interacting with and/or caring for your family or friends							
Standing, Sitting or Walking							
Sleeping							
Enjoyment of life							
Hobbies:							
Exercise							
Other:							

Are you still noticing improvements in your overall function compared to how you were feeling prior to your care provided at JPI? ☐ no ☐ yes If yes, explain: _____

What other types of things have you done to reduce your pain/or to increase function?

- ☐ ice ☐ massage ☐ avoided activity
☐ heat ☐ Walked ☐ used medication
☐ sat more ☐ rested more often ☐ NSAIDS
☐ using a walker or shopping cart

Today, I would describe my pain as: ☐ sharp ☐ stabbing

☐ dull ☐ throbbing ☐ aching ☐ burning

☐ other _____

Any numbness or tingling? ☐ no ☐ yes

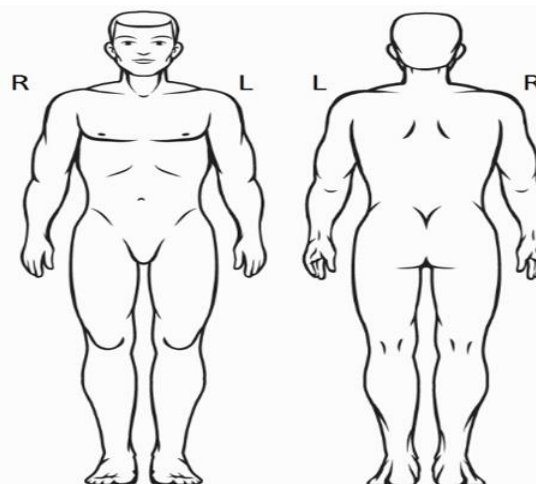
Any increased muscle weakness? ☐ no ☐ yes

New loss of bowel or bladder function? ☐ no ☐ yes

Any new/additional symptoms? ☐ no ☐ yes

If YES to any of the four last questions, please explain: _____

Mark all areas of today's pain on the diagram below



Please rate your pain today on a scale of 1 to 10 (0 = no pain, 10= worst pain you can imagine) Today's pain is _____ / 10

Least pain since last visit _____ / 10, Worst pain since last visit _____

Recent flu shot? ☐ no ☐ yes Oral Antibiotic in last 3 months? ☐ no ☐ yes, IV Antibiotic in last 12 months? ☐ no ☐ yes

Patient Name _____ Date _____

Javery Pain Institute Patient Policies

Short-Notice Cancellation

We understand that a patient may, on occasion, need to cancel or reschedule due to unforeseen circumstances. However, patients who chronically cancel or reschedule appointments *less than 48 hours prior* to their appointment time may be charged a fee and/or may be denied future appointments with the practice. If a patient cancels or reschedules their appointment *less than 48 hours prior* to their appointment time twice, they may be charged a \$25 fee on the second occurrence and every occurrence thereafter, and their status of care at the our practice will be reviewed for possible dismissal. In the event there is a charge due to short-notice cancellation, the fee will not be submitted to any insurance carrier and is payable prior to scheduling further non-urgent appointments within our practice. JPI reserves the right to deny appointments to those who chronically give short-notice cancellations. The decision will be made on a case by case basis.

Prescription Renewal Policy

Prescriptions are renewed during normal office hours, which are 8:30 AM to 5:00 PM, Monday – Friday. Refills generally take between 24 - 48 hours to be processed. If you have questions about how to take your prescription, please do not hesitate to call the office and leave **ONE** message on the prescription line. One of our staff members will call you back within 24-48 hours, or if necessary, talk with the physician and get back to you as soon as possible. **Renewal requests will not be processed outside of normal business hours.**

If at any time you are in need of a new medication, please contact our office during regular business hours and leave **ONE** message on the prescription line or send a request through the Patient Portal. Please note that when you call our office for your refill, because of the volume of calls we receive daily, we will not call to notify you that your prescription is ready, unless there is a problem. **You must give us 48 hours to process your request.**

No Show Policy

We understand that a patient may, on occasion, need to reschedule their appointment time due to unforeseen circumstances. However, patients who do not call the office *at least 24 hours prior to their appointment time* to reschedule/cancel *and* do not present to the office at their appointed time may not be rescheduled unless the patient's referring physician calls to speak with our New Patient Referral Coordinator. JPI continues to reserve the right to deny an appointment even after talking with the referring physician. The decision will be made on a case by case basis.

