Cover sheet. *Fax to: 973-972-2825*
Or send by email to: TailbonePain@gmail.com

Or send by postal mail to the address below.

From an Incoming Coccyx Patient

To: **Patrick M. Foye, M.D.,** (and staff)
Director, Coccyx Pain Center (Tailbone Pain Center)
Professor of Physical Medicine & Rehabilitation,
Rutgers New Jersey Medical School, 90 Bergen Street, DOC-3100, Newark NJ 07103
Phone: 973-972-2802. Fax: 973-972-2825
www.TailboneDoctor.com

From (Patient NAME, *PRINT or Type*): _____

Patient's Fax # or email address: _____

Patient's Phone #: _____

Today's Date: _____

AFTER you **Send in** this COMPLETED paperwork to our office **THEN** an appointment will be made.
You can send in these papers by Fax, by email, or by Postal mail.
Note that we can not guarantee the confidentiality of unencrypted emails, so we offer this option for your convenience but you assume the risks in exchange for the convenience and speed of emails.

Note that visits are ONLY for patients who are willing and planning to travel to see Dr. Foye in-person in New Jersey. Others can use Dr. Foye's free educational videos & articles online, and his book on Amazon.

AFTER completing and sending in this form, staff **will call you** to make your first appointment, possibly as a Telemedicine visit. If you have not heard from us in 4 business days, then call 973-972-2802 to check status.

Checklist of items to send to us before you first appointment:

- **Your Insurance card(s):** include a copy of the front and the back.
- **This paperwork**
  - "**Questionnaire** for Coccyx Patients", fully completed.
  - **Pain Diagram.**
  - **Registration form** (providing your name, address, insurance information, etc)

Optional items below (send them in, if you can):

- **Radiology Reports:** the typed reports from any coccyx-related X-rays, MRI, CT scans, etc.
  - You can usually get these from the Radiology Center or from your doctor's office.
  - If you can not get them, that's OK. But if you can get them then please send these in now.
- **Computer CD images:** from coccyx-related X-rays, MRI, CT scans, etc.
  - You can usually get these from the Radiology Center. Just call them and ask.
  - If you can not get them, that's OK. But if you can get them then please send these in now, or at least get them yourself for now, in case we will need you to send these in later.
  - They need to be on a computer CD. We can not accept USB's or portal links for these.
  - At the initial visit, Dr. Foye will decide which of these imaging studies he needs to review.

UNIVERSITY REHABILITATION ASSOCIATS (Patient Registration Form)

Please verify the completed information for accuracy and provide all information. If an item does not apply, write N/A

1. Name _____ Preferred name (if different) _____ 2. Date of Birth _____

3. Gender Identity: ○ Male/Man ○ Female/Woman ○ Genderqueer/Gender nonconforming ○ Other / Something else

○ Transgender male / TransMan ○ Transgender Female / TransWoman ○ Questioning ○ Choose note to disclose

4. Home Phone _____ 5. Cell Phone _____

6. Social Security # _____

7. Address _____ City _____ State _____ Zip _____

8. Parent/Guardian _____ Address (if different) _____

9. To assist with your care, medical/appointment information can be left at your phone #s unless you mark this box: ☐ No

10. In case you are in a life threatening situation would you like to be kept on life support? ○ Yes ○ No ○ Undecided

11. Race _____ 12. Marital Status ○ Single ○ Married ○ Legally Separated ○ Divorced ○ Widowed

13. Are you an organ donor? ○ Yes ○ No 14. Religion _____ Church _____

15. Your maiden name _____ 16. Mother's maiden name _____

PATIENT'S EMPLOYMENT

17. Patient's Employer _____

18. Work Status: ○ Full time ○ Part time ○ Retired ○ Unemployed 19. Employment Date _____

20. Department _____ 21. Occupation _____ 22. Phone _____

23. Address _____ City _____ State _____ Zip _____

NEAREST RELATIVE

24. Name _____ 25. Relationship to the patient _____

26. Home Phone _____ Work phone _____ Cell Phone _____

27. Address _____ City _____ State _____ Zip _____

EMERGENCY CONTACT (person not living with you)

