MEDICAL CENTER
DWH

1707-1709 W. Hamilton St
Allentown, PA 18104

4518 City Ave. 3rd fl.
Philadelphia, PA 19004

2981 Grant Avenue
Philadelphia, PA 19114

274 Susquehanna Avenue
Wyoming, PA 18644

(P) 610-419-3388
(F) 610-419-3266

Workers Compensation Information

(All information requested is required. Please do not leave anything blank)

Name: _____ DOB: _____

SSN: _____-_____-_____ Phone: _____

Employer Name: _____ Phone: _____

Workers Compensation Carrier: _____

Carrier Address: _____

Carrier Phone Number: _____

Adjuster: _____ Adj. Phone#: _____

Claim #: _____

Date of injury: _____Time: _____ am / pm
Was accident reported to Employer? (Please check one) Yes _____ No _____

Name of person who took accident report: _____
Were x-rays and/or MRIs taken? (Please check one) Yes _____ No _____

Authorization

I hereby assign, transfer, and set over to ***DWH Medical Center, P. C*** all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's signature: _____Date: _____

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Please list any and all allergies to medications below. If none, please circle **NKDA**

_____

_____

Reason for today's visit: _____ Pain level: (0-10) _____

Family Medical History (i.e., diabetes, hypertension, asthma, cancer, anxiety, etc.)

Maternal (moms' side) _____

Paternal (dads' side) _____

Able to care for yourself: (please circle yes or no) **YES | NO**

Are you currently employed: (please circle yes or no) **YES | NO**

What is your general stress level: (please circle one) **LOW | MEDIUM | HIGH**

Number of Children? _____

What is your alcohol intake: (circle one) **NONE | SOCIAL | MODERATE | HEAVY**

Are you hard of hearing in one or both ears: (circle one) **YES | NO ONE | BOTH**
Are you legally blind in one or both eyes: (circle one) **YES | NO ONE | BOTH**

Are you sexually active: (please circle one) **YES | NO**
if yes, protected: (please circle one) **ALWAYS | USUALLY | NEVER**

Are you a current everyday smoker: (please circle one) **YES | NO**
if yes, how many years: _____ how many a day: _____

Please list all surgeries and dates (or year) below:

_____

_____

_____

Are you currently taking any **prescribed** medications: (circle one) **YES | NO**
if yes, please provide a list of names, dosage, and the reason its prescribed:

_____

_____

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Medical History: **PLEASE CIRLCE ALL THAT APPLY TO YOU**

ADD/ADHD AIDS/HIV Abuse/Domestic Violence Allergies/Hayfever Anemia

Anesthesia Complications Anxiety Arthritis Asthma Autism Bedwetting

Bladder/Kidney Problems Blood Disease Blood Transfusion Breast Cancer

Breast Problems COPD Cancer Chicken Pox Chronic Ear Infections

Congestive Heart Failure Constipation Coronary Artery Disease Depression

Developmental/Behavioral Disorder Diabetes Difficulty Swallowing Diverticulitis

Ear/Hearing Problems Easting Disorder Eczema Endometriosis Fibromyalgia

GI Problems Gout Headaches Heart Disease Heart Problems Hepatitis

High Cholesterol High Blood Pressure Infertility Kidney Disease Kidney Stones

Liver Disease Lung Disease MRSA Exposure Maniere's Disease

Mental Disorder Mental Illness Muscle problems Obesity Osteoporosis

Ovarian Cancer Polyps Pre-Eclampsia Pulmonary Embolism Reflux/GERD

Seizures/Epilespy Skin Problems Stroke Thrombophilia's Tuberculosis

Varicosities Vision Problems

The following only applies to women:

Date of last PAP: _____ Was it normal: **YES | NO**
If postmenopausal, age at menopause: _____
HPV Vaccine: **YES | NO** Sexual Problems: **YES | NO** STDs: **YES | NO**
Age at first child: _____
Current birth control method: (indicate NONE if none) _____
Most recent mammogram: (indicate NONE if you never had one) _____
How many pregnancies have you had: (indicate 0 if none) _____
Full term pregnancies: _____Premature pregnancies: _____
Abortions induced: _____Abortions spontaneous: _____
How many children do you have living: _____

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Medication Contract

Controlled substance medications (i.e. narcotics, tranquilizers, and barbiturates) are very useful, but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. They are intended to relieve pain, thus improving function, and/or ability to work. Because my physician is prescribing controlled substance medications to help manage my pain, I agree to the following:

_____1.) I am responsible for the controlled substance medications prescribed to me. If my prescriptions is misplaced, stolen, or if "I run out early", I understand that this medication **will not be replaced** regardless of the circumstances.

