PAIN CENTER NJ
ASMA SIDDIQUI, M.D.
329 SUMMERHILL ROAD
EAST BRUNSWICK, NJ 08816
TELE: 732-636-7888
FAX: 732-636-7887

INITIAL CONSULTATION FORM

Patient Name ____ Todays Date ________________

Date of Birth _______________________________ Height _____________Weight ________________

Medication Allergies ____

Food Allergies ____

Does your child swallow pills? ____

What prescription medications are being taken:

Drug: ____ Dose: ___________________________

Drug: ____ Dose: ___________________________

Drug: ____ Dose: ___________________________

Drug: ____ Dose: ___________________________

Drug: ____ Dose: ___________________________

Drug: ____ Dose: ___________________________

What supplements are being taken:

Supplement: ____ Dose: ____________________________

Supplement: ____ Dose: ____________________________

Supplement: ____ Dose: ____________________________

Supplement: ____ Dose: ____________________________

Supplement: ____ Dose: ____________________________

Supplement: ____ Dose: ____________________________

Please indicate below how your child is doing in each area:

Expressive speech:

Receptive understanding:

Sleep patterns:

Eye contact:

Stereotypies (self-stimulatory behaviors):

Obsessive or Compulsive behavior:

Attention:

Hyperactivity:

Play and interaction with peers (social interaction):

Bowel movements:

Fine motor (ex: buttoning shirt/zippering/writing):

Gross motor (playing with blocks/holding a spoon):

What therapies are currently being used (ABA, speech, OT,etc)?

Diet

Gluten & Casein Free?

Is the child eating adequate quantities and varieties of food?

Please list your child's 3 greatest problems (for example- speech, attention, behavior, etc):

1.
2.
3.

Please list your child's 3 greatest strengths:

1.
2.
3.

What do you want to address during today's consult? For example, what are your 3 top concerns you wish to discuss today?

1.
2.
3.

Please comment on the following parameters:

1. How is speech?
2. How is comprehension?
3. How is sleep?
4. What are the stimming behaviors your child has?
5. Is there any hyperactivity?
6. Does your child interact with siblings/children at school?
7. Is your child potty trained?
8. Does your child make eye contact?
9. How is the attention span?
10. How does your child express frustration?
11. Does your child use an IPAD? Can he/she use a computer mouse?
12. What activities does your child enjoy?
13. What are your child's fears?

Please write in your own words using blank sheets of paper; what your goals are for your child and how autism has affected you and your family.

Diet

Is your child on a gluten or casein free diet?

Is your child a picky eater?

Does he/she gag whilst eating?

Any problems with textures of food?

Does your child have behaviors after eating certain foods?

Have you done any type of feeding therapy?

Is his/her diet limited to certain foods?

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Name of Child: ____

Date of Birth: __________________________________Gender of Child: ____________________________

Medication Allergies: __________________________ Food Allergies: _____________________________

Reporting Relative

1. What is your relationship to the child?
   a. Biological Parent b. Adoptive Parent c. Grandparent d. Foster Parent e. Uncle/Aunt

   f. Sibling g. Other, please specify:

2. Your gender: Male Female

Gestation History

1. Mothers age at birth? _____________
2. Fathers age at birth? _____________
3. Total # of pregnancies _____________
4. # of miscarriages _____________
5. Pregnancy # of this child __________
6. # of Preterm pregnancies ___________
7. Infertility treatments _____________
8. IVF treatment if any _____________
9. How many abortions _____________

Vaccinations for mom just before or during pregnancy

Vaccine	Brand or serial #, if known	Age of Gestation in Weeks	Side Effects
Tetanus toxoid			
MMR			
Hepatitis A			
Hepatitis B			
Influenza (flu)			
Other:			
Other:			

Please indicate if you experienced any of the following problems during pregnancy

Illness	Medication (if any) with dose & treatment length	Gestation in Weeks
Viral illness		
Bacterial illness/ UTI		
Vomiting requiring Hospitalization		
Bleeding or spotting		
Preterm labor		
Pre-eclampsia		
Eclampsia/HELLP syndrome		
Hypertension		
Emotional distress		
Gestational diabetes		
Other:		
Other:		

List any medications or drugs the mother took during pregnancy that were not mentioned above:

Medication	Dose	Gestation in weeks when treatment started	Reason for medication

Birth History

1. Number of weeks of pregnancy? _____________
2. Was labored induced? Pitocin? _____________
3. Birth Weight _____________
4. Birth Length _____________
5. Vaginal or C-Section Delivery? _____________
6. Epidural? _____________
7. Any pain medications/opioids given? _____________

Please circle all of the following complications that apply to the delivery of the child:

a. Drop in fetal heart rate b. Fetal distress c. Meconium d. Planned C-Section e. Emergency C-Section f. Required forceps g. Required vacuum extraction h. Cord around child's neck i. infection in child j. Admitted to NICU k. Others, please specify:

Please specify if any of the below treatments were needed and if so, for how long?

Intubation (breathing tube) ________________

Oxygen without breathing tube ______________

Feeding tube ________________

Please circle all of the following neonatal conditions the child had:

a. Jaundice b. Pneumonia c. Transient breathing difficulties d. Chronic lung disease/ bronchopulmonary e. Feeding difficulties f. Necrotizing enterocolitis g. Intraventricular hemorrhage h. Periventricular leukomalacia i. Seizure(s) j. Brain damage k. Patent ductus-arteriosis l. Congenital heart disease m. Other, please specify:

Early life history of child (up to 1 year old)

Feedings

Breast fed

Breast milk in bottle

Formula

Solids

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Name of Child: ____

Date of Birth: __________________________________Gender of Child: ____________________________

Medication Allergies: __________________________ Food Allergies: _____________________________

Reporting Relative

1. What is your relationship to the child?
   a. Biological Parent b. Adoptive Parent c. Grandparent d. Foster Parent e. Uncle/Aunt

   f. Sibling g. Other, please specify:

2. Your gender: Male Female

Gestation History

1. Mothers age at birth? _____________
2. Fathers age at birth? _____________
3. Total # of pregnancies _____________
4. # of miscarriages _____________
5. Pregnancy # of this child ____________
6. # of Preterm pregnancies _____________
7. Infertility treatments _____________
8. IVF treatment if any _____________
9. How many abortions _____________

Vaccinations for mom just before or during pregnancy

Vaccine	Brand or serial #, if known	Age of Gestation in Weeks	Side Effects
Tetanus toxoid			
MMR			
Hepatitis A			
Hepatitis B			
Influenza (flu)			
Other:			
Other:			

Please indicate if you experienced any of the following problems during pregnancy

Illness	Medication (if any) with dose & treatment length	Gestation in Weeks
Viral illness		
Bacterial illness/ UTI		
Vomiting requiring Hospitalization		
Bleeding or spotting		
Preterm labor		
Pre-eclampsia		
Eclampsia/HELLP syndrome		
Hypertension		
Emotional distress		
Gestational diabetes		
Other:		
Other:		

List any medications or drugs the mother took during pregnancy that were not mentioned above:

Medication	Dose	Gestation in weeks when treatment started	Reason for medication

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Please specify if any of the below treatments were needed and if so, for how long?

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Feeding tube ________________

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Early life history of child (up to 1 year old)

Yes/no, how long, what age, brand?

Breast fed? ____

Formula? ____

Food/Formula allergies? ________________________________

Cow milk intolerance? __________________________________

Pica (eating/chewing non-food items)? ____________________

Developmental History

Is the child right or left handed? _________________________

Age when you first suspected a delay or problem? __________

Which of the following best describes your child:

a. A period of normal development followed by a loss in skills
b. A period of normal development followed by a plateau, stagnation or non-progression in skills
c. Developmental delay from birth or early in life
d. Other (please specify):

Which activities of daily living does your child need help with?

a. Personal hygiene and grooming
b. Dressing and undressing

c. Feeding
d. Transfers (e.g., assistance getting into bathtub)
e. Bowel or bladder management
f. Walking
g. Other (please specify):

Speech Milestones

Please indicate age at which first occurred (months)

a. First speech like sounds _________________
b. First time saying ‘mama’ or ‘dada’ _________________
c. First words other than ‘mama’ or ‘dada’ _________________
d. First time child used words to refer to something specifically (dog) ________________
e. First time the child put words together in a phrase _________________
f. Pointing _________________