28. Name _____ 29. Relationship to the patient _____

30. Home Phone _____ Work phone _____ Cell Phone _____

31. Address _____ City _____ State _____ Zip _____

Accidents

33. Is this a result of an AUTO accident? ○ Yes ○ No (If yes, where in the vehicle were you? ○ Driver ○ Passenger ○ Other)

34. Is this a result of a WORK related injury? ○ Yes ○ No

35. Date of accident _____ 36. Has claim been established? ○ Yes ○ No

37. Attorney name _____ 38. Attorney phone _____

Insurance Information

39. Company _____ 40. Phone _____

41. Address _____ City _____ State _____ Zip _____

42. Policy # _____ 43. Group # _____ 44. Adjuster _____

45. Relation to insured: ○ Self ○ Spouse ○ Child ○ Other: _____

46. Insured _____ 47. Insured's SSN _____ 48. Insured's DOB _____

Other Insurance

49. Company _____ 50. Phone _____

51. Address _____ City _____ State _____ Zip _____

52. Policy # _____ 53. Group # _____ 54. Adjuster _____

55. Relation to insured: ○ Self ○ Spouse ○ Child ○ Other: _____

56. Insured _____ 57. Insured's SSN _____ 58. Insured's DOB _____

59. **Referred by** _____

If you have an HMO

- It is the **patient's responsibility** to know whether a referral is needed to see our physician(s) and to bring it at the time of the visit.
- If no referral is brought in, a referral can not be obtained after the visit and bill for the visit can not be submitted later to the insurance company as per New Jersey State and federal guidelines.
- Although we will try to assist you in any way reasonable possible, it is also the patient's responsibility to know what is covered by his/her contract.
- **Co-pays are due at the time of the visit.**
- If patient does not supply referral and chooses to go out of network, they can not submit bill to insurance company.
- If you choose to self pay for office visit, please sign and date

Outstanding deductible payments are expected at time of service unless special arrangements are made

I certify that outpatient services were rendered to me at the place of service indicated on this date. I hereby authorize release of information needed to collect from my insurance carrier and authorize payment directly to University Rehabilitation Associates of any insurance benefits otherwise payable to me for this visit. I also understand that I am financially responsible for all charges whether or not covered by insurance. By typing your name and date below, you are signing this form electronically, and indicating that you understand and agree with information stated above. You are also indicating that all the information is accurate to best of your knowledge.

Please Sign or Type your name below

Patient Name/Sign _____ Date _____

RUTGERS
New Jersey Medical School

Physical Medicine and Rehabilitation
Musculoskeletal Medicine
Pain Management

COCCYX PAIN CENTER
www.TailboneDoctor.com

Patrick Foye, MD, Professor, PM&R
New Jersey Medical School
Rutgers, The State University of New Jersey
90 Bergen Street, DOC Suite 3100
Newark, NJ 07103-2499
Phone: 973-972-2802 Fax: 973-972-2825

ASSIGNMENT OF BENEFITS FORM

Patient Name (print) _____

I irrevocably assign to "University Rehabilitation Associates" (part of "University Physician Associates") all of my rights and benefits under any insurance contracts for payment for services rendered to me by University Rehabilitation Associates.

I irrevocably authorize all information regarding my benefits under any insurance policy (relating to any claims by University Rehabilitation Associates) to be released to University Rehabilitation Associates.

I irrevocably authorize University Rehabilitation Associates to file insurance claims on my behalf for services rendered to me.

I irrevocably direct that all such payments go directly to University Rehabilitation Associates.

I irrevocably agree to cooperate with the insurer, including, but not limited to, attending requested physical examination(s) and completing all necessary paperwork.

I irrevocably authorize University Rehabilitation Associates to act on my behalf and report any suspected violations of improper claims practices to the proper regulatory authorities.

In the event that my insurance company does not reimburse University Rehabilitation Associates, I understand that I will be held personally responsible for payment of all charges for services rendered, including co-insurance and deductible fees according to the terms of my policy.