_____ 2.) Refills of controlled substance medications;

_____a) Will be made only during regular office hours *Monday through Friday, in person, once a month, and during a scheduled office visit.* Refills will not be made at night, weekends, or during holidays and through answering service.

_____b) Will not be made if "I lost my prescription", ran out early, or misplaced my medication. I am solely responsible for taking the medication as prescribed and for keeping track of the remaining.

_____c) I understand that I must call ahead within 72 hours to schedule an appointment.

_____ 3.) It may be deemed necessary by my doctor that I see a medication-use specialist (pain management) at the time while I am receiving controlled substance medications. I understand that if I do not attend such an appointment, my medications may be discontinued, or may not be refilled beyond tapering dose completion. I understand that if the specialist feels that I am at risk for psychological dependence (addiction); my medications will no longer be filled.

_____4.) I agree to comply with urine testing and pill counts at every appointment, thereby, documenting the proper use of any medications.

_____ 5.) I understand that if I violate any of the above conditions, my prescriptions for controlled medications may be terminated immediately. If the violation involves obtaining these medications from another individual, or the concomitant use of non-prescription illicit (illegal) drugs, I may also be reported to other physicians, pharmacies, medical facilities, and the appropriate authorities.

_____ 6.) I understand that the main treatment goal is to reduce pain, and improve my ability to function and/or work. In consideration of this goal, and the fact that I am being given potent medication to reach my goal, I agree to help myself by following better health habits, exercise, weight control, and avoidance of the use of tobacco and alcohol. I must also comply with the treatment plan as prescribed by my physician.

_____ 7.) I understand that the long term advantages and disadvantages of chronic opioid use may have yet to be scientifically determined and my treatment may change at any time. I understand, accept, and

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agree that there may be unknown risks associated with the long term use of controlled substances that my physician will advise me of advances in the field and will make necessary treatment changes.

_____ 8.) I further understand that if I violate this controlled substance contract due to non-compliance of medical directions, such as, failure in taking medications as prescribed, utilizing other illicit drugs, or abuse of controlled medications, I may be subject to dismissal from this facility.

_____ 9.) I understand that I will only use one pharmacy (or pharmacy brand ex. CVS, Rite aid, etc.)

_____10. I give permission to my physician and staff to monitor my prescription history and current status through PDMP (Prescription Drug and Monitoring Program)

_____ 11. I understand that the office of Dr. Hernandez will not tolerate any abusive, aberrant and negative behavior. This will also give the office permission to dismiss me as a patient if not adhered.

_____ 12. I understand that the pain medication prescribed to me by Dr. Hernandez is for my personal use ONLY. I will take every precaution to safe guard it. I also know and understand that selling my medication is against the law, and will be terminated from the practice immediately and without notice.

Pharmacy name: _____ **Phone Number**: _____

I have been fully informed by **Dr. Hernandez** regarding psychological dependence (addiction) of controlled substance medications. I know that some individuals may develop a tolerance to the medications, necessitating a dose increase to achieve desired effect, and doing so increase the risk of becoming physically dependent on the medication. This may occur if I am on the medication for several weeks. Therefore, when I need to stop taking the medication, I must do slowly and under medical supervision, or I may have withdrawal symptoms.

The office of Dr. Hernandez will be instituting the following policies effective immediately.

1. All schedule 2, 3, and 4 medications* will be written for only one month at a time. Every month, I will be seen in the office and will review my pain management contract with Dr. Hernandez

*This includes the following:

- All forms of hydrocodone – (vicodin, Lorcet, Lortab)
- All forms of oxycodone- (Percocet/percodan, oxycontin, Tylox)
- Most muscle relaxers- (valium, soma, Etc.)
- Duragesic, Fentanlyl patches
- Most sleeping agents- Ambien (Zolpidem), Lunesta,
- All Benzodiazepines- Klonopin (clonazepam), Restoril (temazepam), Serax (oxazepam), Xanax (Alprazolam)

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- Codeine Preparations (Tylenol # 3, Tussionex)
- Testosterone replacements (Testim, Androgel, Fortesta, Axiron, Cypionate, Enanthate)

2.) I understand that **THERE WILL BE NO REPLACEMENT PRESCRIPTIONS GIVEN. NO EXCEPTION>** a police report will be required to continue as a patient of the practice.