Motor Milestones

Please indicate age at which first occurred (months)

a. Rolling over __________________
b. Sitting without support __________________
c. Crawling __________________
d. Standing independently __________________
e. Walking independently __________________
f. Potty trained: urine/ stool __________________

If your child lost skills (regressed) please indicate age lost, was it slow or abrupt and was it regained?

a. Speech ____
b. Fine motor skills ____
c. Coordination ____
d. Social interaction ____
e. Pointing ____
f. Eye contact ____
g. Multiple episodes of regression ____

Was the regression associated with any of the following factors?

a. Viral illness ____
b. Seizure ____
c. Fever ____
d. Rash ____
e. Mitochondrial dysfunction ____
f. Vaccine (if so, which one, what age) ____
____

Child's Medical Disorders

Allergy disorders, if any please indicate age diagnosed, severity, duration and treatment

a. Asthma ____
b. Allergies ____
c. Allergic rhinitis ____
d. Seasonal allergies ____
e. Eczema ____
f. Food allergies ____
g. Others (please specify) ____

Neurological disorders, if any please indicate age diagnosed, severity, duration and treatment

a. Microcephaly ____
b. Macrocephaly ____
c. Hypotonia (low muscle tone) ____
d. Hypertonia (increased tone) ____
e. Tremor ____
f. Ataxia/ unsteadiness ____
g. Apraxia/ poor coordination ____
h. Easily fatigued ____
i. Exercise intolerance ____
j. Muscle disorder/ myopathy ____
k. Chronic headaches ____
l. Epilepsy ____
m. Febrile seizures ____
n. Nystagmus ____
o. Head injury ____
p. Traumatic brain injury ____
q. Cerebral palsy ____
r. Tic disorder ____
s. PANDAS/PANS ____
t. PITANDS ____
u. Tourette syndrome ____
v. Landau-Kleffner syndrome ____
w. Other (please specify) ____

Infectious diseases, if any please indicate age diagnosed, severity, duration and treatment

a. Sore throat ____
b. Strep throat ____
c. Ear infections ____
d. RSV ____
e. Other (please specify) ____

Sleep disorders, if any please indicate age diagnosed, severity, duration and treatment

a. Sleep apnea ____
b. Restless leg syndrome ____
c. General insomnia ____
d. Periodic limb movements ____
e. Narcolepsy ____
f. Sleep disordered breathing ____
g. Other (please specify) ____

Gastrointestinal disorders, if any please indicate age diagnosed, severity, duration and treatment

a. Colic ____
b. Chronic constipation ____
c. Chronic diarrhea ____
d. Gastroesophageal reflux disease ____
e. Food intolerance ____
f. Eosinophilic esophagitis ____
g. Dysbiosis/ Bacterial overgrowth ____
h. Lymphoid nodular hyperplasia ____
i. Celiac disease ____
j. Enterocolitis/ inflammation ____
k. Ulcer ____
l. Ulcerative colitis ____
m. Crohn's disease ____
n. Other (please specify) ____

Psychiatric disorders, if any please indicate age diagnosed, severity, duration and treatment

a. Mood disorder (e.g., bipolar) ____
b. Depression ____
c. Aggressive/self-harm ____
d. Obsessive compulsive disorder ____
e. Anxiety disorder ____
f. Eating/body image disorder ____
g. Addiction ____
h. Sensory integration disorder ____
i. Other (please specify) ____

Other disorders, if any please indicate age diagnosed, severity, duration and treatment

a. Seizures/ Epilepsy ____
b. Growth failure ____
c. Failure to thrive ____
d. Accelerated growth ____
e. Hearing loss ____
f. Visual loss ____

g. Cardiovascular disease ____
h. Renal (kidney) disease ____
i. Hematological disease ____
j. Mitochondrial disease ____
k. Metabolic disorders ____
l. Immunological disorder ____
m. Cerebral folate deficiency ____
n. Chronic abdominal pain ____
o. Cancer ____
p. Diabetes ____
q. Genetic disorder ____
r. Sickle-cell anemia ____
s. Hypothyroidism ____
t. Hyperthyroidism ____
u. Obesity ____
v. Incontinence ____
w. Other (please specify) ____