This assignment of benefits has been explained to my full satisfaction and I understand its nature and effect.

By typing your name and date below, you are signing this form electronically, and indicating that you understand and agree with information stated above.

Patient Name/Sign _____ Date _____

PAIN DRAWING

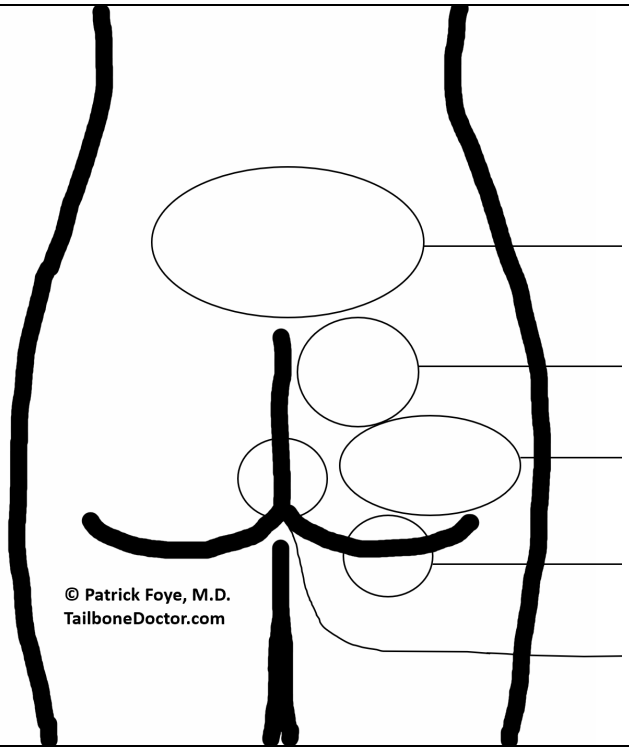
Patrick Foye, M.D., Director of the Coccyx Pain Center, Rutgers New Jersey Medical School
90 Bergen St., DOC Suite 3100, Newark, NJ 07103 Phone: 973-972-2802. Fax: 973-972-2825

Name: _____ **Date:** _____
[Nombre y Apellido] *[Fecha]*

Part 1)
Look at the sketch showing the back of the body, at the buttock area.

Which of the circled, labeled areas are places where you are having pain?

[Mira la imagen. ¿Cuáles de las áreas etiquetadas son lugares donde tiene dolor?]



BACK [*DE ESPALDAS*]
LEFT (Lado Izquierda) **RIGHT** (Lado derecho)

Part 1, continued)
For the areas matching the circles and ovals, mark any areas where you have pain:

○-Low Back: ○-Right ○-Left

○-Upper Buttocks: ○-Right ○-Left

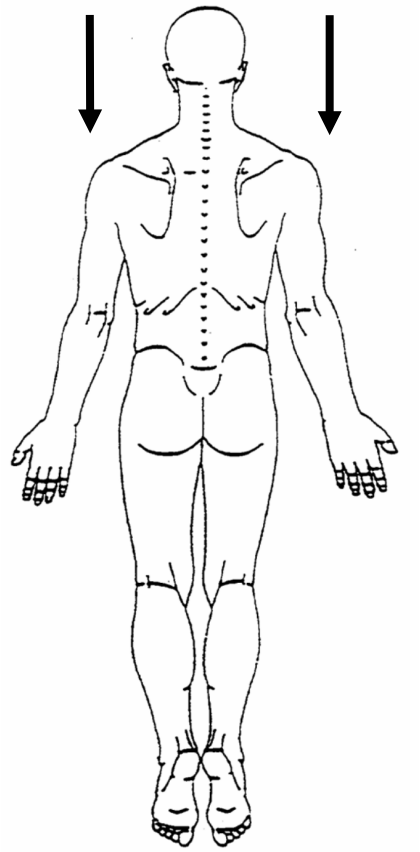
○-Lower Buttocks: ○-Right ○-Left

○-Sit bone: ○-Right ○-Left

○-**Tailbone**

Part 2)
Draw on the diagram to show where your pain is.