3.) I understand that I must bring all medication bottles and/or pills to every appointment for pill count verification.

We do accept that these policies may produce some hardships for a few people. We ask only that you understand that it is our intention to practice the art and science of medicine in the safest and most efficacious manner possible.

Patient Signature _____ Date ____/____/____

Dr. Danny Hernandez _____ Date ____/____/____

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Consent to Communicate

I, the undersigned, give the office of Dr. Hernandez permission to communicate with myself and with the following persons and/or phone numbers.

Name	Phone number/email	Relationship	Leave message Yes/NO	Able to discuss medical info Yes/NO

THIS CONSENT WILL REMAIN IN FULL FORCE UNTIL REVOKED IN WRITING.

Patient signature:_____ Date:_____

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Consent to Treat

Please read and sign

1. I, the undersigned, herby consent to the following:
    a. Administration and performance of all treatment
    b. Use of prescribed medications
    c. Performance of diagnostic procedures/tests
    d. Performance of medically necessary laboratory tests
2. I understand that this is given in advance of any specific diagnosis or treatment.
3. I intend this consent to be continuing in nature even after s specific diagnosis has been made and treatment recommended. THIS CONSENT WILL REMAIN IN FULL FORCE UNTIL REVOKED IN WRITING.

Treatment outcome: include, but limited to, performance and administration of all treatments, the use of prescribed medications, diagnostic procedures and tests, laboratory testing.

Procedure outcome: risks and benefits including complications were discussed to my full understanding. These include, infection, wound healing problems, vascular events.

Payment: include, but not limited to, authorization of payment directly to DWH Medical Center, PC, office of Dr. Danny Hernandez. I also authorize the disclosure of my personal information to third party billing, collection agency, auto accident, Workers compensation, and attorneys. I understand that I Am financially responsible for charges not covered. I understand that my medical record is stored electronically.

PHOTOCOPY /SCANNED COPY OF MY CONSENT SHALL BE CONSIDERED AS VALID AS THE ORGINAL.

Patient name: _____ Signature: _____

Date: _____

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AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Name of Patient: _____

Date of Birth: ____/____/_____ **Social Security Number:** _____-_____-_____

I requested and authorized, the release of healthcare information or access to the information specified below from the medical record(s) of the above-named patient.

RECORDS TO BE RELEASED FROM:

_____

(Doctor, Hospital, Clinic, etc.)

(____) _____-_____ (____) _____-_____

Fax Phone

INFORMATION SHOULD BE RELEASED TO:

DWH Medical Center, PC
1707-1709 W Hamilton Street
Allentown, Pa 18104

THIS REQUEST AND AUTHORIZATION APPLIES TO:

- ☐ History & Physical
- ☐ Operative Report
- ☐ Pathology Report
- ☐ Consultation Report
- ☐ Discharge Summary
- ☐ X-Ray Report
- ☐ Emergency Room Record
- ☐ Laboratory Reports
- ☐ Entire Medical Record
- ☐ Other: _____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to his authorization may be subject to re-disclosure by the recipient and is no longer protected. I understand that the specific information to be released may include, but is not limited to: history, diagnosis, and or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency System (AIDS). I authorize the release of specific data. I also understand that this authorization may be revoked by the person giving authorization by a written and dated notice, except to the extent that disclosure of the information has been made prior to receipt of the revocation. This authorization expires one year from the date of signature unless I specifically request or otherwise revoke it. I understand I may be charged a fee for retrieval/processing and copying of my medical records.

I HAVE READ AND UNDERSTAND THIS CONSENT AND I HAVE SIGNED IT VOLUNTARILY AND OF MY OWN FREE WILL.

_____

(Signature of Patient) (Signature of Parent/Legal Representative)

_____/_____/_____

(Date)

THIS AUTHORIZATION EXPIRES IN NINETY (90) DAYS AFTER IT IS SIGNED

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UDS Point of Care Results: 13 Panel

Date: _____

Patient Name: _____ Patient DOB: _____/_____/_____

Patient is prescribed a narcotic medication. Per office protocol, UDS is obtained at every point of contact. Risk of not testing include, but not limited to, misuse, diversion, and/or use of illicit drugs. Patients are seen on a monthly basis to reduce miscues behavior. Results are listed below.