Surgical procedures, please circle if performed and indicate which age

a. Tonsillectomy b. Adenoidectomy c. Ear tube placement d. Appendix e. Hernia
f. Circumcision g. Other (please specify)

Immune disorders, has your child been tested for any of the following? If so, please give result

a. Immunoglobulin IgG ____
b. Immunoglobulin IgM ____
c. Immunoglobulin IgA ____
d. Immunoglobulin IgE ____
e. ANA (Antinuclear Antibody) ____
f. Thyroid autoantibodies ____
g. Brain endothelial autoantibodies ____
h. PANDAS/ Strep autoantibodies ____
i. Folate transporter autoantibodies ____
j. CAM kinase ____
k. Other (please specify) ____

Neurodevelopment disorders, if any please indicate age diagnosed, severity, duration and treatment

a. Speech delay ____
b. Fine motor delay ____
c. Gross motor delay ____
d. Global delay ____
e. Mental retardation ____
f. Low I.Q. ____
g. Other (please specify) ____

Please circle if child has been diagnosed with any of the following

a. ADHD b. ADD (no hyperactivity) c. Learning disability d. Dyslexia e. Dysgraphia
   f. Dyscalculia g. Other, please specify:

Social developmental disorders, please indicate age diagnosed, severity, duration and treatment

a. Pervasive developmental disorder (PDD) ____
b. Asperger Syndrome ____
c. Hyperlexia ____
d. Autism ____
e. Other (please specify) ____

Behavioral and educational treatments, please indicate age, length of treatment and intensity

a. Resource room ____
b. Inclusion class ____
c. Accommodations ____
d. Special education ____
e. Speech therapy ____
f. Physical therapy ____
g. Occupational therapy ____
h. Applied behavioral analysis ____
i. Reading or writing assistance ____
j. Assistance in study skills ____
k. Assistance in mathematics ____
l. Assistance in social skills ____

Family History

Please indicate if any history in the child's biological family - mom, dad, aunts, uncles or grandparents:

Insomnia ______________________________

Snoring ______________________________

Sleep apnea ______________________________

Restless leg syndrome ____________________

Periodic limb movement __________________

Sleep walking/ terrors ____________________

Sleep talking ___________________________

Narcolepsy ___________________________

Pervasive developmental disorder___________

Epilepsy/ Seizures _______________________

Speech delay ____________________________

Gross motor delay _______________________

Fine motor delay ________________________

Global developmental delay _______________

Mental retardation _______________________

Low IQ ____________________________

Autism ____________________________

Asperger syndrome _______________________

Febrile seizures __________________________

Headaches ___________________________

Tic disorders ____________________

PANDAS/ PANS ____________________

PITANDS ____________________

Tourette syndrome ____________________

Cerebral palsy ____________________

SIDS ____________________

Recurrent strep throat ____________________

Recurrent ear infections ____________________

Learning disability ____________________

Dyslexia ____________________

Dysgraphia ____________________

Dyscalculia ____________________

ADHD ____________________

ADD ____________________

Chronic diarrhea ____________________

Chronic constipation ____________________

Gastro-esophageal reflux ____________________

Food intolerance ____________________

Irritable bowel syndrome ____________________

Ulcers ____________________

Celiac disease ____________________

Ulcerative colitis ____________________

Crohn's disease ____________________

Mood disorder ____________________

Depression ____________________

Obsessive compulsive disorder ____________________

Aggression/ self-harm ____________________

Anxiety disorder ____________________

Alcoholism ____________________

Bipolar disorder ____________________

Schizophrenia ____________________

Allergies ____________________

Asthma ____________________

Psoriasis ____________________

Hashimoto's thyroiditis ____________________

Lupus ____________________

Rheumatoid Arthritis ____________________

Autoimmune disorders ____________________

Hypothyroidism ____________________

Chronic abdominal pain ____________________

Chronic fatigue syndrome ____________________

Fibromyalgia ____________________

Bulimia ____________________

Anorexia ____________________

Breast cancer ____________________

Cancer ____________________

Diabetes ____________________

Genetic disorders ____________________

Hypertension ____________________

Blood clots ____________________

Anemia ____________________

Sickle-cell anemia ____________________

Alzheimer's disease ____________________

Parkinson disorder ____________________

Prematurity ____________________

Neural tube defects ____________________

Multiple miscarriages ____________________

Other ____________________

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CONSENT FOR THE USE OF E-MAIL FOR PATIENT COMMUNICATIONS

PARENTS OR PATIENT (OVER AGE 18) ARE/IS TO READ EACH PARAGRAPH AND INITIAL AT THE BOTTOM OF EACH PAGE

Patient's Name: ____

Date of Birth: _________________________________ Today's Date: ____________________________