[Dibuje en el diagrama de abajo para mostrar la ubicación de su dolor.]



Part 3)
Also mark any of these areas if you have pain there:

☐-Groin pain: ○-Right ○-Left

☐-Hip pain: ○-Right ○-Left

☐-Leg pain: ○-Right ○-Left

☐-Anal pain
☐-Rectal pain
☐-Pain with Bowel Movements

☐-Genital pain

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QUESTIONS for Patients to Complete In Advance and Send to Dr. Foye

(Questionnaire for Patients with COCCYX PAIN) This helps us to take care of you. (Unanswered questions decrease our ability to help you.)

Last Name: _____ First Name: _____

Date form completed: _____

Is coccyx (tailbone) pain a primary area of concern? ◯ Yes | ◯ No. If no, explain:

_____

Referred by: ◯ Self / Internet ◯ Clinician (name): _____

Patient's Home city/state: _____

How are you coming to see Dr. Foye in N.J.? ◯ Driving | ◯ Flying (FYI: best airport is 'Newark Liberty') | ◯ Train

Email address – where patient wants personal medical emails from Dr. Foye (Type, or print very *very* very clearly):

_____

What is your best phone number? _____

Age: _____

Gender: ◯ Male | ◯ Female | ◯ Other: _____

Occupation (specify job title): _____

When did your symptoms start?: _____

Mark here if your coccyx/pelvic pain was caused by: ◯- An on-the-job injury. | ◯- An automobile injury.

Do you have a current or potential legal case or lawsuit regarding your coccyx/pelvic issues? ◯ Yes | ◯ No

Please write a few paragraphs (summarizing how your symptoms started and your treatment so far)

Identifiable traumatic incident:

Was there any recent coccyx trauma:
(e.g. within a few months before symptoms started): _____

Was there any remote (long ago) coccyx trauma: _____

What makes your pain worse?

Is your pain worse **while sitting**? ……. ◯ Yes | ◯ No

Is pain with sitting worse when you **lean partway backwards**? …… ◯ Yes | ◯ No

Does the pain initially feel **worse** when first going **from sitting to standing**? ◯ Yes | ◯ No

Any other things that make the coccyx pain worse? Explain: _____

Cushions

Have you tried a "**donut**" cushion? (i.e. with the hole in the middle?) ◯ Yes | ◯ No |

Have you tried a "**wedge**" cushions? (i.e. with cut out of the back?) ◯ Yes | ◯ No |

Sitting Tolerance: How long can you sit before the pain makes you change position? _____ minutes

Severity of the coccyx pain: (0-10 scale, 0=no pain, 10=most painful): At best _____ At worst _____ Average _____

Skin: near you coccyx / buttock, have you had any of the following: (check if positive)

☐ Rash ☐ Itching ☐ Pressure sore (Bed sore) ☐ None

Pilonidal cyst: near midline at crease/crevice between buttocks, have you had: (check if positive)

☐ Tender lump ☐ Itching ☐ Hole / Opening ☐ Discharge / Drainage ☐ Odor ☐ None

Have you ever been **TOLD** that you **HAVE** a "pilonidal cyst? ◯ No | ◯ Yes (if yes, specify what year: _____)

Cancer Risk factors: (check if positive) (For any of these, promptly see your primary doctor and/or other specialists)

☐ Unexplained weight loss ☐ Blood from your anus ☐ Abnormal vaginal bleeding ☐ None

Have you ever been diagnosed with any cancer?