Results:

Screening	Positive	Negative	Medically Appropriate
AMP (Amphetamines)			
THC (Cannabinoids)			
COC (Cocaine)			
PCP (Phencyclidine)			
BAR (Barbiturates)			
BZO (Bensodiazepines)			
OPI (Opiates)			
OXY (Oxycodone)			
BUP (Buprenorphine)			
MET (Methamphetamine)			
MDMA (Methylenedioxymethamphetamine)			
MTD (Methadone)			
TCA (Tricyclic Antidepressants)			

Doctor Signature: _____ **Date:** _____

Patient Acknowledgement statement: My signature below verifies this is my sample and indicates consent to submit my sample to PMP (Pinnacle Medical Plus) for testing.

Patient donation statement: My signature below completes and validates that the specimen was collected properly, and that the specimen provided is my own and was not substituted or adulterated. I freely consent to the testing of my urine specimen for drug(s)/metabolite(s).

Patient Signature: _____ **Date:** _____

1010 N Hancock St.
Philadelphia, PA 19123
P: 215-383-2064
F: 888-201-4032

DME Rx / Order Form:

ALIKAI HEALTH
alikaihealth.com

Patients Name_____DOB:_____Phone: _____

Address: _____ City_____ State_____ Zip Code _____

Insurance Carrier: _____ Phone: _____ Type: [ ] Comp [ ] Auto Claim #: _____

Carrier Address: _____ City_____ State____ Zip Code _____

DOI (WC/NF): _____ ICD-10 Code(s)_____ Adjuster (WC): _____

***InfraRx*™ Infrared Heating Pad Unit**

☐ Shoulder ☐ Back ☐ Ankle/Foot ☐ Hip ☐ Neck ☐ Knee ☐ Wrist/Hand ☐ Thigh ☐ Elbow ☐ Calf

Side: [ ] RIGHT [ ] LEFT

I certify that the Far-Infrared Heating Pad ("FIR Heat Pad") that I have prescribed for use in the patient's home is medically necessary as part of my prescribed treatment plan for the patient. Clinical trials have proven the efficacy of infrared technology for various types of pain that is often left unchanged by traditional pain management strategies. For instance, a double blind, placebo-controlled study published in 2006 concluded that "The FIR Heat Pad has clearly demonstrated that it is easy to use, safe and effective, and reduced chronic back pain by 50% over six weeks".[1]

Infrared products are unique in that the heat doesn't burn or dehydrate and penetrates 2.36 inches beneath the surface of the skin, targeting pain and inflammation where it originates. This offers a therapeutic advantage over and above traditional heat that is only capable of shallow penetration. Infrared heat acts to increase the flexibility of collagen tissue, reduce inflammation, decrease joint stiffness, relieve muscle spasms, reduce pain, increase range of motion and promote healing in the affected area.

Use of the FIR Heat Pad ***should minimize the necessity for narcotic pain medication***.

In my opinion, a home FIR Heat Pad as part of the patient's treatment protocol will facilitate the patient's quicker return to functional restoration and participation in the active duties of daily living.

Since I am acquainted with the efficacy of the FIR Heat Pad, I would like it to be considered as medically necessary as my prescribed treatment plan to have my patient return to normal functionality. This is NOT prescribed as convenience equipment. Substitution for this device is NOT ALLOWED without my written approval.

If I can provide further information, please do not hesitate to contact my office.

PROVIDER NAME PRINTED: _____

PROVIDER SIGNATURE: _____ **DATE:** _____

My Signature and date below authorizes each of the following:

1. Direct billing to appropriate healthcare insurance policies.
2. Alikai Health to obtain medical or other information necessary in order to process claim(s), including determining eligibility and seeking reimbursement for medical equipment or supplies provided.
3. Alikai Health to contact me by telephone or mail regarding my medical equipment or supplies.

PATIENT SIGNATURE: _____ **DATE:** _____

(Patient signature indicates understanding of the return policy and acknowledges receipt of the above product)

DELIVERY METHOD: ☐ **Shipped with Tracking Confirmation #:** _____

☐ **Dispensed by Alikai Health Personnel** *By:* _____

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[1] GD Gale, PJ Rothbart, Y Li. Infrared therapy for chronic low back pain: A randomized, controlled trial. Pain Res Manage 2006;11(3):193-196.