Email to be used: ____

Pain Center NJ/ Asma Siddiqui, M.D. offers patients the opportunity to communicate by email for non-urgent matters. This form provides the guidelines regarding email communications and documents your consent.

IN CASE OF A MEDICAL EMERGENCY, DO NOT USE E-MAIL – CALL 911 OR GO TO THE EMERGENCY ROOM

Email communications should be between Pain Center NJ and any adult patients 18 years of age or older, or the parent/guardian of a minor. Do not use email for communicating sensitive medical information such as sexually transmitted diseases, HIV/AIDS, hepatitis, substance abuse, mental health or presence of malignancy. Do not use email to request records, please contact the office.

Although the office has implemented reasonable technical safeguards, the office cannot and does not guarantee the privacy, security or confidentiality of any email messages sent or received over the internet. There is a potential risk that email sent or received over the internet can be intercepted, altered, forwarded, and/or read by others. The office is not responsible for email messages that are lost due to technical failure during composition, transmission, or storage.

The office will not forward emails to independent third parties without your prior written consent, except as authorized or required by law.

Although the office will strive to read and respond within 24 hours to an email, we cannot guarantee that any particular email will be responded to within any particular period of time. If you have not received a response within 3 days, please call the office.

*I have read and understand the content of this page __________ (initials)

Email communications regarding treatment may be documented in your medical record by placing a copy of the message in your file. You may discontinue using email as a means of communication by

sending an email or letter to our office. I understand that I should only email the office from the email address that I have provided to the office. I understand that it is my responsibility to notify the office, in writing, of any change to this email address. Email should be only be used for non-sensitive and non-urgent issues.

By signing below, I certify that the email address which I have provided is accessible only by me, and that I do not share my email address with a spouse, my child, or any other person. I acknowledge that I have read and fully understand this consent form and that I voluntarily request the use of email as one form of communication with Pain Center NJ/Asma Siddiqui, M.D.

*I have read and understand the content of this page __________ (initials)

If patient is less than 18 years of age, or can't legally sign for himself/herself, parents' or legal guardians' handwritten signature are required.

____ ____

Patient's Name (Printed) Patient's Signature (if adult)

____ ____

Parent or Legal Guardian Name (Printed) Parent or Legal Guardian Signature

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Limited Authorization for Communication of Protected Health Information (PHI)

Patient Name _____________________________________ DOB _____________________

Persons to whom your medical information may be disclosed
Except for other physicians in connection with your ongoing care, insurance companies in connection with billing or claims, and state or federal healthcare agencies or law enforcement agencies (which are allowed by federal law), we cannot release ANY of your individually identifiable medical information any person or organization (including family members) unless you list their name below.

You agree that information described above may be disclosed to the following persons or organizations: (Please print legibly)

1. ____ Relationship _____________________
2. ____ Relationship _____________________
3. ____ Relationship _____________________
4. ____ Relationship _____________________

The purpose and type of information use or disclosure

A. Reporting of laboratory or other medical test results
B. General information (current medical condition, prognosis, medications, etc.)
C. Financial details of your billing activity or charges

Revocation: You may revoke this authorization by sending a written letter to: c/o Jaclyn Tedesco 329 Summerhill Road East Brunswick, New Jersey 08816. The letter must identify the name and date shown on the original form. It must also include the date you wish to cancel. Your letter will not affect any actions taken before your letter is received.

If the patient is less than 18 years of age, or can not legally sign for himself/herself, the parent's or legal guardian's handwritten signature is required.