☐ None ☐ Colon/Rectum ☐ Prostate ☐ Testicular ☐ Ovarian ☐ Cervical

☐ Other cancers (explain): _____

If yes, what year was that and how was it treated? _____

Pudendal nerve: **at your GENITAL region, have you had:** ☐ Pain ☐ Numbness ☐ Tingling ☐ None

Have you ever been told that you have pudendal nerve problems? ◯ Yes | ◯ No

Specialists (Who you have already seen? Indicate if you have seen any of the following for this pain)

Primary Care Physician: ◯ Yes | ◯ No

Pain Management Doctor: ◯ Yes | ◯ No

Orthopedics/Musculoskeletal/PM&R: ◯ Yes | ◯ No

Surgeon: ◯ Yes | ◯ No

Chiropractor: ◯ Yes | ◯ No

Gynecologist: ◯ Yes | ◯ No

Physical Therapy: ◯ Yes | ◯ No

Pelvic Floor Physical Therapy: ◯ Yes | ◯ No

Other: _____

Interventional Pain Management INJECTIONS (and whether the injection helped)

Type of Injection	How many?	Dates (or at least the year)	Was it helpful?
Coccyx injection with **STEROID** (**blind = withOUT** fluoroscopy)			◯ Yes | ◯ No
Coccyx injection with **STEROID** (**with** fluoroscopy)			◯ Yes | ◯ No
Ganglion Impar (sympathetic nerve block)			◯ Yes | ◯ No
Epidural steroid			◯ Yes | ◯ No
Piriformis muscle			◯ Yes | ◯ No
Pudendal nerve			◯ Yes | ◯ No
Sacroiliac joint			◯ Yes | ◯ No
Facet joint			◯ Yes | ◯ No
Other low back / pelvic injections			◯ Yes | ◯ No

Imaging Studies: Please obtain and **PROVIDE** the typed **radiology reports** for any tests **related to the coccyx**.
Dr. Foye will want to see the **actual images** (on computer CD or actual films) **AND** see the **radiology reports**.
Call your radiology facility to get a copy of the actual images and the official/typed radiology report (**important**).

	Done?	Dates	If done, Can you **provide** to us the:	
			Radiologist report?	**Actual images? (computer CD)**
LumboSacral Spine (X-ray)	◯ Yes | ◯ No		◯ Yes | ◯ No	◯ Yes | ◯ No
LumboSacral Spine (CT scan)	◯ Yes | ◯ No		◯ Yes | ◯ No	◯ Yes | ◯ No
LumboSacral Spine (MRI)	◯ Yes | ◯ No		◯ Yes | ◯ No	◯ Yes | ◯ No
Coccyx (X-ray) **withOUT seated**	◯ Yes | ◯ No		◯ Yes | ◯ No	◯ Yes | ◯ No
Coccyx (X-ray) **seated/dynamic**	◯ Yes | ◯ No		◯ Yes | ◯ No	◯ Yes | ◯ No
Pelvis (X-ray)	◯ Yes | ◯ No		◯ Yes | ◯ No	◯ Yes | ◯ No
Pelvis / Coccyx (CT scan)	◯ Yes | ◯ No		◯ Yes | ◯ No	◯ Yes | ◯ No
Pelvis / Coccyx (MRI)	◯ Yes | ◯ No		◯ Yes | ◯ No	◯ Yes | ◯ No
Bone Scan	◯ Yes | ◯ No		◯ Yes | ◯ No	◯ Yes | ◯ No

Medications

Current Pain Medications List and specify doses and how often you take these:	**Any other current** medications (NOT for pain). List **withOUT** specifying any dose or frequency:

Prior Pain medications that you have tried in the past

Non-Steroidal	Nerve pain	Opioid painkillers	Topical	Other pain meds	Any other medications you tried:
☐ Ibuprofen Motrin Advil ☐ Naproxen Naprosyn	☐ Neurontin Gabapentin ☐ Lyrica ☐ Cymbalta	☐ Percocet / Roxicet ☐ Oxycodone ☐ OxyContin ☐ Tylenol /w Codeine (T#3)	☐ Lidoderm Lidocaine ☐ Flector Diclofenac ☐ Voltaren gel	☐ Tylenol ☐ Tramadol Ultram	

Allergies (check if positive): ☐ Medical contrast | ☐ Iodine | ☐ Shellfish | ☐ Lidocaine
List any **other medication allergies**: (reaction – what happens)