Designated Driver Policy

In order to make our patients more comfortable during procedures, we offer sedation. In order for a patient to receive sedation, a designated driver must be present during the patient's entire appointment. **Under no circumstances will we allow this policy to vary.**

Payment Policy

As a courtesy to our patients, the office will submit the charge(s) to the patient's insurance carrier for payment, however, payment is expected at the time of a patient's visit in the office. If however, the physician participates with the patient's insurance policy, and the visit is a covered benefit under the policy, our office will submit the charge to their insurance carrier for payment. Any co-pay and/or deductible amount will be collected prior to your appointment.

No Children In The Exam Rooms

For many reasons we have had to make it a policy that children cannot enter beyond the clinic doors. Due to the sometimes considerable amount of time spent waiting, the Javery Pain Institute is not very enjoyable for young children. If there is no other alternative and you must bring your children with you to your appointment, please make arrangements to have your adult driver watch your children in the waiting room. If a patient comes to an appointment, and does not have an adult with them to supervise his/her children, they will have to reschedule their appointment. No exceptions can be made. We are sorry for any inconveniences this may cause.

Lost/Stolen Property

JPI is not responsible for lost or stolen items and we recommend that valuable items be left at home or with your adult driver.

Abusive or Violent Behavior

JPI's mission is to provide a safe environment for care in our office. We have a **Zero Tolerance Policy** for abusive or violent behavior towards our staff, patients or visitors.

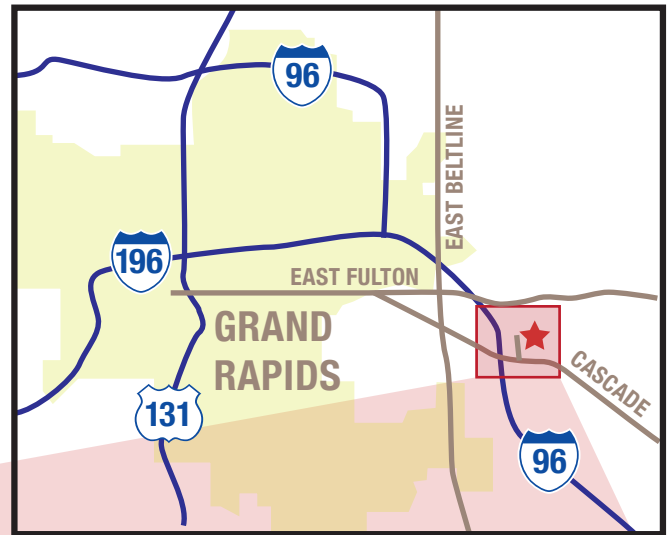


Our office is an **Outpatient Procedural-based office**. We have both “**Office consultation/exam appointment days**”, along with “**Procedure appointment days**”. If you are scheduled for a procedure after your initial appointment follow the bullet points below.

- Please arrive 15 minutes before your appointment time.
- **Be prepared to stay** longer than your “Consultation/exam appointment”. Most procedures require a minimum of 30 minutes in our recovery room once they are completed, but your procedure appointment could last up to 1 hour depending on how long the actual procedure takes and also if sedation was administered. A good estimate to start with would be 1 ½ hours, and then after your first “Procedure appointment”, you will know what to expect. We have made our lobby comfortable and entertaining for you and your driver should there be a longer wait time!
- **Please make sure your driver is aware** of how long your “Procedure appointment” is expected to take. They will need to remain on the property while you are in our office.
- We have **free WIFI** so bring your tablet or laptop! Bring your book or knitting, or watch a variety of comedy and travel videos that are showing in our lobby. We also suggest your driver bring something to entertain themselves too.
- **Do not eat or drink for 4 hours before your “Procedure appointment”**. If you have a medical condition that makes this impossible, talk to the staff prior to your “Procedure appointment” and notify our staff the day of your “Procedure appointment”. If you have any medications to take prior to your “Procedure appointment”, please do so with a small sip of water.
- We have a variety of snacks available for sale in our micro-mart called “**The Numb Numb Café**”, as well as free coffee and tea for our guests/drivers, or for patients that are not scheduled for a “Procedure appointment”.
- Please read over the enclosed information and fill out our New Patient Forms. Feel free to call our office at 616-588-7246 with questions or concerns that you may have.



710 Kenmoor Ave SE, Suite 200
Grand Rapids, MI 49546
616-588-7246



**From East Belt Line,
turn East on Cascade
Road. Follow Cascade over
Interstate 96. Turn left
(North) at the first traffic
light onto Kenmoor Avenue.
Proceed north on
Kenmoor to Javery on the
right (East) side of Kenmoor.**

**From Interstate 96,
Exit Cascade Road East.
Turn left (North) at
the first traffic light
onto Kenmoor Avenue.
Proceed north on
Kenmoor to Javery on
the right (East) side
of Kenmoor.**