___________________________________	___________________________________
Patient's Name (Printed)	Signature of Patient (if adult)
___________________________________	___________________________________
Parent or Legal Guardian Name (Printed)	Signature of Parent or Legal Guardian

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Patient Consent for Use and Disclosure of Protected Health Information and Receipt of Notice of Privacy Practices

I hereby give my consent for Pain Center NJ to use and disclose protected health information (PHI) about me or my child to carry out treatment, payment and healthcare operations (TPO). I have the right to review the Notice of Privacy Practices prior to signing this consent. Pain Center NJ reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Jaclyn Tedesco, phone 732-636-7888, fax 732-636-7887 or email paincenternj@gmail.com.

With this consent, Pain Center NJ may call my home or alternative location and leave a detailed message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my child's or my own clinical care, including laboratory results among others. With this consent, Pain Center NJ may mail to my home or other alternative location any items that assist with the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Pain Center NJ restrict how it uses or discloses my child's or my own PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Pain Center NJ using and disclosing my child's or my child's PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I don not sign this consent, or later revoke it, Pain Center NJ may decline to provide treatment to me or my child. I acknowledge I have received a copy of Pain Center NJ Notice of Privacy Practices.

If the patient is less than 18 years of age, or can not legally sign for himself/herself, the parent's or legal guardian's handwritten signature is required.

______________________________	______________________________
Patient's Name (Printed)	Signature of Patient (if adult)
______________________________	______________________________
Parent or Legal Guardian Name (Printed)	Signature of Parent or Legal Guardian

____
Date

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PATIENT CONTACT INFORMATION

Patient's First Name ______________________________________ DOB ____________________

Patient's Last Name ______________________________________ Gender __________________

Home Address ____

STREET

____

CITY STATE ZIP

Cell Phone # ____

Email Address ____

Who lives in the house? ____

Who referred you? ____

Parent or Legal Guardian Information

Mother's Name ____

Mother's DOB ____

Mother's Address ____

____

Mother's Tele # ____

Father's Name ____

Father's DOB ____

Father's Address ____

____

Father's Tele # ____

Insurance Information (for processing labs)

Policyholder's Name ______________________________________ DOB __________________

Insurance Company Name ____

Member ID # ____

Ins Group ID # ____

Claims Address ____

____

Provider Tele # ____

Pharmacy Information

Pharmacy Name ____

Pharmacy Address ____

____

Pharmacy Telephone ____

Pharmacy Fax ____

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PATIENT'S INFORMED CONSENT DOCUMENT FOR TESTING AND TREATMENT

PARENTS OR PATIENT (OVER AGE 18) IS TO READ EACH PARAGRAPH AND INITIAL AT THE BOTTOM OF EACH PAGE

Patient's Name: ____

Date of Birth: _________________________________ Today's Date: ____________________

1. I am the parent or legal representative of the minor child or person listed above for whom I am seeking treatment with Dr. Asma Siddiqui; or I am an adult, 18 years or older listed above seeking treatment with Dr. Asma Siddiqui. I do voluntarily consent for me or my child to receive care at Pain Center NJ encompassing, but not limited to, review of historical data, physical exam, laboratory tests, diagnosis and treatment by Dr. Siddiqui and her office.
2. I have specifically sought out the services and perspective of Dr. Asma Siddiqui for the way in which they practice medicine, including complementary and alternative medicine. I fully understand the following:
   a) Much of Dr. Siddiqui's treatment being recommended is not generally recognized as traditional but is an alternative method. This may include higher than the recommended daily allowance (RDA) of certain vitamins and minerals. Complementary and alternative medicine, like any other treatment or medication, may or may not alleviate or cure the condition(s) for which it is offered.
   b) Dr. Siddiqui believes that complementary and alternative medicine may be valuable to your or your child's health. However, as with any type of treatment or testing, you should fully understand the potential risks and benefits of the testing and/or treatments, as well as other available testing and treatment options, including lab work, before deciding where the work-up and following medical analysis and possible treatment provided by Pain Center NJ is right for you or your child. It is important that you read and understand the information contained in this form so that you can make an informed choice about being treated at Pain Center NJ and by Dr. Asma Siddiqui. If after reading this form you have any concerns or questions regarding testing and treatments, you should talk to your provider.
   c) The federal government, including Medicare and Medicaid, and most insurance companies, do not generally pay or reimburse for treatments (including intravenous treatments), vitamin and mineral supplementations recommended by the office.
   d) Some of the testing being recommended by Dr. Siddiqui is not recognized as traditional but are alternative testing methods.