Past Medical History: List any medical conditions that you have had

◯ High Blood Pressure | ◯ Diabetes | ◯ High Cholesterol | ◯ Pelvic Floor Pain

◯ Cancer (if yes, explain): _____

Other (please list):

Surgical History: Have you had coccyx surgery (coccygectomy)? ◯ No | ◯ Yes (If yes: Date _____)

List any/all other surgeries you have had and the approximate year of each surgery:

Body Weight

Current height: _____ ft _____ in Current weight: _____ pounds

Did your weight significantly change before the coccyx pain started? ◯ No | ◯ Increase | ◯ Decrease

If yes, please explain _____

SCREENING for OTHER conditions (different from the focal coccyx pain that Dr. Foye will see you for):

Dr. Foye provides expert-level, laser-focus attention for your coccyx . For other areas, other specialists may be needed:

	***If* you have any of the symptoms listed below…**	***Then* see this type of Specialist:**
Rectum/anus:	Any constipation, diarrhea, bright red blood per rectum, melena [black, tarry stool], fecal incontinence, rectal or anal pain or itching, hemorrhoids, pain with bowel movements [including coccyx pain with bowel movements], etc.	See: Colorectal doctor or Gastroenterologist.
Urinary/Bladder:	Any urinary incontinence, urgency, pain with urination, other urine symptoms	See: Urologist.
Cancer	Any current/prior cancers, especially prostate, ovarian, cervical, colon, testicular or other intra-pelvic cancers. Any abnormal rectal or vaginal bleeding, any unexplained weight loss, fevers, chills, night sweats, etc.	See: Primary doctor and Oncologist.
Pudendal nerve:	Any pain, tingling, or numbness in the genital region. Pain with sex.	See: Urologist or Gynecologist.
Pilonidal cyst	Any history of prior pilonidal cyst? Any tender lump, itching, or rash near the midline at the crease/crevice between the buttocks, any notable “hole” [opening, i.e., sinus tract] perhaps with discharge/drainage and odor.	See: General surgeon.
Infections:	Any fevers/chills, local skin redness/warmth/swelling/discharge/odor/abscess:	See: Primary doctor or Infectious Disease
Mental Health:	Depression, Anxiety, Hopelessness, Thoughts of harming yourself.	See: Psychiatrist, Psychologist.
Pelvic Floor:	Any pain/difficulty with sex, urination, bowel movements, pelvic muscle pain, etc.	See: Pelvic Floor Physical Therapy
OB/GYN	Any pregnancy, uterine/vaginal pain, abnormal vaginal bleeding, any imaging studies showing uterine fibroids, ovarian cysts, endometriosis, etc..	See: Gynecologist

Patient Signature (Below)

The patient agrees to see any relevant Primary Care Physician, Gastroenterologist, Urologist, Ob/Gyn, Surgeon, Dermatologist, etc., for any care related to those or other medical specialties (areas not treated by Dr. Foye). Patients who send or accept medical emails accept the inherent potential confidentiality risks of unencrypted emails.

By typing or signing your name and date below, you are indicating that all the information you provided is accurate to the best of your knowledge. You are also indicating that you understand and agree with information stated above.

Please sign or type your name:

Patient Name/Signature: _____ **Date:** _____

RADIOLOGY: IMAGING STUDIES

REMINDER:

This page is to remind you to include a copy of any **RADIOLOGY REPORTS** for imaging studies that you have had done of your lumbosacral spine, pelvis or coccyx.

Optional items below (send them in, if you can):

- **Radiology Reports:**
  - These are the typed reports from any coccyx-related X-rays, MRI, CT scans, etc.
  - You can usually get these from the Radiology Center or from your doctor's office.
  - If you can *not* get them, that's OK.
  - But if you *can* get them then please send these in now.

- **Computer CD images:**
  - Dr. Foye will probably want to see the actual images from coccyx-related X-rays, MRI, CT scans, etc., that you have already done.
  - You can usually get these images from the Radiology Center. Just call them and ask.
  - The Radiology center will usually give them to you on a computer CD.
  - If you can *not* get them, that's OK.
  - But if you *can* get them then please send these in now, or at least get them yourself for now, in case we will need you to send these in later.
  - They need to be on a *computer CD*. We can *not* accept USB's or portal links for these.
  - At the initial visit with you, Dr. Foye will decide which of these imaging studies he will need to review.