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Patient Name: _____ Date: _____

Diagnoisis Code(s) :

_____ _____ _____

_____ _____ _____

MEDICAL EQUIPMENT & SUPPLIES:

MODALITIES:

[ ] (E0215) Electric Heating Pad, Moist (NU)

[ ] (E0217) Water Circulating Heat Pump (NU)
[ ] (E0249) Heating Pad that Attaches to pump (NU)

[ ] (E0235) Paraffin Bath Unit (NU)

[ ] (E0730) TENS Unit, 4 lead, w/ _____ month supplies
*Model #: NeuMed NMS-30 (NU)
[ ] (E0745) EMS Unit, 4 lead, with _____ month supplies
*Model #: NeuMed NMS-30 (NU)

[ ] TENS/EMS MONTHLY SUPPLIES ONLY: _____ months
*(A4595) Electric Stim Supplies x 4
*(A4630) Replacement Battery x 1

PILLOWS, CUSHIONS, WEDGES:

[ ] (E0190) Positioning cushion/Pillow/Wedge/Roll (NU)
[ ] (E0190) Cervical Pillow (NU)
[ ] (E0190) Lumbar Roll/Seat Cushion (NU)
[ ] (E0190) Foamed Seat Pad/Cushion (NU)
[ ] (E0199) Egg Crate pressure pad (NU)
[ ] (L0999) OBUS Style Contoured Spinal Cushion (NU)
[ ] (E0191) Elbow or heel protector pad (NU)
[ ] (L0120) Cervical Collar: Foam (NU)
[ ] (L0180) Cervical, Multiple Collar, Adjustable (NU)

EXERCISE EQUIPMENT:

[ ] (A9300): _____

CANE, CRUTCHES, WALKERS:

[ ] (E0100) Cane, Single Point (NU)
[ ] (E0105) Cane, Multi-Point (NU)
[ ] (E0110) Crutches, Forearm (NU)
[ ] (E0143) Walker: Rolling (NU)
[ ] (E0135) Walker: Non Rolling (NU)

SPINAL BRACES:

[ ] (L0626) Lumbo-Sacral (LSO), Flexible
[ ] (L0631) Lumbo-Sacral (LSO), Flexible w/ semi rigid panels
[ ] (L0450) TLSO, Flexible
[ ] (L0456) TLSO, Flexible w/ semi rigid posterior panels

[ ] (L0637) LSO, Hard shell Ant/Post Frame/Panels

[ ] (L0974) TLSO, Full Corset
[ ] (L0976) LSO, Full Corset

LOWER EXTREMITY BRACES:

[ ] (L1810) Knee (KO), Elastic w/ Joints
[ ] (L1820) Knee (KO), Elastic w/ Open Knee Cap
[ ] (L1832) Knee (KO), Adjustable Joints, Rigid Support
[ ] (L1830) Knee Immobilizer
[ ] (L4350) Ankle, Air cast (control splint)
[ ] (L4360) Ankle, Air cast (walking splint)
[ ] (L1902) Ankle (AFO), Elastic Type
[ ] (L1906) Ankle (AFO), w/ Joints/Straps

[ ] Other: _____

UPPER EXTREMITY BRACES:

[ ] (L3674) Shoulder (Acromio/Clavicular)
[ ] (L3650) Shoulder Orthosis, Elastic
[ ] (L3762) Elbow (EO), Elastic Type
[ ] (L3710) Elbow (EO), w/ Joints/Straps
[ ] (A4466) Elbow, Med/Lat Epicondyle Brace
[ ] (L3908) Wrist, Cock-up Splint
[ ] (L3908) Thumb Spica Support/Splint

TRACTION

[ ] (E0860) Traction, over the door pulley (NU)
[ ] (E0860) Shoulder Traction, over the door pulley (NU)
[ ] (E0849) Traction, cervical, pneumatic, free standing (NU)
[ ] (E0900) Traction, pelvic, pneumatic, free standing (NU)

OTHER: _____

Patient statement: I certify that the information above is correct and I also confirm that I received delivery of medical equipment listed above. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for covered services rendered by Dr. Hernandez and authorize Dr. Hernandez to submit claims to your insurance carriers for payment. I authorize payment of my insurance benefits directly to Dr. Hernandez. And durable medical equipment (DME) listed above is medically necessary to treat the specific condition listed under diagnosis. Any DME recommended to you is not in any way for general health; and is not for cosmetic purposes to improve appearance. I will assist you to achieve or maintain maximum functional capacity in performing daily activities.

_____ _____

Signature of attending physician *Patient Signature*