   *I have read and understand the content of this page _______________ (initials)

e) The United States Food and Drug Administration (FDA) reviews the safety and effectiveness of particular uses of drugs but does not prohibit a physician from using his or her judgement to prescribe approved medications for "off-label" use. Some of the medications and other treatments that Dr. Siddiqui recommends or offers are considered off-label (e.g., not FDA approved for the particular use).
f) Some of the formulations prescribed at Pain Center NJ have not been tested by the FDA for determination of actual contents or the medical effectiveness of the formulations.
g) The medical/scientific proof of effectiveness/therapeutic value of some of the treatments prescribed by the office is disputed.
h) While Dr. Siddiqui believes that the complementary and alternative treatments may be beneficial to your or your child's health and well-being, the traditional medical and scientific communities sometimes dispute the medical/scientific proof of effectiveness or therapeutic value of these treatments. You are free to contact any medical group, doctor, or association on their view of any testing or treatment before you begin. Dr. Siddiqui believes the testing and treatments she oversees are valuable and might improve your or your child's health.
i) I may leave the care of Dr. Asma Siddiqui at any time. It was my independent choice to see Dr. Siddiqui and it was always my choice whether to continue with her. I also understand that Pain Center NJ reserves the right at any time and without cause, to discontinue treating any patient due to poor compliance with Dr. Siddiqui's recommended program or for any other reason.

3. I desire to have further investigation into the possible biological and/or biochemical problems which either coexist with and/or contribute to my or my child's problems.
4. I agree to the use of blood, urine, hair, fecal and/or other body fluid or tissue specimens for study by various laboratories selected by Pain Center NJ in consultation with me.
5. I have been informed that Pain Center NJ does not accept any type of insurance for <u>any and all</u> treatments/services rendered for Autism treatment and are unable to bill insurance for me. I understand that I am responsible for payment for all services, and that payment is due when services are rendered. I have had an opportunity to review the fee(s) prior to consultation and/or procedures.
6. I understand that I am responsible for filing my own insurance claims, and that my insurance company may not provide coverage for consultations, diagnostic testing, and/or other procedures or treatments. I understand that insurance companies, Medicare and Medicaid, always reserve the right to not pay for certain medical services, including laboratory tests and treatments. Medicare, Medicaid and some insurance companies sometimes do not cover some of the labs and medications/treatments ordered by Dr. Siddiqui. Dr. Siddiqui orders lab tests for those things which she deems are medically necessary or appropriate. You may be asked to pay for these services by the individual laboratory companies if your insurance refuses to pay for the claim. I understand that if I submit my bill to my insurance company, the insurance company may request a letter of medical necessity, phone calls and/or medical documentation to support the coverage of the medical procedure or visit. I understand that Pain Center NJ reserves the right to charge me for any letters and other related services.
7. I understand that Pain Center NJ/Dr. Asma Siddiqui makes no promise or guarantee of outcome, or offer of cure or improvement through any process, procedure or medical treatment offered
*I have read and understand the content of this page ________________ (initials)

by PCNJ/Dr. Asma Siddiqui. I understand and have been advised that the treatments and