This Page is a Reminder to
Make a Copy of Your *INSURANCE CARD*, Both Front and Back.

Send a Copy of Your *INSURANCE CARD:* send it in with your other papers.

If you are using this as a Fillable-PDF, you can click on the box and insert a photo of your insurance card below.

Front of Insurance Card:

Back of Insurance Card:

Understanding medical costs… Your Out-of-Network billing and Out-of-Pocket costs

- This office is in-network with the following: Medicare, essentially all versions of Medicaid in New Jersey, New Jersey Charity Care, and various other insurance plans.
- But essentially no medical office is in-network with every single insurance plan nationwide.
- So, we also see patients from around the county (and from around the world) as "Out-of-Network."
- **Thus, we are happy to see you here *either way*: whether you are In-Network *or* Out-of-Network.**

1. **If your insurance company is out-of-network**, then the university has zero guarantee of any payment from your insurance company. Out-of-network means that your insurance company has no written contract with the university to say how much your insurance company will pay, if anything at all.

2. **Your out-of-pocket payment is due on the date of service**. This serves as a deposit towards covering the costs of the medical care provided. This is typically a small fraction of the overall medical bill. This is paid by the patient on the date of service. Most patients find this to be very affordable and a terrific value, especially for the high-quality, subspecialty, expert medical care that is provided. Please call the office staff here and they can provide you with a very detailed estimate of those costs. This way your Out-of-Pocket payment on the date of service will be very predictable for you. Note that medical care here is not considered as a medical 'emergency' and the Out-of-Pocket costs are not considered as a 'surprise' since we make those fully available to you in advance. (For example, usually that amount is between $200-230 for the Initial Evaluation, and $100-130 for a Follow-Up Visit.) (This is the same for both in-person office visits and Telemedicine visits.)

3. **The university will attempt to collect the full billing amounts from your insurance company.** This can take several months. You will probably receive copies of bills/letters that go back and forth between the university and your insurance company. Thus, you can watch as they sort that out between them. Do not stress out regarding those mailings. **It is often best to just let them work that out between them until they reach a final agreement.** They will eventually decide whether the insurance company will pay any of the bills, and if so then how much.

4. **If you are still getting copies of bills/letters more than 6-7 months after your date of service, then call our office or fax us a copy.** Then our staff can reach out to the medical billing service to help look into that for you. (Billing here is not done directly by this office. The university uses an off-campus medical billing service.)

5. Your insurance company may decide to pay some of the bills for the medical care that you receive here. That payment typically is paid from your insurance company to the university here (to the university's billing service). But in rare instances this money that is owed to the university instead gets sent to the patient (sent by the insurance company). This is an weird situation since the money is owed to the university but is sent instead to you. **If your insurance company sends their payment to you personally, then you are required to promptly forward that payment to the university.**

6. **Seated x-rays at University Hospital:** The sitting-versus-standing coccyx x-rays done here in our building are done through the outpatient part of University Hospital's Radiology Department. From an insurance perspective this is a totally different facility/visit than our private doctor's office. Thus, you can check whether "University Hospital, Newark" is in-network for your x-rays. (Note that most other radiology centers have never even heard of sitting-versus-standing coccyx x-rays. They have no experience doing them, so they fail to do them properly. Thus, it is usually very, very worthwhile to have them done here.) The billing for the x-rays is via "University Hospital". It is not through our office.

7. Note that this is not formal or rigid advice about your medical bills/insurance. Every insurance plan is different, so while our office staff can provide this general information and answer various billing/insurance questions, patients can also get information directly from their insurance company if such details are needed. Meanwhile, the ultimate decisions regarding whether to come for medical care is up to the patient, not their insurance company. We are happy to provide your medical care here, regardless of whether your insurance company is in-network or not. You should seek the best care.