8. therapies offered by PCNJ may not have been proven effective by traditionally accepted medical studies (e.g., randomized, double-blind, placebo-controlled studies) for my or my child's diagnosis.
9. I also understand and have been advised regarding possible adverse effects of the treatments and therapies that PCNJ will be providing me such as the possible adverse effects of intravenous (IV) treatments which may include, but are not limited to the possibility of infections, phlebitis, headaches, dizziness, hypoglycemia, electrolyte imbalance, mineral depletion, fatigue, kidney failure, or even death.
10. I understand that is may be necessary for my child to be restrained for the purpose of drawing blood or providing intravenous medications, and that my child would be restrained for those purposes only with my consent. At no time will my child be restrained without my constant physical presence or left unmonitored by a PCNJ staff member.
11. I agree to allow a PCNJ staff member to photograph my child/self for in-office use.
12. If seeking care for my child, I will continue to provide appropriate behavioral, speech, physical, occupational and/or other therapies to my child, which may be prescribed by another physician, to assist in his/her care.
13. I consent to the use of data derived from the study, testing or treatment of myself or my child, apart from his/her/my name and other identifying information, in the eventual publication of outcomes of this treatment or care.
14. I agree to let PCNJ consult with or share the data concerning myself or my child, absent my or my child's name and other identifying information, with other physicians, professors, and other affiliations that they deem relevant.
15. I acknowledge that I have received and reviewed a copy of the Notice if Privacy Practices (HIPAA privacy laws) under which PCNJ practices.
16. I acknowledge that I have received and reviewed a copy of the Frequently Asked Questions form and a copy of the Appointment Cancellation Policy for PCNJ. I understand that I may be billed for missed appointments as stated in the policy.
17. I understand if PCNJ prescribes certain medications to me or my child, I agree that certain laboratory tests must be conducted. I understand that certain laboratory tests, such as complete blood count and chemistry screen, among others must be monitored for evidence of side effects, which are rare, but important to identify when they occur. Potential side effects of some medicine prescribed by PCNJ include elevations in liver enzymes or changes in white blood cell counts. I understand that PCNJ will obtain these labs at baseline and then every 4-8 weeks while on certain medications. The PCNJ staff has been instructed not to refill medications when the indicated lab work has not been completed. When labs are obtained outside the local area, it is the patient's or parent's responsibility to give our contact information to the lab in order for us to receive the results.
    a) I understand that I have the right to review the laboratory monitoring results with the medical group. I also have the right to ask questions and understand the risks and benefits associated with laboratory monitoring.
    b) I understand that I must comply with laboratory monitoring. I also understand while I am, or my child is, undergoing laboratory monitoring, I or my child should maintain a healthy

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lifestyle. I agree that I or my child should maintain the prescribed program of nutritional supplements. Further, I am responsible to disclose any health concerns which arise while complying with laboratory monitoring.

c) I understand that results will only be reported to PCNJ, or designee and/or others as entitled by law. I also understand and agree that information obtained from the lab may be used in scientific publications or presentations, but the identity of all individuals studied will not be revealed in such publications or presentations.

18. I understand that Dr. Siddiqui is not a primary care physician for my child or me, and that I will maintain a relationship with a primary care physician/provider for myself or my child.
19. I understand that I or my child need to have an in-office appointment with PCNJ at least once per year.
20. I understand that I have the right to ask questions and understand the risk and benefits associated with any treatment that may be recommended by PCNJ. I understand I may ask questions I may have about treatment at any time and that my physician and other staff will try to answer my questions as fully, fairly and understandably as possible.

*I have read and understand the content of this page ________________ (initials)

I, THE UNDERSIGNED, HAVE READ AND FULLY UNDERSTAND THE ABOVE INFORMATION, THE ELEMENTS OF MY INFORMED CONSENT TO UNDERGO COMPLEMENTARY AND ALTERNATIVE TESTING AND TREATMENT WITH DR. ASMA SIDDIQUI/ PAIN CENTER NJ. I UNDERSTAND THAT THE TESTING AND TREATMENT BEING UTILIZED AND DESCRIBED BY PCNJ IN THIS DISCLOSURE STATEMENT IS NOT ALWAYS ENDORSED, APPROVED, ACCEPTED, OR SUPPORTED BY OTHER PHYSICIANS OR THE GENERAL MEDICAL COMMUNITY. INFORMATION ABOUT ME AND MY RECORDS WILL BE CONFIDENTIAL. DATA WILL BE STORED SECURELY AND WILL BE MADE AVAILABLE ONLY TO THE PERSONS PARTICIPATING IN MY OR MY CHILD'S EVALUATION AND SUBSEQUENT TREATMENT, IF ANY, UNLESS I SPECIFICALLY GIVE PERMISSION IN WRITING UNLESS OTHERWISE REQUIRED BY LAW.

If the patient is less than 18 years of age, or cannot legally sign for himself/herself, parent's or legal guardian's handwritten signature are required.

______________________________	______________________________
Patient's Name (Printed)	Patient Signature (if adult)
______________________________	______________________________
Parent or Legal Guardian (Printed)	Parent or Legal Guardian Signature